2021 Indiana Legislative Health Summary

September 20, 2021

In this document, we summarize 10 health related bills passed into law during the 2021 Indiana Legislative session. The Indiana 2021 session was a budget year and began on January 4th and adjourned on April 29, 2021. In total, 1,011 bills were introduced including 220 bills which succeeded in the legislative process for a 22% total passing rate.

The 2021 Legislative Session was a budget year. A summary of the FY 22/23 budget can be found here.

Bills for this legislative summary were reviewed in May-June 2021, and as such it's possible that not all end-of-session Conference Committee Report edits are captured in the text as they were not yet updated on the Indiana General Assembly website. By September 2021, all Conference Committee edits were incorporated into the "latest version" text. Thus, for bills of high interest, please review the latest version link noted at the end of each bill summary.

Contents

Senate Enrolled Acts

I. SEA 1: Civil Immunity Related to COVID-19 (Sen. Mark Messmer)

A. Civil Immunity

1. Effective February 18, 2021 and expires December 31, 2024.
2. This bill outlines who is protected from damages from COVID-19 and defines relevant terms.
3. This chapter applies to a cause of action that accrues on or after March 1, 2021.
4. "Arising from COVID-19" means an injury or harm caused by or resulting from:
    a. the actual, alleged, or possible exposure to or contraction of COVID-19,
    b. services, treatment, or other actions performed for COVID-19.
5. Subject to the other provisions, a person is immune from civil tort liability for damages arising from COVID-19:
    a. on the premises owned or operated by the person,
    b. on any premises on which the person or an employee or agent of the person provided property or services to another person,
    c. during an activity managed, organized, or sponsored by the person.
6. This does not grant immunity from civil tort liability to a person whose actions or omissions constitute gross negligence or willful or wanton misconduct.

B. COVID-19 Related Products Liability

1. An emergency is declared for this act.
2. This chapter applies to a cause of action that accrued on or after March 1, 2020 and expires December 31, 2024.
3. A manufacturer or supplier is immune from civil tort liability for harm that results from the design, manufacture, labeling, sale, distribution, or donation of a COVID-19 protective product.
4. This immunity for manufacturers or suppliers does not apply to an act or omission that constitutes gross negligence or willful or wanton misconduct.
5. The civil tort immunity provided is in addition to any other immunity protection that might apply under state or federal law.

Click here to read the latest version

II. SEA 3: Telehealth Matters (Sen. Ed Charbonneau)

A. Effective April 20, 2021.

B. *Definition of Telehealth Activities*

1. An office may not impose any distance restriction on providers of telehealth activities or telehealth services.
2. Subject to federal law, the office may not impose any location requirements concerning the originating site or a distance site in which a telehealth service is provided to a Medicare recipient.
3. A Medicare recipient or other patient waves confidentiality of any medical information discussed with the health care provider that is provided during a telehealth visit and heard by another individual in the vicinity of the Medicare recipient during a health care service or consultation.
4. Telehealth may not be used to provide any abortion, including the writing or filling of a prescription for any purpose that is intended to result in an abortion.

C. *Telehealth for Employers*
   1. An employer may not require a practitioner, by an employment contract, an agreement, a policy, or any means, to provide a health care service through telehealth if the practitioner believes providing a health care service through telehealth would:
      a. negatively impact the patient's health, or
      b. result in a lower standard of care than if the health care service was provided in an in-person setting.
   2. Any applicable contract, employment agreement, or policy to provide telehealth services must explicitly provide that a practitioner may refuse to provide health care services if in the practitioner believes the:
      a. quality of the patient's health would be negatively impacted, or
      b. the practitioner would be unable to provide the same standards of care as that provided in-person.

D. Telehealth Coverage
   1. Effective April 20, 2021.
   2. If a policy provides coverage for telehealth services via secure video conferencing, store and forward technology, or remote patient monitoring technology between a provider in one location and a patient in another location, the policy may not require the use of a specific information technology application for those services.

E. Outlines exclusions in policy provider coverage for telehealth services.
F. An emergency is declared for this act.

Click here to read the latest version

III. SEA 325: Hospitals (Sen. Justin Busch)

A. Hospital Public Forum Meetings
   1. Effective April 29, 2021.
   2. Before December 31 of each year, a nonprofit hospital shall hold a public forum in which the nonprofit hospital, including the nonprofit hospital's board of directors, shall:
      a. obtain feedback from the community about the nonprofit hospital's performance in the previous year,
      b. discuss the pricing of health services provided at the nonprofit hospital,
      c. discuss the contributions made by the nonprofit hospital to the community, including uncompensated care, charitable contributions, and any other charitable assistance programs.
   3. At least 14 days before this forum, the nonprofit hospital shall post on their internet web site a printed notice that:
      a. is clearly featured on the internet web site,
      b. states the date, time, and location of the public forum,
      c. states the purpose of the meeting is to provide members of the community with an opportunity to:
         i. comment on the nonprofit hospital's performance in the previous year,
         ii. discuss the pricing of health services provided at the nonprofit hospital,

iii. discuss the contributions made by the hospital to the community, including uncompensated care, charitable contributions, and any other charitable assistance programs.

2. The following financial and pricing information is to be discussed at the public forum:
   a. The nonprofit hospital's Indiana specific income statement from the previous calendar year.
   b. The nonprofit hospital's pricing of health services relative to the reimbursement for the same health services under the Medicare program.
   c. The rationale for any pricing of health services by the nonprofit hospital that is higher than the corresponding reimbursement for the health services under the Medicare program.
   d. Any increase in the nonprofit hospital's pricing of health services that occurred in the previous year.
3. The public forum may be held through an interactive real time audio and video internet meeting that is accessible to the community.

