EMPLOYERS' FORUM OF INDIANA
Addressing the challenges of the local healthcare marketplace

2020 Legislative Health Summary

In this document, we summarize 13 health-related bills passed into law during 2020 Indiana legislative session. This short, non-budget legislative session began January 6th and concluded March 11th. In total, 911 bills were introduced including 455 House of Representative bills of which 89 passed into law for a 19.6% pass rate and 456 Senate bills of which 79 passed for a 17.3% passing rate. SEA 5 and HEA 1004 were the Forum's primary focus this legislative session. We hope this legislative summary is of benefit.

Of note, weblinks are best suited to open with Google Chrome. This summary information is provided as a courtesy and is not to be construed as authoritative. Readers are encouraged to review legislative enrolled act links provided after each section. The information presented in this document is based upon the "latest version" of enrolled acts noted on the Indiana General Assembly Website, as of June 28, 2020.

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SENATE ENROLLED ACTS

I. SEA 1: Tobacco and Vaping Smoking Age (Sen. Ed Charbonneau)

A. Effective July 1, 2020.

B. *Age Restrictions*

1. Prohibits a person who is less than 21 years of age from buying or possessing tobacco, e-liquids, or electronic cigarettes.

C. *Retail Establishments*

1. A retail establishment that sells an e-liquid to a person less than 21 years of age is subject to a civil judgment for an infraction.
2. Provides that a retail establishment in which tobacco products, electronic cigarettes, and e-liquids account for at least 85% of the retail establishment's gross sales:
    a. may not allow a person who is less than 21 years of age to enter the retail establishment
    b. is not subject to a statute prohibiting sales of tobacco or electronic cigarettes through a self-service display
3. Makes changes regarding enforcement provisions, sales certificates, prohibition of delivery sales, and notices posted at retail establishments and at vending machines.
4. Requires a merchant who mails or ships cigarettes as part of a delivery sale to use a shipping service that requires a customer to present identification if they appear to be less than 30 years of age.
5. Prohibits a tobacco business from operating within 200 hundred feet of a public or private elementary or secondary school, unless:
    a. operating before April 1, 1996;
    b. operating after April 1, 1996, if at the time the tobacco business was not located in an area prohibited under this section; or
    c. began operating after June 30, 2020
6. Prohibits a tobacco and vaping business from operating within 1000 feet of a public or private elementary or secondary school unless:
    a. operating before July 1, 2020; or
    b. began operating after June 30, 2020, if at the time the tobacco and vaping business began operating in an area not prohibited under this section.

D. *Tobacco Sales Certificate*

1. Provides that a tobacco sales certificate may only be issued to a person who has not had such a certificate revoked by the commission within one year.

E. *Reprimands*
   1. A retail establishment that sells or distributes tobacco, an e-liquid, or an electronic cigarette to a person less than 21 years old commits a Class C infraction and civil penalties double to $400-$2000 depending on how many prior infractions the establishment has had.
   2. Violations of a tobacco or a tobacco and vaping business result in a Class C misdemeanor, with exceptions noted above.
   3. Makes it a Class B infraction for a person to knowingly sell tobacco, an e-liquid, or an electronic cigarette that contains vitamin E acetate.

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II. SEA 5: Health Provider Contracts (Sen. Ed Charbonneau)

A. *Provider Price Transparency (note: the federal final rule on price transparency which is more comprehensive goes into effect January 1, 2021. It is currently being litigated and should the federal rule be upheld, it likely will supersede state law)*
   1. Effective March 31, 2021.
   2. Requires hospitals and ambulatory outpatient surgical centers to post certain information on their Internet web sites about health care services they provide, including the "weighted average negotiated charges" for the services.
      a. Requires the weighted average negotiated charge per service and a description of shoppable and common services be posted for the following:
         1. As many of the 70 shopping services that have been specified per existing CMS rules (84 FR 65524), in addition to the 30 most common services provided per individual hospitals and ambulatory care centers, for a total of 100 services.
         2. The weighted average negotiated charge per service must be displayed for the following categories:
            a. An employer described as "any non government sponsored health benefit plan or insurance plan provided by a health carrier in which the provider is in the network".
            b. Medicare, including fee for service and Medicare Advantage.
            c. Self-pay without charitable assistance from the hospital or ambulatory outpatient surgical center.
            d. Self-pay with charitable assistance from the hospital or ambulatory outpatient surgical center.
      b. Updated on an annual basis.

3. Requires Urgent Care Facilities to post a description and weighted average negotiated charge (as described above) and update an annual basis for the 15 most common services provided by the facility.

