HB 1405

Requires the legislative services agency to conduct a study of market concentration in Indiana in the health insurance industry, the hospital industry, and five other industries and to present the findings of the study to the combined interim study committees on financial institutions and insurance and public health, behavioral health, and human services, the legislative council, and the governor before December 31, 2022. Prohibits a pharmacy benefit manager (PBM) from: (1) imposing limits on a pharmacy's access to medication that differ from those existing for a PBM affiliate; or (2) sharing any covered individual's information, except as permitted by the federal Health Insurance Portability and Accountability Act (HIPAA). Prohibits the inclusion of certain provisions in a contract between a PBM and an entity authorized to participate in the federal 340B Drug Pricing Program, with certain exceptions. Requires a PBM: (1) to update the PBM's maximum allowable cost list at least every seven days; (2) to determine that a prescription drug is not obsolete, is generally available for purchase by pharmacies, and is not temporarily unavailable, listed on a drug shortage list, or unable to be lawfully substituted before placing the prescription drug on a maximum allowable cost list. Provides that: (1) if a PBM approves an appeal concerning maximum allowable cost pricing, the PBM must notify each pharmacy in the PBM's network that the maximum allowable cost for the drug has been adjusted; and (2) if a PBM denies an appeal, the PBM must provide the reason for the denial and other information, and the appealing pharmacy or other entity may then file a complaint with the department of insurance (department). Also allows a contracted pharmacy or pharmacy services administrative organization to file a complaint with the department if it believes that its contract with a PBM contains an unlawful contractual provision. Provides that a PBM's violation of these requirements or prohibitions is an unfair or deceptive act or practice in the business of insurance. Amends code sections requiring an insurer to "deliver" or "provide" certain notices within a certain time period to make those sections provide instead that the insurer is required to "mail" the notices.

SB 287

Health care strategy task force. Establishes the health care strategy task force. Sets forth membership and requires the task force to report to the general assembly by November 1, 2022. The health care strategy task force is established for the purpose of establishing

recommendations for improving quality, access, and affordability of health care in Indiana.

HB 1286

Telehealth matters. Provides for a standard definition of telehealth in titles 12, 16, 25, and 27. Prohibits the Medicaid program from specifying originating sites and distant sites for purposes of Medicaid reimbursement. Changes the use of the term “telemedicine” to “telehealth”. Expands the application of the telehealth statute to additional licensed practitioners instead of applying only to prescribers. Provides that veterinarians may provide telehealth services only when an existing veterinarian-client-patient relationship has been established. Amends the definition of “telehealth”. Requires that the telehealth medical records be created and maintained under the same standards of appropriate practice for medical records for patients in an in-person setting. Amends requirements for a prescriber issuing a prescription to a patient via telehealth services. Specifies that a patient waives confidentiality of medical information concerning individuals in the vicinity when the patient is using telehealth. Prohibits certain health care policies that provide coverage for telehealth services from requiring the use of a specific information technology application for those services.

SB 62

Prescription drug rebates and pricing. Provides that the defined cost sharing for a prescription drug under a policy of accident and sickness insurance or a health maintenance organization contract must be calculated at the point of sale and based on a price that is reduced by an amount equal to at least 85% of all rebates received by the insurer or health maintenance organization in connection with the dispensing or administration of the prescription drug.

HB 1347

Telemedicine. Expands the list of medical professionals from which home health agencies may accept written orders. Changes the requirements for the issuance of a prescription via telemedicine. Provides that advanced practice registered nurses may operate in multiple locations in collaboration with a physician. Increases the number of pharmacy technicians that a single licensed pharmacist may supervise. Provides that pharmacy technicians may perform certain work remotely without the direct supervision of a licensed pharmacist.

HB 1393

Pharmacy benefit managers. Prohibits the inclusion of certain provisions in a contract between a pharmacy benefit manager and an entity authorized to participate in the federal 340B Drug Pricing Program. Provides that a pharmacy benefit manager’s violation of the prohibition is an unfair or deceptive act or practice in the business of insurance.

HB 1217

Notice of change to provider agreement. Requires an insurer and a health maintenance organization to provide a contracted provider with a current reimbursement rate schedule: (1) every two years; and (2) when three or more CPT code rates change in a 12 month period. Requires an insurer and a health maintenance organization to provide a contracted provider with notice of a proposed material change to the agreement between the insurer or health maintenance organization and the contracted provider at least 90 days prior to the proposed effective date. Establishes requirements for the contents of a notice of a proposed material change. Requires an insurer or health maintenance organization to provide a contracted provider with notice at least 15 days prior to a change to an existing prior authorization, precertification, notification, referral program, edit program, or specific edits.

HB 1374

Medicaid providers and managed care organizations. Allows a provider that has entered into a contract with a managed care organization, after exhausting any internal procedures of the managed care organization for provider grievances and appeals, to request an administrative appeal within the office of Medicaid policy and planning of the managed care organization's action in denying or reducing reimbursement for claims for covered services provided to an applicant, pending applicant, conditionally eligible individual, or member. Establishes a procedure for an administrative appeal, including a hearing before an administrative law judge that could be followed by agency review and then by judicial review. Prohibits a provision in a contract between a provider and a managed care organization that would negate or restrict the right of a provider to an administrative appeal and provides that such a contract provision is void and unenforceable. Repeals a provision under which Medicaid law is controlling when Medicaid law conflicts with insurance law. Provides that if the office of the secretary of family and social services or a contractor of the office fails to pay or denies a clean claim for any eligible Medicaid service within certain time limits due to the office or contractor incorrectly processing the clean claim because of errors attributable to the internal system of an insurer or managed care organization, the office or contractor may not assert that the provider failed to meet the time filing requirements for the claim.

SB 3

Telehealth matters. Prohibits the Medicaid program from specifying originating sites and distant sites for purposes of Medicaid reimbursement. Specifies certain activities that are considered to be health care services for purposes of the telehealth laws. Expands the application of the telehealth statute to additional licensed practitioners instead of applying only to prescribers. Provides that a practitioner who directs an employee to perform a specified health service is held to the same standards of appropriate practice as those standards for health care services provided at an in-person setting. Requires that the telehealth medical records be created and maintained under the same standards of appropriate practice for medical records for patients in an in-person setting. Prohibits an employer from requiring a practitioner to provide a health care service through telehealth if

the practitioner believes: (1) that health quality may be negatively impacted; or (2) the practitioner would be unable to provide the same standards of appropriate practice as those provided in an in-person setting.

Updated: States with Certificate of Public Advantage (COPA) Laws

In the most recent legislative session, Indiana enacted a new certificate of public advantage (COPA) law (SB 416) that allows mergers of certain hospitals to receive immunity from claims of state antitrust laws for the duration of the certificate. Specifically, hospitals eligible for the COPA must be located in a predominately rural county with a specific population cap and has no more than two hospitals in the statewide comprehensive trauma care system.

Indiana joins 17 other states with existing COPA laws and 1 states with limited COPA laws, mostly enacted since 1993. Five other states, including North Carolina and Montana, have repealed their COPA statutes.

See map below for an overview of existing and repealed COPA laws across the country. Click on the state for citations and to download the statute text available in the SLIHCQ Database.