B. *Health Carrier Public Forum Meetings*
1. Requires that before December 31 of each year:
   a. A health carrier shall hold a public forum in which the health carrier shall:
      i. obtain feedback from the community about the health carrier's performance in the previous year, and
      ii. discuss the premiums charged by the health carrier.
   b. At least 14 days before the public forum required by this chapter is held, the health carrier shall post on the health carrier's internet website a printed notice that:
      i. is designed, lettered, and featured on the internet web site in a manner that is conspicuous to and readable by any individual with normal vision who visits the internet web site,
      ii. states the date, time, and location of the public forum, and
      iii. states that the purpose of the public forum is to provide members of the community with an opportunity to comment on the health carrier's performance in the previous year and discuss the premiums charged by the health carrier.
2. The following information is to be discussed at the public forum:
   a. the health carrier's Indiana based profits (if the health carrier is publicly traded),
   b. the premiums charged by the health carrier,
   c. the health carrier's strategy to lower health care costs,
   d. any increase in the health carrier's premiums, on average statewide, that occurred in the previous year for each health carrier, and
   e. annual audited financial reports (if required under IC 27-1-3.5-6 and if publicly traded).
3. The public forum may be held through an interactive real time audio and video internet meeting that is accessible to the community.

C. *Price Transparency Definitions for an Ambulatory Outpatient Surgical Center*
1. Effective March 2021 (Retroactive).
2. "De-identified minimum negotiated charge" means the lowest charge that an ambulatory outpatient surgical center has negotiated with any third-party payer for an item or service.

3. "Discounted cash price" means the charge that applies to an individual who pays cash or the cash equivalent for an ambulatory outpatient surgical center item or service.
4. "Gross charge" means the charge for an individual item or service that is reflected on an ambulatory outpatient surgical center's chargemaster, absent any discounts.
5. "Item or service" means any item or service, including service packages, that could be provided by an ambulatory outpatient surgical center to a patient. The term includes the following:
    a. Supplies
    b. Procedures
    c. Use of the facility and other facility fees
    d. Services of employed physicians and non-physician practitioners, including professional charges
    e. Anything that an ambulatory outpatient surgical center has established as a standard charge
6. "Payer-specific negotiated charge" means the charge that an ambulatory outpatient surgical center has negotiated with a third-party payer for an item or service.
7. "Standard charge" means that regular rate established by the ambulatory outpatient surgical center for an item or service provided to a specific group of paying patients. This term includes:
    a. Gross charge
    b. Payer-specific negotiated charge
    c. De-identified minimum negotiated charge
    d. De-identified maximum negotiated charge
    e. Discounted cash price.

D. Hospital Price Transparency Rule

1. In effect March 1, 2021 (retroactive).
    a. No later than December 31, 2021 an ambulatory outpatient surgical center shall post on its web site, pricing and other information specified for the following:
        i. For as many of the 70 shoppable services specified in the final rule of the Centers for Medicare and Medicaid Services that are provided by the ambulatory outpatient surgical center.
        ii. In addition to these services, the 30 most common services that are provided by the ambulatory outpatient surgical center not included above or if the ambulatory outpatient surgical center offers less than 30 services not provided by the ambulatory outpatient surgical center.
    b. The following information was added be included on the internet web site by an ambulatory outpatient surgical center for the shoppable and common services:
        i. The weighted average negotiated was changed to standard charge per item or service.
2. Hospital transparent pricing exclusions
    a. Effective July 1, 2021.
    b. This section does not apply to a nonprofit critical access hospital that is not part of a hospital or hospital system or an affiliate of a hospital or hospital system or a county hospital.
3. Urgent care internet website
    a. Effective March 1, 2021 (retroactive.)
    b. The standard charge, weighted average negotiated was deleted, per item or service for each of the categories.

E. An emergency is declared for this act.

Click here to read the latest version

IV. SEA 416: Hospitals and Certificates of Public Advantage (Sen. Jon Ford)

A. Effective July 1, 2021.

B. Certificate of Public Advantage of Hospital Mergers

1. Applies to a merger agreement between hospitals located in a county which meets certain criteria.
2. Nothing in this chapter affects antitrust immunity provided through any other provision of state or federal law.
3. A hospital which has been issued a certificate of public advantage may not be purchased by another hospital or system of hospitals unless the purchase has been approved by the Federal Trade Commission.
4. A hospital entering into a merger agreement with another hospital may submit an application to the state department for a certificate of public advantage to govern the merger agreement in the manner prescribed by the state department. A hospital may not submit an application under this chapter after July 1, 2026.
5. The application for a certificate of public advantage must include a written copy of the merger agreement and a written description of the nature and scope of the merger.
6. The state department, in consultation with the office of the secretary of family and social services, will review an application for a certificate of public advantage and coinciding documentation to determine whether there is clear evidence that the proposed merger agreement:
    a. will benefit the population's health outcomes, health care access, and quality of health care, and
    b. meets the standards described in this section.
7. The state department should consider the following while reviewing the application and documentation of the merger agreement:
    a. the quality and price of hospital and health care services provided to Indiana residents,
    b. the preservation of sufficient health care services within the geographic area to ensure public access to acute care,
    c. the cost efficiency of services, resources, and equipment provided or used by the hospitals that are a party to the merger agreement,
    d. the ability of health care payors to negotiate payments and service agreements with hospitals proposed to be merged under the merger agreement,
    e. employment, and
    f. economic impact.
8. The state department shall grant the certification if after review of the application:
    a. There is clear evidence that the proposed merger would benefit the population's health outcomes, health care access, and quality of care in the county.
    b. The likely benefits resulting from the proposed merger agreement outweigh any disadvantages attributable to a reduction in competition that is authorized to result from the proposed merger.