B. *Insurer Disclosure of Fees and Commissions*
   1. Effective July 1, 2020.
   2. Provides that an insurer that issues a group health insurance policy or a health maintenance organization that enters a group health maintenance organization contract shall disclose to the policyholder or subscriber:
      a. the amount of the commission, service fee, or brokerage fee to be paid to an insurance producer for selling, soliciting, or negotiating the policy or contract, and
      b. whether the commission or fee is based on a percentage of total plan premiums or a flat per member fee
   3. Requires that this information be disclosed at the outset and upon renewal of the policy or contract.

C. *Prohibition of Gag Clauses (permits employers to know the negotiated price of provider services)*
   1. While noted as Effective July 1, 2020, this was amended in conference committee in HEA 1004 to apply to contracts entered into or renewed after June 30, 2020.
   2. A health provider contract, including a contract with a pharmacy benefit manager or a health facility may not contain a provision that prohibits the disclosure of health care service claims data to employers providing the coverage.
   3. Any disclosure of claims data must comply with health privacy laws, including HIPAA.
   4. A violation of this act is considered an unfair or deceptive act or practice in the business of insurance under SEA 5 IC 27-4-1-4.

D. *Establishment of* an *All Payer Claims Data Base (APCD)*
   1. Effective March 14, 2020.
   2. Requires the department of insurance (DOI) to submit a request for information (RFI) and a request for proposals (RFP) concerning the establishment and operation of an APCD, which will receive and contain information on claims paid by insurers, health maintenance organizations, pharmacy benefit managers, and other payers. An employer may opt-in to share claims data with the APCD.
      a. RFI by to be submitted by DOI by July 1, 2020, and must include the following:

1. How the person would collect all relevant claims data for the data base from a health payer in a manner that would minimize technical barriers for a health payer to submit a claim.
2. How the person would promote and encourage self-funded plans to voluntarily submit claims data for inclusion in the data base.
3. What funding sources the person would seek to offset costs to implement and maintain the data base.
4. How the person would make data from the data base available, including what sufficient fee would need to be assessed, to researchers, companies, and other interested parties in analyzing the data.
5. How the person would include; that the data is submitted and released in a machine readable format, that the data from the base is used in an ethical manner, that the data is not personally identifiable and is properly secured and maintained and that the personal complies with federal and state health care privacy laws.
6. How the person would establish a public web portal for individuals to quickly and easily compare prices for the full spectrum of medical billing codes as well as check quality rating of providers.
7. What threshold should be set for health payers to submit data for the data base.
8. How the person would work with other states and relevant stakeholders to either; use a data language that is already available or facilitate the establishment of a common data language to be used by states for the data.
9. Whether any changes to state law would increase the functionality and effectiveness of the data base recommendations of the statutes and necessary changes.
10. Any other questions the department determines are relevant to the implementation of a robust and transparent data base.

3. RFI due to DOI by November 30, 2020.
4. RFP to be issued by DOI after May 30, 2021 to request an entity that is not a state agency or political subdivision to create, operate and maintain the APCD.
5. DOI will publish their decision of who they wish to contract with by November 30, 2021.
6. A health payer shall begin submitting the required data in a format specified by the administrator of the data base no later than 3 months from the first day the DOI declares the APCD to be operational.

E. *Physician Credentialing*
    1. Effective January 1, 2021.
    2. A fully credentialed provider shall be reimbursed by an insurer or health maintenance organization for eligible services at the rates determined by the contract provided at an in-network hospital if certain conditions are met.

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III. SEA 21: Out-of-State Prescriptions (Sen. Linda Rogers)

A. *Honoring Prescriptions*
    a. Effective March 14, 2020
    b. A pharmacist has a duty to honor all prescriptions from a practitioner or from a physician, podiatrist, dentist, advanced practitioner, registered nurse, physician assistant, or veterinarian licensed under the laws of another state.

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IV. SEA 241: Pharmacy Benefit Managers (Sen. Liz Brown)

A. *Pharmacy Benefit Manager (PBM) Transparency*
    1. Effective January 1, 2021.
    2. Requires a PBM to obtain a license issued by the department of insurance.
    3. Requires a PBM to accept any willing pharmacy provider who meets contractual provisions and provides equal access and incentive to all pharmacies within the pharmacy benefit network. A violation is an unfair or deceptive act or practice in the business of insurance.
    4. A person or entity that has contracted with a PBM for the performance of services is entitled to full disclosure from the PBM of the terms of a contract between the PBM and any other person or entity within the same network concerning the performance of the services including:
        a. The purchase price for prescription drugs within the same network and set by a contract entered into by the PBM.
        b. The amount of any rebate provided in connection with the purchase of prescription drugs within the same network by a contract entered into by the PBM.
    5. A PBM cannot:

a. Condition participation in any network on accreditation, credentialing, or licensing of a pharmacy provider, other than a license or permit required by the Indiana Board of Pharmacy or other state or federal regulatory authority for the services provided by the pharmacy. However, nothing in this subdivision precludes the department from providing credentialing or accreditation standards for pharmacies.
b. Discriminate against any pharmacy provider.
c. Directly or indirectly retroactively deny a claim or aggregate of claims after the claim or aggregate of claims has been adjudicated unless; the original claims was submitted frequently or incorrect because of the pharmacy or pharmacist had already been paid for the drug, or the pharmacist services were not properly rendered by the pharmacy or pharmacist.
d. Reduce, directly or indirectly, payment to a pharmacy for pharmacist services to an effective rate of reimbursement, including permitting an insurer or plan sponsor to make such a reduction.
e. Reimburse a pharmacy that is affiliated with the PBM, other than solely being included in the PBM's network, at a greater reimbursement rate than other pharmacies in the same network.