9. The holder of a certificate of public advantage issued by the state department under this chapter receives immunity from claims of state antitrust laws for the duration of the certificate.
10. The state department has 120 days from filing to review, to determine approval of the application.
11. The state department may include terms or conditions of compliance with the issuance of a certificate of public advantage.
12. A hospital that is a party to a merger agreement for at least 5 years that was issued a certificate of public advantage by the state department may voluntarily terminate the certificate of public advantage by filing notice of termination with the state department at least 30 days before the hospital's requested date of termination of the certificate.
13. The state department shall annually review a certificate of public advantage issued by the state department, and consider whether the hospital continues to meet the standards required for issuance of a certificate.
14. Provides responsibilities and requirements for both the state department and hospital to continue operation under a certificate of public advantage.
15. The office of the attorney general may issue a civil investigation concerning the state department's review or revocation of an issued certificate of public advantage and demand the attendance of witnesses and the production of documents to investigate whether a hospital that holds the certificate continues to meet the requirements of the certificate.

Click here to read the latest version

House Enrolled Acts

I. HEA 1002: Civil Immunity Related to COVID-19 (Rep. Jerry Torr)

A. Professional Disciplinary Action during a State Disaster Emergency

1. Effective March 1, 2020 (retroactively) during a period of a state disaster emergency declared to respond to COVID-19 if the state of disaster emergency was declared after February 29, 2020 and before April 1, 2022.
2. Provides definitions for certain terms.
3. A health care provider is not subject to professional discipline for any of the following situations in response to COVID-19:
    a. Health care services provided.
    b. An act or omission of the health care provider committed with respect to the provision, withholding, delay or withdrawal of health care services.
    c. Compliance with an executive order or local health order.
    d. An injury, a death, or a loss to a person or property alleged to have occurred because the health care provider was unable to treat, diagnose, or test the person for any illness, disease, or condition, including an inability to perform any elective procedure.
4. Does not protect a health care provider from professional discipline if the health care provider's action, omission, decision, or compliance constitutes gross negligence, willful or wanton misconduct, fraud, or intentional misrepresentation.
5. Provides what does NOT constitute as gross negligence, willful or wanton misconduct, fraud, or intentional misrepresentation in response to COVID-19.

B. Health Care Services

1. Effective March 1, 2020 (retroactively).
2. Provides amendments to add additional services to the definition of "health care services" to cover services provided by health care volunteers and individuals with provisional or temporary licenses in response to COVID-19.

C. *Provision of Health Care Services During a State Disaster Emergency*
1. Effective during a period of a state disaster emergency declared to respond to COVID-19 if the state of disaster emergency was declared after February 29, 2020 and before April 1, 2022.
2. The following apply to the provision of health care during COVID-19:
    a. A person providing health care services or emergency services or emergency medical services, whether in person or through telemedicine, at a facility or other location where health care services or emergency medical services are provided may not be held civilly liable for an act or omission relating to the provision or delay of health care services or emergency medical services.
    b. An employer, including an agency that provides or arranges health care services or emergency medical services, of a person may not be held civilly liable for an act or omission relating to the provision or delay of health care services or emergency medical services.
3. Provides that a facility or other location, including a location used to provide emergency medical services or used to provide telemedicine services, that provides health care services or emergency medical services in response to or arising from COVID-19 may not be held civilly liable for an act or omission relating to the provision of health care services with respect to which an individual providing health care services, a provider, an agent, or an employee are not liable.
4. Provides what does NOT constitute gross negligence, willful or wanton misconduct, fraud, or intentional misrepresentation.

D. *Facilities or Locations that Provide Health Care Services due to COVID-19*
1. Effective during a period of a state disaster emergency declared to respond to COVID-19 if the state of disaster emergency was declared after February 29, 2020 and before April 1, 2022.
2. A facility or other location, including a location used to provide emergency medical services or telemedicine services, that provides health care services or emergency medical services may not be held civilly liable for an act or omission relating to the provision of health care services with respect to which an individual providing health care services, a provider, an agent, or an employee are not liable.
3. An individual or entity that has a financial interest in, serves on the board of directors of, or provides management or administrative services for a facility or other location that provides health care services or emergency medical services may not be held civilly liable for an act or omission.

E. If a claim is for injury or death resulting from medical malpractice, and not barred by the immunity provided under this subsection, then the claimant is required to comply with all of the provisions of the medical malpractice act.