6. A PBM shall:
    a. Identify to contracted pharmacy service administration organizations (PSAOs) or pharmacies if the PBM contracts directly with pharmacies; the source used by the PBM to calculate the drug product reimbursement paid for covered drugs available under the pharmacy health benefit plan administered by the PBM.
    b. Establish an appeal process for contracted pharmacies, PSAOs, or group purchasing organizations to appeal and resolve disputes concerning the maximum allowable cost pricing. The appeal process must include numerous criteria outlined in statute.
    c. Update and make available to pharmacies at least forty-five (45) days or in a different time frame of contracted between PBM and pharmacy; the PBMs maximum allowable cost list.
    d. The establishment of procedures for auditing submitted claims by a contract pharmacy in a manner established by administrative rules.
    e. For every drug for which the PBM establishes a maximum allowable cost to determine the drug product reimbursement, the PBM shall make available to a contracted PSAO to make available to the pharmacies, or to a pharmacy if the PBM contracts directly with a pharmacy, in a manner established by the department by administrative rule described the following:

1. Information identifying the national drug pricing compendia or sources used to obtain the drug price data.
2. The comprehensive list of drugs subject to maximum allowable cost and the actual maximum allowable cost for each drug.

f. Disclose, upon request from a party that has contracted with a PBM, to the party the actual amounts paid by the PBM to any pharmacy.

g. Provide notice to a party contracting with the PBM any consideration that the PBM receives from a pharmacy manufacturer for any name brand dispensing of a prescription when a generic or biologically similar product is available for the prescription.

7. Requires a PBM to obtain the license not later than December 31, 2020, in order to do business in Indiana and provide services for any health provider contract beginning January 1, 2021.
8. Makes violations of the chapter concerning PBMs an unfair or deceptive act or practice in the business of insurance.
9. Beginning June 1, 2021 and annually after, a PBM shall submit a report containing data from the immediately preceding calendar year to the commissioner.
10. Allows a party that has contracted with a PBM to request an audit of compliance at least one time per year.

B. *Commissioner Language*

1. Effective July 1, 2020.
2. Provides for the commissioner of the department of insurance to adopt rules to specify licensure, financial and other standards, and reporting requirements that apply to a PBM.
3. The commissioner may establish a procedure to release information from an audit performed by the department to a party that has requested an audit under this section in a manner that does not violate confidential or proprietary information laws.
4. Commissioners shall:
    a. Prescribe an application for use in applying for a license to operate as a PBM.
    b. Adopt ruled to establish PBM licensing requirements, licensing fees, a license application, reporting requirements, financial standard for PBMs and a time frame for the resolution of an appeal.
    c. Determine what must be included in the PBM annual report and consider the following information to be included in the report:

1. The aggregate amount of all rebates; administrative fees; and the highest, lowest and mean aggregate retained rebate that the PBM received from all pharmaceutical manufacturers for the following with which the PBM contracted during the immediately preceding calendar year:
    a. all insurers; and
    b. each insurer
2. The aggregate amount of retained rebates that the PBM received from all pharmaceutical manufacturers and did not pass through to insurers with which the pharmacy benefit manager contracted during the immediately preceding calendar year.

5. Commissioner may:
    a. Charge a license application fee and renewal fees established under subsection in an amount not to exceed $500 to be deposited in the department of insurance fund established.
    b. Examine or audit the books and records of a PBM once a year to determine if PBM complies.

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V. SEA 246: Mental Health Services (Sen. Michael Crider)

A. *School Corporation, Charter Schools or Accredited Nonpublic Schools*

1. Effective July 1, 2020 unless otherwise noted.
2. Before July 1, 2021, each school corporation, charter school, or accredited nonpublic school shall certify to the department of homeland security that the school corporation, charter school, or accredited nonpublic school has a memorandum of understanding in place with a community mental health center provider certified or licensed by the state to provide mental or behavioral health services to students before applying for a grant under this chapter.
3. Provide appropriate and necessary mental or behavioral health services to students.
4. The division of mental health and addiction shall develop a memorandum of understanding for referral and assist school corporations and charter schools in obtaining a memorandum of understanding with a community mental health center or an appropriate provider.
5. Before providing a referral under a memorandum of understanding, each school corporation and charter school shall comply with specific requirements noted in statute.