Click here to read the latest version

II. HEA 1402: All Payer Claims Database (APCD) (Rep. Donna Schaibley)

A. Effective April 29, 2021.

B. Defines the terms "administrator", "advisory board", and "executive director".
C. Changed implementation dates for requests asked in Section 5 IC 27-1-44.5-4 from May 30, 2021 to December 31, 2021.
D. The state, the Indiana Medicaid state plan, and Medicaid managed care entities must submit data for the data base.
E. Provides the duties of the administrator including but not limited to securing the data, protecting the privacy of the data, ensuring uniform data collection and determining data elements to be collected, audit the accuracy of the data submitted, and sharing data with certain institutes.
F. Provides the qualities and necessities of the data base.
G. Provides the duties of the executive director to report on the status of the operations of the data base, the financial stability of the data base, and the status of efforts to obtain funding for the data base among various other duties.
    1. The executive director may contract with third parties to collect and process the health care data collected under this chapter.
H. The collection, storage, and release of health care data and other information is subject to the federal Health Insurance Portability and Accountability Act.
I. Provides emergency rules for the department to adopt. The rules must include a requirement that health payer data sources submit necessary information to the administrator. Rules enacted under this subsection must cover all health payer data sources as follows:
    1. The department shall adopt rules that apply to health payers.
    2. The office of the secretary of family and social services shall adopt rules that apply to health payers.
J. The department shall adopt emergency rules establishing a fee formula for data licensing and the collection and release of claims data.
K. The department may impose a civil penalty on a health payer that is required to submit information under this chapter and fails to comply. A civil penalty collected under this section must be deposited in the department of insurance fund.
L. Provides the duties of the APCD Advisory Board to provide executive director candidate recommendations, advise the executive director and administrator in the administration of the APCD among other various duties.
M. The advisory board consists of nine (9) members appointed by the governor.
    1. Provides the initial appointment date and term timelines for members of the advisory board.
N. Provides oversight of the functioning and responsibilities of the APCD advisory board.

Click here to read the latest version

III. HEA 1405: Insurance Matters (Rep. Martin Carbaugh)

A. Medicaid Reimbursements for State Plan Amendments for School Corporations
    1. Effective July 1, 2021.
    2. The Office of Medicaid Policy and Planning, in consultation with the Department of Education, may apply to the United States Department of Health and Human Services for a state plan amendment to allow school corporations to seek Medicaid reimbursements for medically necessary, school based Medicaid covered services that are provided under federal or state mandates. If the state plan amendment is approved and implemented, services may be provided by a qualified practitioner in a school setting to Medicaid enrolled students.

a. Provides specifications on which services are included and excluded.

B. *Audit of Prescription Drug Cost Sharing*
1. Effective July 1, 2021.
2. Once every 3 state fiscal years, an audit will be conducted examining prescription drug cost sharing for the Medicaid program.
3. The audit "look back" period must be the previous 3 state fiscal years.
4. A conducted audit must evaluate all prescription drug cost sharing for the Medicaid program for the audit look back period, including for prescription drugs paid for by the Medicaid program and by managed care organizations. Must provide audit results to the office of the secretary.

C. *State Plan Amendments for Long-Term Care Partnership Programs*
1. Effective July 1, 2021.
2. Before September 1, 2021, the Office of Medicaid Policy and Planning must apply to the US Department of Health and Human Services for a state plan amendment that:
   a. provides for establishment of the long-term care partnership program,
   b. provides that the long-term care program established will be discontinued on the date when the long-term care partnership program is fully implemented, and
   c. ensures that an individual who purchased a qualified long-term care policy before the discontinuation of the long-term care program will be eligible for an asset disregard.
3. Provides the responsibilities of the Office of Medicaid Policy and Planning after receiving or not receiving approval for the state plan amendment.

D. Amended to state that the Department of Insurance, or the agency with which the Department of Insurance has contracted with, will also make the following available to any individual interested in participating in a long term care program information:
1. The Indiana long term care insurance partnership program.
2. Long term care insurance policies, including qualified long term care policies and qualified long term care insurance policies.

E. *Long Term Care Insurance Partnership Program*
1. Effective July 1, 2021.
2. Applies to qualified long term care insurance policies that are entered into, issued, or renewed after June 30, 2022.
3. Defines "program" and "qualified long term care insurance policy".
4. The program will be in accordance with Section 6021 of the federal Deficit Reduction Act of 2005.
5. The Office of Medicaid Policy and Planning must exclude and disregard an amount equal to the amount of benefits an individual receives under a qualified long term care insurance policy when determining the individual's resources for purposes of determining the eligibility for Medicaid under IC 12-15-3 or the amount to be recovered from the individual's estate under IC 12-15-9 if the individual is eligible for Medicaid.
6. The Department of Insurance will develop a training program for Insurance Producers who sell qualified long term care insurance policies and includes what the course must cover. Provides the educational requirements for Insurance Producers and who regular reports of the long term insurance policy must be given to.

F. *Nonemergency Transport Coverage*

1. Effective July 1, 2021.
2. Provides the situation in which nonemergency transport to a facility by the county sheriff or deputy sheriff will be reimbursed by the individual's health care coverage.

G. COVID-19 Immunization Records

1. Effective April 29, 2021.
2. Provides definitions for certain terms.
3. The state or a local unit may not issue or require an immunization passport.
4. Provides what a state or local unit can do such as maintain, create, or store a medical record of the individual's immunization status and provide a medical record of the individual's immunization status to the individual's medical provider.

H. Upon referral by a licensed school psychologist, a licensed physical therapist, who is an employee or contractor of a school corporation, may provide mandated school services to a student that are within the physical therapist's scope of practice.

I. Physical Therapy Licensure Compact

1. Effective January 1, 2022.
2. The purpose of this Compact is to facilitate interstate practice of physical therapy with the goal of improving public access to physical therapy services. The practice of physical therapy occurs in the state where the patient or client is located at the time of the patient or client encounter. The Compact preserves the regulatory authority of states to protect public health and safety through the current system of state licensure.
3. Provides objectives of the Compact such as increasing public access to physical therapy services, and encouraging the cooperation of member states in regulating multi-state physical therapy practice among others.
4. Provides definitions for certain terms.
5. Provides requirements for a state to participate in the Compact.
6. Upon adoption, the member state shall have the authority to obtain biometric-based information from each physical therapy licensure applicant and submit this information to the FBI for a criminal background check (in accordance with 28 U.S.C. 534 and 42 U.S.C. 14616).
7. Compact Privilege
    a. "Compact privilege" is defined as the authorization granted by a remote state to allow a licensee from another member state to practice as a physical therapist or work as a physical therapist assistant in the remote state under its laws and rules. The practice of physical therapy occurs in the member state where the patient or client is located at the time of the patient or client encounter.
8. Provides additional information and oversight regarding the Compact.

J. Establishment of the Physical Therapy Compact Commission

1. Effective January 1, 2022.
2. "Physical Therapy Compact Commission" or "Commission" is defined as the national administrative body whose membership consists of all states that have enacted the Compact.
3. The Commission is an instrumentality of the Compact states.
4. Nothing in this Compact shall be construed to be a waiver of sovereign immunity.
5. Provides additional information and oversight regarding the Commission.

K. Renewal of a License for a Resident Insurance Producer

1. Effective after December 31, 2021.

2. Outlines requirements for renewal of a license for resident insurance producers.

L. Pharmacy Benefit Manager (PBM)

1. Effective July 1, 2021.
2. Provides an addendum to what a PBM cannot do:
    a. Impose limits, including quantity limits or refill frequency limits, on a pharmacy's access to medication that differ from those existing for a PBM affiliate.
    b. Share any covered individual's information, received from a pharmacy or PBM affiliate, except as permitted by the federal Health Insurance Portability and Accountability Act.
3. Contracts Between PBMs and 340B Covered Entities
    a. Applies to a Medicaid managed care organization and does NOT apply to the state Medicaid program when Medicaid provides reimbursement for covered outpatient drugs on a fee for service basis.
    b. "340B Covered entity" is defined as an entity authorized to participate in the federal 340B Drug Pricing Program of the federal Public Health Service Act and includes any pharmacy under contract with the entity to dispense drugs on behalf of the entity.
    c. The following provisions may NOT be contained in a contract between a PBM and a 340B covered entity:
        i. A reimbursement rate for a prescription drug that would diminish the 340B benefit to a 340B covered entity.
        ii. A fee or adjustment that is not imposed on a pharmacy that is not a 340B covered entity.
        iii. A fee or adjustment amount that exceeds the fee or adjustment amount imposed on a pharmacy that is not a 340B covered entity.
        iv. Any provision that prevents or interferes with an individual's choice to receive a prescription drug from a 340B covered entity, including the administration of the drug.
        v. Any provision that excludes a 340B covered entity from PBM networks based on the 340B covered entity's participation in the federal 340B Drug Pricing Program.
        vi. Any provision that discriminates against a 340B covered entity.
        vii. Any violation of this by a PBM constitutes an unfair or deceptive act or practice in the business of insurance.
    d. For contracts between a PBM and a 340B covered entity that are entered into, amended, or renewed after June 30, 2021, a provision that violates the above is considered void and unenforceable.
4. Amended to state that PBMs have to at least every **7 days** or in a different time frame if contracted between a PBM and a pharmacy, update and make available the PBMs maximum allowable cost list.
5. Amended the duties of a PBM to include:
    a. Before the prescription drug is placed or continued on a maximum allowable cost list, the PBM shall determine that a prescription drug:
        i. is not obsolete,
        ii. is generally available for purchase by pharmacies in Indiana from a national or regional wholesaler licensed in Indiana, and

iii. is not temporarily unavailable, listed on a drug shortage list, or unable to be lawfully substituted.

6. The PBM must notify each pharmacy in their network that the maximum allowable cost for the drug has been adjusted as a result of an approved appeal.
7. Amended to add that if an appeal to resolve a dispute concerning the maximum allowable cost pricing is denied, the PBM must provide:
    a. the reason for the denial, and
    b. the appealing contracted pharmacy, pharmacy services administrative organization, or group purchasing organization with the national drug code number of the prescription drug that is available from a national or regional wholesaler operating in Indiana.
8. If a PBM denies an appeal, the appealing contracted pharmacy, pharmacy services administrative organization, or group purchasing organization may file a complaint with the department no later than 30 days from the date of the denial.
9. If a contracted pharmacy or pharmacy services administrative organization believes that its contract with a PBM contains an unlawful contractual provision regarding reimbursement rates, the contracted pharmacy or pharmacy services administrative organization may file a complaint with the department.
10. A PBM that receives written notice of a complaint shall conduct an investigation of the matters alleged in this complaint. No later than 20 business days after the complaint, the PBM shall provide to the department and the complaining party a written report containing the following information:
    a. The specific actions taken by the PBM with respect to the appeal or the contract for the complaint.
    b. A good faith estimate of the time required for a resolution of the complaint.
    c. If a pharmacy believes that its contract with a pharmacy services administrative organization contains an unlawful contractual provision regarding reimbursement rates, the pharmacy may file a complaint with the department.
11. Amends that an insurer must mail a written notice of cancellation to a person insured under a policy issued by the insurer.
12. Provides the method in which a notice of cancellation of a policy should be written and delivered.

M. Activities Not Prohibited as Rebates

1. Effective July 1, 2021.
2. Provides definitions for certain terms.
3. Provides the reasons for which an insurer or an insurance producer may offer or provide, for free or at a discounted price, products, or services.
4. A person holding a license may offer or provide, for free or for less than fair market value, services that are at least tangentially related to an insurance contract or the administration of an insurance contract if the services meet certain criteria.
5. Before the recipient of services receives a quote of insurance, purchases insurance, or an agent of record is assigned to the recipient of the services, the person offering or providing the services must disclose conspicuously in writing to the recipient of the services that receiving the services is not contingent on the purchase of insurance.