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VI. SEA 255: Insulin Drugs (Sen. Ed Charbonneau)

A. *Insulin Purchasing*
   a. Effective January 1, 2021.
   b. Repeals a provision that requires an individual to possess a prescription to purchase an insulin drug.

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VII. SEA 273: Indiana Behavioral Health Commission (Sen. Michael Crider)

A. *Establishes/Sets Requirements for Indiana Behavior Health Commission*
   1. Effective March 18, 2020.
   2. Specifies the membership of the commission.
   3. Requires the commission to prepare an interim report not later than October 1, 2020 and a final report not later than October 1, 2022.
   4. Specifies the issues and topics to be discussed in the commission reports.
   5. Requires commission reports to be issued in an electronic format and to be issued to the Governor, the Legislative Council, and any other party specified by the commission chairperson.
   6. Abolishes the commission on December 31, 2022.

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HOUSE ENROLLED ACTS

I. HEA 1004: Health Matters (Rep. Ben Smaltz)

A. *Prohibit Surprise Billing*

1. Does not apply to emergency services.
2. Effective July 1, 2020
    a. An in-network practitioner who provides covered health care services to a covered individual may not charge more for the covered health care services than allowed according to the rate or amount of compensation established by the individual's network plan.
        i. A practitioner or facility is not required to provide a covered individual with a GFE required if the nonemergency health care service is scheduled to be performed by the practitioner within 5 business days after the health care service is ordered.
    b. An out of network practitioner who provides health care services to a covered individual in an in network facility may not charge more for the health care services provided to a covered individual than allowed according to the rate or amount of compensation established by the covered individual's network plan unless:
        i. at least 5 days before the health care services are scheduled to be provided, the covered individual is provided a Good Faith Estimate (GFE) statement to inform the covered individual in writing that the facility or practitioner intends to charge more than allowed under the network plan and sets forth an estimate of the charge.
        ii. The GFE must be a separate form, be at least 14 point type, and meet the following requirements:
            a. includes a notice reading substantially as follows:"[Name of practitioner] intends to charge you more for [name or description of health care services] than allowed according to the rate or amount of compensation established by the network plan applying to your coverage. [Name of practitioner] is not entitled to charge this much for [name or description of health care services] unless you give your written consent to the charge."
            b. sets forth the amount the practitioner intends to charge

c. Includes a notice reading substantially as follows, "The estimate of our intended charge for [name or description of health care services] set forth in this statement is provided in good faith and is our best estimate of the amount we will charge. If our actual charge for [name or description of health care services] exceeds our estimate, we will explain to you why the charge exceeds the estimate.".

iii. the covered individual signs the statement, signifying the covered individual's consent to the charge.

c. If an out of network practitioner does not comply with the above, the out of network practitioner must include on any bill remitted to a covered individual a written statement in 14 point type stating that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan plus any required copayment, deductible, or coinsurance.

d. If a covered individual's network plan remits reimbursement to the covered individual for health care services by an out of network practitioner, network plan shall provide with the reimbursement a written statement in 14 point type that states that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan plus any required copayment, deductible, or coinsurance.

e. If the out of network practitioner's charge for health care services provided to a covered individual exceeds the GFE provided, the facility or practitioner must explain in a writing to the covered individual why the charge exceeds the estimate.

3. Effective July 1, 2021

a. All practitioners and facilities shall provide a covered individual, at least five (5) days before the health care service is scheduled, a GFE.

B. *Practitioner Good Faith Estimates (GFE)*

1. Effective July 1, 2020
2. An individual for whom a nonemergency health care service has been ordered, scheduled, or referred may request from the practitioner who may provide the nonemergency health care service a GFE of the total price the practitioner will charge for providing the nonemergency health care service.
3. A practitioner who receives a request from a patient shall, not more than 5 business days after receiving relevant information from the individual, provide to the individual a GFE of the price that the practitioner will charge for providing the nonemergency health care service.

4. A practitioner must ensure that a GFE provided to an individual is accompanied by a notice stating that:
    a. an estimate provided under this selection is not binding on the practitioner,
    b. the price the practitioner charges the individual may vary from the estimate based on the individual's medical needs,
    c. the estimate is only valid for thirty (30) days.
5. A practitioner may not charge an individual for providing a GFE.
6. If the individual who requests a GFE from a practitioner under this chapter is a covered individual with respect to a network plan; and the practitioner from which the individual requests the GFE is in network with respect to the same network plan; the GFE that the practitioner provides to the individual under this chapter must be based on the negotiated price to which the practitioner has agreed as an in network provider.
7. If the individual who requests a GFE from a practitioner who is not a covered individual with respect to any network plan; or is not a covered individual with respect to a network plan with respect to which the practitioner is in network; the GFE that the practitioner provides to the individual under this chapter must be based on the price that the practitioner charges for the nonemergency health care service in the absence of any network plan.
8. A practitioner may provide a GFE to an individual, in a writing delivered to the individual, by electronic mail or through a mobile application or other Internet web-based method.
9. A GFE provided by a practitioner to an individual under this chapter must meet the following requirements:
    a. Provide a summary of the services and material items that the GFE is based upon to include:
        i. The price charged for the services and material items that the practitioner will provide and charge the individual.
        ii. The price that the provider facility in which the health care services will be performed charged for:
            a. the use of provider facility to care for individual nonemergency health care services,
            b. the services rendered by staff of the provider facility connection with the nonemergency health care service,

c. medication, supplies, equipment, and material items to be provided to or used by the individual while the individual is present in the provider facility in connection with the nonemergency health care service; for imaging, laboratory services, diagnostic services, therapy, observation services, and other services expected to be provided to the individual for the episode of care.

iii. Include a total figure that is a sum of the estimate prices referred to above.

10. A practitioner has the option to provide an individual a GFE that indicates how much of the total figure will be the individual's out-of-pocket expense after the health carrier's payment of charges.
11. A health carrier and a provider facility must provide a practitioner with the information needed by the practitioner to comply with, not more than 2 business days after receiving the request. The provider facility shall provide the practitioner with all relevant information for services and costs for the GFE that are to be provided by the provider facility for inclusion in a GFE by the practitioner.
12. A practitioner is not subject to penalties if:
    a. a health carrier or provider facility fails to provide the practitioner with the information required,
    b. the practitioner provides the individual with a GFE based on any information the practitioner has,
    c. the practitioner provides the individual with an updated GFE after the health carrier or provider facility has provided the information required.
13. If a practitioner is expected to provide a nonemergency health care service to an individual in a provider facility; and the provider facility receives a request from an individual for a GFE, the practitioner, upon request from the provider facility, shall provide to the provider facility a GFE of the practitioner's price for providing the nonemergency health care service to enable the provider facility to comply.
14. A practitioner that has ordered the individual for a nonemergency health care service shall provide to the individual an electronic or paper copy of a written notice that states the following, or words to the same effect: "A patient may at any time ask a health care provider for an estimate of the price the health care providers and health facility will charge for providing a nonemergency medical service. The law requires that the estimate be provided within 5 business days."
15. If a practitioner receives a request for a GFE and the patient is eligible for Medicare coverage; the practitioner shall provide a GFE to the patient within 5 business days based on available Medicare rates.

16. A practitioner shall ensure that each waiting room of the practitioner's office includes at least 1 printed notice that states the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in this practitioner office. The law requires that an estimate be provided within 5 business days.".
17. If a practitioner maintains an Internet web site, the practitioner shall ensure that the Internet web site includes at least one printed notice that:
    a. is designed, lettered, and featured on the Internet web site so as to be conspicuous to and readable by any individual with normal vision who visits the Internet web site
    b. states the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in our office. The law requires that an estimate be provided within 5 business days."
18. If the charge of a facility or practitioner for health care services provided to a covered individual exceeds the estimate provided to the covered individual, the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.
19. Penalty - the appropriate board may take action against a practitioner for an initial violation, isolated violations, repeated or persistent violations of this chapter.

C. *Provider Facility Good Faith Estimates (GFE)*
    1. Effective July 1, 2020.
    2. Provider Facility = hospital, ambulatory outpatient surgery center, abortion clinic, birthing center, a facility that provides diagnostic services to the medical profession or the general public (except for an urgent care facility), outpatient facilities, laboratories, imaging centers, infusion centers.
        a. Provider facility does not include private mental health institutions, Medicare certified freestanding rehabilitation hospitals, emergency department of a hospital, or a nonprofit or government operated health clinic.
    3. Nothing in this chapter prohibits a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.), or a self-insurance program established to provide group health coverage, or a contract for health services, from providing information requested by a practitioner or provider facility.
        a. This chapter does not apply to Medicaid recipients.
    4. An individual for whom a nonemergency health care service has been ordered, scheduled, or referred may request from the provider facility in which the nonemergency health care service will be provided a GFE of the price that will be charged for the nonemergency health care service.