N. Specialty Drugs

1. Effective April 29, 2021 and will expire December 31, 2021.
2. "Specialty drugs" are prescription drugs typically high in cost that also meets certain other criteria.
3. Provides that before July 1, 2021, the State Department of Health shall submit to the legislative council a report about specialty drugs, best practice guidelines in providing specialty drugs, and information about adverse effects.

O. The legislative services agency shall conduct a study of market concentration in Indiana in certain areas and shall present those findings to interim study committees on financial institutions and insurance, and public health, behavioral health, and human services, the legislative council, and the office of the governor before December 31, 2022.
   1. This will expire on January 1, 2023.

P. Emergency declared for this act.

Click here to read the latest version

IV. HEA 1421: Various Health Care Matters (Rep. Donna Schaibley)

A. Effective July 1, 2021.

B. Nothing prohibits the state personnel department from directly contracting with health care providers for health care services for state employees.

C. Repealed the definition and calculation of "weighted average negotiated charge".

D. *High Risk Pregnancies and Premature Infants*
   1. Defines "born alive" as the complete expulsion or extraction from the infant's mother, at any stage of development or gestational age, of an infant who after the expulsion or extraction (regardless of whether the umbilical cord has been cut or whether the expulsion of extraction occurs via a natural or induced labor, cesarean section, or induced abortion):
      a. breathes,
      b. has a beating heart or pulsation of the umbilical cord, or
      c. has a definite movement of voluntary muscles.
   2. If a woman in premature labor presents to a hospital, the hospital must inform the woman of the hospital's capabilities of treating the born alive infant and managing a high-risk pregnancy.
   3. If the hospital does not have the capability to treat the premature born alive infant or the ability to manage a high-risk pregnancy, the hospital must provide the woman with options to get to a hospital that can appropriately manage her care.
   4. Provides what entails an appropriate level of care for hospitals to provide to a born alive infant or woman in premature labor.
   5. Provides direction for what information the hospital must provide after the medical screening to a woman in premature labor or a parent of the born alive infant.
   6. The hospital must determine the appropriate level of perinatal care for the born alive infant and mother and arrange for transport if necessary. If a hospital violates this, they are subject to penalties.
   7. A health care provider who is licensed, employed or under contract with a hospital, and is responsible for providing treatment or examination of a born alive infant or woman with a high-risk pregnancy is subject to the standards of practice and if this standard is violated, the provider is subject to disciplinary sanctions.

E. Hospital Price Transparency

1. Definitions
    a. "De-identified maximum negotiated charge" is defined as the highest charge that an ambulatory outpatient surgical center has negotiated with any third party payer for an item or service.
    b. "De-identified minimum negotiated charge" is defined as the lowest charge that an ambulatory outpatient surgical center has negotiated with any third party payer for an item or service.
    c. "Discounted cash price" is defined as the charge that applies to an individual who pays cash or the cash equivalent for an ambulatory outpatient surgical center item or service.
    d. "Gross charge" is defined as the charge for an individual item or service that is reflected on an ambulatory outpatient surgical center's chargemaster, absent any discounts.
    e. "Item or service" is defined as any item or service, including service packages, that could be provided by an ambulatory outpatient surgical center to a patient for which the ambulatory outpatient surgical center has established a standard charge. The term includes the following: supplies, procedures, use of the facility and other facility fees, services of employed physicians and non-physician practitioners, including professional charges, and anything that an ambulatory outpatient surgical center has established as a standard charge.
    f. "Payer-specific negotiated charge" is defined as the charge an ambulatory outpatient surgical center has negotiated with a third party payer for an item or service.
    g. "Standard charge" is defined as the regular rate established by the ambulatory outpatient surgical center for an item or service provided to a specific group of paying patients. This term includes gross charge, payer-specific negotiated charge, de-identified minimum charge, de-identified maximum charge, and discounted cash price.
2. Amended to say that by no later than December 31, 2021, an ambulatory outpatient surgical center shall post on their website pricing and other information.
    a. If the ambulatory outpatient surgical center offers less than 30 services, then they must provide information for all the services they do provide.
    b. Amended to state that the standard charge per time or service for each of the categories is to be provided.
3. If the federal Hospital Price Transparency Rule is repealed or federal enforcement is stopped, then the state health commissioner has to notify the legislative council in an electronic format.
4. A hospital shall post pricing information in compliance with the federal Hospital Price Transparency Rule of the federal Centers for Medicare and Medicaid Services in effect on January 1, 2021.
    a. Amended to state that the standard charge per time or service for each of the categories was to be provided.
5. Amended to say that a health provider contract may not contain a provision that prohibits the disclosure of health care service claims data to another person for use in the APCD, beginning July 1, 2021.
6. *Health Provider Contract*
    a. Applies to a health provider contract entered into, amended, or renewed after June 30, 2021.
    b. A health provider contract may NOT contain a provision that does any of the following:

i. Limits the ability of either the health carrier or the health provider facility to disclose the allowed amount and fees of services to any insured or enrollee, or to the treating health provider facility or physician of the insured or enrollee.
ii. Limits the ability of the health carrier or the health provider facility to disclose out-of-pocket costs to an insured or an enrollee.
iii. Any provision of a health provider contract that violates the above is severable and the provision in violation is null and void. The remaining provisions of the health provider contract, excluding the provision in violation, remain in effect and are enforceable.
iv. Limits the ability of either the health carrier or the health provider facility to disclose the allowed amount and fees of services to any insured or enrollee, or to the treating health provider facility or physician of the insured or enrollee.
v. Limits the ability of the health carrier or the health provider facility to disclose out-of-pocket costs to an insured or an enrollee.

7. Before September 1, 2021, the Department of Insurance shall issue an electronic report to the legislative council and certain interim study committees setting forth suggestions for revising the rules adopted to reduce the regulatory costs incurred by employers seeking to provide health coverage for their employees through multiple employer welfare arrangements.
    a. This will expire on January 1, 2022.

Click here to read the latest version

V. HEA 1447: Good Faith Health Care Estimates (Rep. Ann Vermillion)

A. "Out of network" Defined

1. Effective June 30th, 2021.
2. "Out of network" means that the health care service provided by the practitioner to a covered individual are not subject to the covered individual's health carrier network plan.

B. "Good Faith Estimate" (GFE)

1. Effective July 1, 2021.
2. "Good Faith Estimate" means a reasonable estimate of the price **each provider** anticipates charging for an episode of care for nonemergency health care services that is made by:
    a. a practitioner **or provider facility** under this chapter, or
    b. a provider upon the request of the individual for whom the nonemergency health care service has been ordered and is not binding upon the **provider**.

C. *Non-Emergency Care*

1. Effective July 1, 2021.
2. A practitioner that has scheduled or ordered for an 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 ask a health care provider for an estimate of the price the health care providers and health facility will charge for providing a nonemergency health care service. The law requires that the estimate be provided **within 5 business days of scheduling the nonemergency health care service unless the nonemergency health care service is scheduled to be performed by the practitioner within 5 business days of the date of the patient's request.**

D. Patient's rights for "Good Faith Estimate" (GFE)

1. Effective July 1, 2021.
2. Each provider must make diligent attempts to ensure that the patient is aware of the patient's right to request a GFE. The communication by each provider of information to the patient concerning the right to a GFE must be conspicuous and must be provided by at least 3 of the following means:
    a. Notice of provider's Internet web site.
    b. On holding messaging.
    c. Waiting room notification.
    d. Pre-appointment reminders, including through electronic mail (email) or text messaging.
    e. During appointment or services check in.
    f. During appointment or services check out.
    g. During patient financial services or billing department inquires.
    h. Through an electronic medical and patient communication portal.
3. The communication required must state 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 the estimate be provided within 5 business days of scheduling the nonemergency health care service unless the nonemergency health care service is scheduled to be performed by the practitioner within 5 business days of the date of the patient's request.

E. Failure or refusal to provide "Good Faith Estimates" (GFE)

1. Effective July 1, 2021.
2. If a provider facility fails or refuses to provide a GFE or to provide communication to a patient of information concerning the patient's right to a GFE 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.
3. This civil penalty collected shall be deposited in the Department of Insurance fund.
4. Provides penalty to health carriers not providing the required GFE information.

F. Out of Network and In Network Practitioners

1. Effective July 1, 2021.
2. 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 by an amount greater than $100 or 5%, the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

G. Medicare

1. Effective July 1, 2021.
2. If a provider facility receives a request for a GFE and the patient is eligible for Medicare coverage the provider facility shall provide a GFE to the patient within 5 business days based on available Medicare cost sharing rates.

H. An emergency is declared for this act.

Click here to read the latest version

VI. HEA 1468: Various Health Matters (Rep. Steven Davisson)

A. Medicare Rehabilitation

1. Effective July 1, 2021.

2. Before December 1, 2021 the office shall apply to the United States Department of Health and Human Services for an amendment to the state Medicaid plan that would require reimbursement by the office or a contractor of the office for eligible Medicaid rehabilitation option services provided by a behavioral health professional authorized to provide Medicaid services working in a community mental health center for any Medicaid eligible recipient who is undertaking initial assessment, intake, or counseling in a community mental health center before the development of a plan of treatment. This subsection expires December 31, 2021.
3. A community mental health center shall commence a plan of treatment within 2 weeks for a Medicaid recipient who receives services under this section.
4. Before December 1, 2021, the office shall apply to the United States Department of Health and Human Services for an amendment to the state Medicaid plan to require Medicaid reimbursement for the purpose of authorizing Medicaid rehabilitation option services as an eligible service concurrent with reimbursement under the residential treatment program, level of care 3.1 for the clinically managed low-intensity residential services facilities, as set forth by the American Society of Addiction Medicine (ASAM), if the authorized Medicaid rehabilitation option services are not currently reimbursed as an eligible service under the ASAM 3.1 level of care Section 1115 Medicaid demonstration waiver bundled rate.

B. *"Telehealth Activities" Defined*
   1. Effective July 1, 2021.
   2. For purposes of a community mental health center, telehealth services satisfy any face-to-face meeting requirement between a clinician and consumer.