5. A provider facility that receives a request from an individual shall, not more than 5 business days after receiving relevant information from the individual, provide to the individual a GFE of:
    a. the price that the provider facility in which the health care service will be performed will charge for:
        i. the use of the provider facility to care for the individual for the nonemergency health care service,
        ii. the services rendered by the staff of the provider facility in connection with the nonemergency health care service,
        iii. medication, supplies, equipment, and material items to be provided to or used by the individual while the individual is present in the provider facility in connection with the nonemergency health care service.
    b. the price charged for the services of all practitioners, support staff, and other persons who provide professional health services:
        i. who may provide services to or for the individual during the individual's presence in the provider facility for the nonemergency health care service,
        ii. for services the individual will be charged separately from the charge of the provider facility
6. The price that must be included in a GFE under this section includes all services for imaging, laboratory services, diagnostic services, therapy, observation services, and other services expected to be provided to the individual for the episode of care.
7. A provider facility shall ensure that a GFE states that:
    a. an estimate provided under this section is not binding on the provider facility,
    b. the price the provider facility charges the individual may vary from the estimate based on the individual's medical needs,
    c. the estimate provided is only valid for thirty (30) days.
8. Provider facility may not charge an individual for requesting a GFE.
9. If the individual who requests a GFE from a provider facility under this chapter and has been verified as a covered individual with respect to a network plan; and the provider facility from which the individual requests the GFE is in network with respect to the same network plan; the GFE that the provider facility provides to the individual under this chapter must be based on the price to which the provider facility and any practitioners have agreed as in network providers.

10. If the individual who requests a GFE from a provider facility under this chapter is not a covered individual with respect to any network plan; or is not a covered individual with respect to a network plan with respect to which the provider facility is in network; the GFE that the provider facility provides to the individual under this chapter must be based on the price that the provider facility and any practitioners referred to in section of this chapter charge for the nonemergency health care services in the absence of any network plan.
11. A GFE can be provided in writing delivered to the individual, by electronic mail or through a mobile application or other Internet web-based method.
12. A GFE provided by a provider facility to an individual under this chapter must:
    a. provide a summary of the services and material items that the GFE is based on
    b. include a total figure that is a sum of the estimated prices
13. Does not prohibit a provider facility from providing to an individual a GFE that indicates how much of the total figure will be the individual's out-of-pocket expense after the health carrier's payment of charges.
14. A health carrier or practitioner must provide a provider facility with the information needed by the provider facility to comply with the requirements under this chapter not more than 2 business days after receiving the request.
15. A provider facility is not subject to the penalties if:
    a. a health carrier or practitioner fails to provide the provider facility with the information as required
    b. the provider facility provides the individual with a GFE based on any information that the provider facility has
    c. the provider facility provides the individual with an updated GFE after the health carrier or practitioner has provided the information required
16. If a practitioner maintains an Internet web site, the practitioner shall ensure that the Internet web site includes at least one (1) printed notice that:
    a. is designed, lettered, and featured on the Internet web site so as to be conspicuous to and readable by any individual with normal vision who visits the Internet web site
    b. states the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in our office. The law requires that an estimate be provided within 5 business days."
17. Penalty - If a provider facility fails or refuses to provide a GFE as required, the insurance commissioner may, after notice and hearing, impose on the provider facility a civil penalty of not more than $1,000 for each violation.

D. Health Carrier Good Faith Estimates (GFE)

1. Nothing in this chapter prohibits a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.); or a self-insurance program established to provide group health coverage as described in IC 5-10-8-7(b); or contract for health services, as described in IC 5-10-8-7(c) from providing information requested by a practitioner or provider facility under this chapter.
2. A covered individual may request from the health carrier a GFE for nonemergency services the amount of the cost of the health care service that the health carrier will pay for or reimburse to the covered individual, the applicable benefit limitations an individual is entitled to receive, if the provider facility is in network, and whether each scheduled practitioner is in network, if:
    a. a health carrier provides coverage to a covered individual through a network plan; and
    b. the health carrier receives a request for a GFE from a covered individual for whom a nonemergency health care service has been ordered.
3. A health carrier may not charge for this information.
4. A health carrier that receives such a request from a covered individual patient shall not more than 5 days after receiving relevant information provide to the individual a GFE
5. A health carrier GFE is only valid for 30 days.
6. A practitioner and provider facility shall provide a health carrier with the information needed by the health carrier to comply with the requirements under this chapter not more than 2 business days after receiving the request.
7. A health carrier may provide a GFE to an individual in a writing, by electronic mail or through a mobile application or other Internet web based method according to the preference expressed by the individual.
8. GFE must include itemization of services, sum of service, and out-of-pocket costs the covered individual will incur.
9. If a provider facility or practitioner fails to provide the health carrier with the information required, the health carrier provides the individual with a GFE based on any information that the health carrier has the health carrier provides the individual with an updated GFE after the provider facility or practitioner has provided the information.
10. A health carrier must note on their website that covered individuals may request a GFE following similar language as practitioners and facilities.
11. If a health carrier fails or refuses to provide a GFE as required or to provide notice on the health carrier's Internet web site as required, the insurance commissioner may, after notice and hearing under IC 4-21.5, impose on the health carrier a civil penalty of not more than $1,000 for each day of noncompliance.

E. *Amendment to Gag Clauses (added in conference committee to apply to gag clause language in SEA 5 replacing "*beginning July 1, 2020" with "entered into or renewed after June 30, 2020").