C. *9-8-8 Crisis Hotline Centers and Mobile Crisis Teams*
   1. Provides certain definitions and criteria/duties the 9-8-8 crisis hotline/center must meet.
   2. The division has primary oversight over suicide prevention and crisis services activities and essential coordination with designated 9-8-8 crisis hotline centers. The division shall work with the national suicide prevention lifeline and the Veterans Crisis Hotline Networks for the purpose of ensuring consistency of public messaging concerning 9-8-8 services.
   3. No later than July 1, 2022, the division may designate at least one 9-8-8 crisis hotline center in Indiana to coordinate crisis intervention services and crisis care coordinate to individuals accessing the 9-8-8 suicide prevention and behavioral health crisis hotline from anywhere in Indiana, 24 hours a day, 7 days a week.
   4. The division shall adapt rules to allow appropriate information sharing and communication between and across crisis and emergency response systems for the purpose of real time crisis care coordination, including deployment of crisis and outgoing services and linked, flexible services specific to crisis response.
   5. Before March 1 of each year, a designated 9-8-8 crisis hotline enter shall submit a written report to the division concerning 9-8-8 crisis hotline's usage and the services provided by the center.
   6. The division shall coordinate available onsite response services of crisis calls using state and locally funded mobile crisis teams and crisis receiving and stabilization services resulting from a 9-8-8 call.
   7. The mobile crisis team MUST include jurisdiction based behavioral health teams that include a licensed behavioral health professional and peers certified by the division, licensed emergency medical services personnel, and law enforcement based coresponder behavioral health teams.

8. The statewide 9-8-8 trust fund is established for purposes of creating and maintaining a statewide 9-8-8 suicide prevention and mental health crisis system. The fund shall be administered by the division.

D. "Home Health Services" Defined and Outlined

1. Effective April 29, 2021.
2. Expands the scope of a licensed advanced practice registered nurse and a licensed physician assistant for home health services, home health written orders, home health services administration, and home health services vaccine administration and home health services drug regulations.

E. Prescription Drug Program

1. Effective July 1, 2021.
    a. Adds that a non-profit association of cities and towns may participate in the Prescription Drug Program.

F. Student Identification Cards

1. Effective July 1, 2021.
2. Applies to a student identification card issued to a student after July 30th 2022.
3. Outlines regulations on student identification cards for regarding the 9-8-8 crisis hotline.

G. Controlled Prescription Requirements

1. Effective December 31st 2020 (retroactive).
2. After December 31st 2021, except as provided, a prescriber shall issue a prescription for a controlled substance:
    a. in an electronic format, and
    b. by electronic transmission from the prescriber to a pharmacy, in accordance with rules adopted by the board.

H. Controlled Prescription Requirements

1. Effective December 31, 2020 (retroactive).
2. Beginning January 1, 2022, a prescriber may issue a prescription for a controlled substance in a written format, a fax format, or an oral order if any of the following apply:
    a. The prescriber cannot transmit and electronically transmitted prescription due to:
        i. temporary technological or electrical failure,
        ii. the technological and ability to issue a prescription electronically, included but not limited to failure to possess the requisite technology, or
        iii. the inability of the dispensing pharmacy or provider to receive or process an electronically transmitted prescription.
    b. The prescriber issues a prescription to be dispensed by a pharmacy location outside of Indiana.
    c. The prescriber and the pharmacist are the same entity.

I. Pharmacist Supervision and Responsibilities

1. Effective July 1, 2021.
2. Updated pharmacy technician role in remote work.
    a. A pharmacy technician may work remotely for non-dispensing job responsibilities, including:
        i. data entry,
        ii. insurance processing, or

iii. other responsibilities that do not require the pharmacy technician to be physically present at the pharmacy.

J. Requirements of Opening a Pharmacy

1. Effective July 1, 2021.
2. Adds to the requirements that the board hold the permit holder responsible and may not discipline or otherwise hold the qualifying pharmacist responsible for staffing deficiency of the pharmacy if the qualifying pharmacist does not have authority for staffing determinations of the pharmacy.

K. Control II Prescription Requirements in the Pharmacy

1. Effective July 1, 2021.
2. Upon request of a patient, a pharmacy shall transfer to another pharmacy a prescription for the patient, including a prescription for a schedule II controlled substance, that the pharmacy has received but not filled unless:
    a. prohibited in writing on the prescription by the prescriber, or
    b. otherwise prohibited by federal law.
3. Unless prohibited by federal law, a prescription for a patient may be transferred electronically or by facsimile by a pharmacy to another pharmacy if the pharmacies do not share a common database.

L. Pharmacist Ability to Vaccinate

1. Effective April 29, 2021.
2. Adds the COVID-19 immunization to the list of immunizations which a pharmacist can administer.

M. Pharmacy Technician Immunization Administration

1. The pharmacy technician may administer an influenza or coronavirus disease immunization to an individual or group of individuals under a drug order, under prescription, or according to a protocol approved by a physician.
2. The board must approve all programs that provide training to pharmacy technicians to administer influenza in coronavirus disease immunizations as permitted.

N. "Therapeutic Alternative" Defined

1. Effective July 1, 2021.
2. "Therapeutic alternative" means a drug product that:
    a. has a different chemical structure from,
    b. is in the same pharmacological or therapeutic class as, and
    c. usually can be expected to have similar therapeutic effects and adverse reaction profiles when administered to patients in therapeutically equivalent doses as another drug.

O. Provides that a pharmacist may make adjustments to the drug regimen if the pharmacist makes a therapeutic substitution, and outlines protocol for this adjustment.

1. Effective July 1, 2021.

P. "Health plan" defined

1. Effective July 1, 2021.
2. "Health plan" updated to include any other plan or program that provides payment, reimbursement, or indemnification to a covered individual for the cost of prescription drugs.

Q. An emergency is declared for this act.

Click here to read the latest version

Additional Information

- Indiana Legislative Scorecard 2021: Link
- Dr. Richard Feldman: Session falls short on health care bills: Link