F. *Definition of Weighted Average Negotiated Charge (added in conference committee to apply to price transparency section noting "weighted average negotiated charge" in SEA 5)*
   1. Defines "weighted average negotiated charge" to be calculated as follows:
      a. STEP 1: For each insurer with whom the hospital or an ambulatory outpatient surgical center negotiates a charge for a particular procedure, determine the percentage of the hospital's patients or the ambulatory outpatient surgical center's patients insured by the insurer in the previous calendar year rounded to a whole percentage.
      b. STEP 2: Multiply each percentage determined under STEP 1 by one hundred (100) and express the results as whole numbers so that the sum of the percentage points determined under STEP ONE is one hundred (100).
      c. STEP 3: For a particular procedure, determine the amount of the negotiated charge for the procedure for each insurer described in STEP 1.
      d. STEP 4: For each insurer described in STEP 1, multiply the STEP 3 amount determined for a particular procedure by the result determined under STEP 2 for that insurer.
      e. STEP 5: For a particular procedure, determine the sum of the amounts determined under STEP 4 for all of the insurers described in STEP ONE with respect to that procedure.
      f. STEP 6: For a particular procedure, determine the quotient of the sum determined under STEP 5 for that procedure; divided by one hundred.

   2. Amended Weighted average negotiated charge to include Medicaid, (added in conference committee to amend SEA 5, "Medicaid, including fee for service and risk based managed care" added to the payer mix of price transparency requirements for hospitals, ambulatory care surgical centers, and urgent care centers).

G. *Physician Noncompete Agreements (refer to Sec. 8, pg.13)*

H. Physician's Patient Information (refer to Sec. 9. pg. 15)
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II. HEA 1094: Substance Use Prevention and Recovery (Rep. Cindy Ziemke)

A. Effective July 1, 2020.
B. Requires the executive director of the Indiana criminal justice institute to work with local coordinating councils and other stakeholders when implementing certain recommendations concerning substance use and substance use disorder.

C. Includes public safety programs in the statutory definition of "criminal justice services and activities".
D. Specifies that local coordinating councils responsible for the combating of drug and substance use are collaborative and open to the public.
E. Permits county drug free community funds to support local substance use recovery and prevention initiatives by supplementing local funds for treatment, intervention, prevention, education, criminal justice services and defines certain terms.

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III. HEA 1182: HIV, Fatality Reviews, and Syringe Exchange Programs (Rep. Edward Clere)

A. *HIV*

1. Requires the state department of health to specify, in any literature provided to children and young adults concerning HIV, that abstinence is the best way to prevent the transmission of HIV as a result of sexual activity.
2. Requires a physician or an authorized representative of the physician to inform a patient of the counseling services and treatment options available to the patient if an HIV test indicates that the patient is HIV positive.
3. Requires a patient to be notified of their right to a hearing and counsel in certain situations involving a court ordered HIV test.
4. Provides that a physician or the authorized representative of a physician may not order an HIV test unless the physician or the authorized representative of a physician:
    a. informs the patient of the test orally or in writing
    b. provides the patient with an explanation of the test orally, in writing, by video, or by a combination of these methods
    c. informs the patient orally or in writing of the patient's right to ask questions and to refuse the test
5. Specifies that the use of antiretroviral drugs and other medical interventions may lessen the likelihood of transmitting HIV to a child during childbirth.
6. Provides that the requirement to dispose of semen that contains the HIV antibody does not apply if the semen is used according to safer conception practices endorsed by the federal Centers for Disease Control and Prevention or other generally accepted medical experts.
7. Provide testing for communicable diseases, and if an individual tests positive for a communicable disease, provide health care services or a referral to a health care provider for the services.

8. Establish a referral process for program participants in need of information or education concerning communicable diseases or health care.

B. *Fatality Reviews*
   1. Requires a suicide and overdose fatality review team (SOFR team) to review certain suicide and overdose fatalities.
   2. Allows a SOFR team to make recommendations concerning the prevention of suicide and overdose fatalities.

C. *Syringe Exchange Programs*
   1. Extends the expiration date for certain syringe exchange programs from July 1, 2021, to July 1, 2022.
   2. Requires a syringe exchange program to:
      a. provide testing for communicable diseases and provide services or a referral for services if the individual tests positive
      b. establish a referral process for program participants in need of information or education concerning communicable diseases or health care
   3. Before November 1, 2020, as part of the report to the general assembly, the state department shall ensure the report includes the following additional information concerning the program:
      a. The number of programs operating in Indiana.
      b. The data, compiled for each program, reported to the state department under section 10 of this chapter.
      c. Any other information the state department deems relevant to the general assembly in assessing the effectiveness of having a program in the state.

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IV. HEA 1199: Palliative Care (Rep. Edward Clere)

A. *Palliative Care*
   1. Effective July 1, 2020.
   2. Defines the terms "community based palliative care" and "palliative care".
   3. Provides that a hospice provider may provide community based palliative care to a patient who is not eligible for hospice care if the hospice provider:
      a. meets certain licensing requirements

b. is certified in community based palliative care by an organization approved the state department of health

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V. HEA 1207: Pharmacy Matters (Rep. Steven Davisson)

A. *State Employee Plan*

1. Effective July 1, 2020.
2. Provides that a state employee plan, a health maintenance organization, an insurer, or a pharmacy benefits manager (health plan provider) may not require a pharmacy or pharmacist to collect a higher copayment for a prescription drug from a covered individual than the health plan provider allows the pharmacy or pharmacist to retain.
3. A state employee health plan shall implement a procedure to allow a covered individual to submit a claim to offset the covered individual's deductible for the cost of a purchase by the covered individual of a prescription drug that:
    a. is covered under the state employee health plan
    b. was purchased by the covered individual without submitting at the point of purchase the claim through the state employee health plan.
4. If a covered individual submits a claim to the state employee health plan in accordance with the procedure, the state employee health plan shall verify the purchase and count the amount paid by the covered individual for the purchased covered prescription drug against the covered individual's deductible.

B. *State Department Courses*

1. Effective July 1, 2020.
2. The state department shall approve courses concerning allergies and the administration of auto-injectable epinephrine that are offered by an approved organization.
3. The state department shall do the following:
    a. Maintain, on its Internet website, a list of all approved courses.
    b. Prescribe the certification process for the courses.
    c. Revoke the certification of an organization that fails to comply with any certification prerequisite specified by the state department.
4. A person who successfully completes a certified course shall receive a certificate of completion. The state department may contract with a third party for the purpose of creating or manufacturing the certificate of completion.
5. A certificate of completion issued must include the following:

a. Dimensions that permit the certificate of completion to be carried in a wallet and display the following information.
b. The first and last name of the person.
c. The first and last name of the course instructor.
d. The name of the entity responsible for providing the course if applicable
e. The data the course described was completed.
f. Any other information required by the state Department.

C. *Pharmacist Language*

1. Effective July 1, 2020.
2. A pharmacist may, by standing order, dispense auto-injectable epinephrine without examining the individual to whom it may be administered if all of the following conditions are met:
    a. The auto-injectable epinephrine is dispensed to a person who:
        1. presents a certificate of completion to the pharmacist before the auto-injectable epinephrine is dispensed
        2. is an individual who is or may be in a position to assist an individual who is at risk of experiencing anaphylaxis.
    b. The pharmacist provides instruction concerning how to properly administer auto-injectable epinephrine from the specific device being dispensed at the time of the device's dispensing.
    c. The pharmacist instructs the individual receiving the auto-injectable epinephrine to summon emergency medical services either immediately before or immediately after administering the auto-injectable epinephrine to an individual experiencing anaphylaxis.
3. A person wishing to receive auto-injectable epinephrine by standing order must do the following:
    a. Successfully complete the course
    b. Present a certificate of completion to a pharmacist at the time the
    c. auto-injectable epinephrine is requested.
4. An individual may administer auto-injectable epinephrine to an individual that the person reasonably believes is experiencing anaphylaxis.
5. An individual may not be considered to be practicing medicine without a license if the individual, acting in good faith:
    a. obtains auto-injectable epinephrine from a pharmacist by standing order
    b. administers auto-injectable epinephrine to an individual that the person reasonably believes is experiencing anaphylaxis in a manner that is consistent with:
        1. the training provided during the course

2. the instruction provided to the person by a pharmacist at the time the auto-injectable epinephrine was dispensed

c. attempts to summon emergency medical services either immediately before or immediately after administering the auto-injectable epinephrine

6. The state department shall ensure that a statewide standing order for the dispensing of auto-injectable epinephrine in Indiana is issued under this section. The state health commissioner may, as part of the individual's official capacity, issue a statewide standing order that may be used for the dispensing of auto-injectable epinephrine under this section.

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VI. HEA 1209: Reimbursement for Emergency Medical Services (Rep. Cindy Kirchhofer)

A. *Reimbursement*

1. Effective July 1, 2020.
2. Requires the state employee health plan, Medicaid, policies of accident and sickness insurance, and health maintenance organization contracts that provide coverage for emergency medical services to reimburse for emergency medical services that are:
    a. rendered by an emergency medical services provider organization
    b. within the emergency medical services provider organization's scope of practice
    c. performed or provided as advanced life support services
    d. performed or provided during a response initiated through the 911 system, regardless of whether the patient was transported
3. If multiple emergency medical services provider organizations qualify and submit a claim for reimbursement under this section for an encounter, the insurer:
    a. may reimburse under this section only for 1 claim per patient encounter
    b. shall reimburse the claim submitted by the emergency medical services provider organization that performed or provided the majority of advanced life support services for the patient

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