SB 416

Hospitals and certificates of public advantage. Establishes a certificate of public advantage (certificate) pertaining to mergers between hospitals located in counties that meet certain requirements to be issued by the state department of health (state department). Provides that a hospital that has been issued a certificate may not be purchased by another hospital or system of hospitals unless the purchase has been approved by the Federal Trade Commission. Sets forth the procedure and standards for obtaining a certificate and maintaining the certificate. Requires the state department to establish fees for the application of a certificate and the monitoring of an entity holding a certificate in an amount reasonably sufficient to fully fund the costs of the review and supervision of the application. Provides that for the first five years that a hospital is operating under a certificate the hospital: (1) may not increase the charge for each individual service that the hospital offers by more than the increase in the Consumer Price Index for Medical Care; and (2) must invest the realized cost savings for the benefit of the community. Requires a hospital the has been issued a certificate to file an annual report. Allows the office of the attorney general to issue an investigative demand concerning the issuance or maintenance of a certificate. Provides for an appeal of a determination made by the state department concerning the issuance or maintenance of a certificate.

Enacted at Ind. Code §§ 16-21-15-1 through 16-21-15-11.

Ind. Code §§ 16-21-15-1 through 16-21-15-11: Certificate of Public Advantage of Hospital Mergers

Provides that any 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.

New on The Source: Downloadable Chart of Merger Review Legal Authority for All 50 States

Newly available on the Source: our health policy research team compiled a user-friendly, downloadable Excel spreadsheet of all provider merger review authority for all 50 states, now on the Market Consolidation interactive key issue page. The detailed chart provides clickable citations of all statutes, regulations, and state authority for mergers, acquisitions, conversions, or changes in ownership of healthcare providers.

The comprehensive spreadsheet allows side-by-side comparisons of the level of legal authority for each state to receive notice of impending transactions, review those transactions, and approve, conditionally approve, or disapprove them. It is conveniently organized by each type of state entity:

- Attorney general notice, approval, and review criteria
- Court approval requirement and criteria
- State health agency notice, approval and review criteria
- Certificate of Need (CON) notice, approval, and review criteria

Click on each citation for a direct link to the statutory text and other detailed information as provided by the Database of State Laws Impacting Healthcare Cost and Quality (SLIHCQ). All laws and regulations are current as of July 2021.

Click here to download.

HB 1447

Good faith health care estimates. Revises the definition of “practitioner” in the laws concerning good faith estimates of costs for health care services. Postpones, from July 1, 2021, to January 1, 2022, the effective date of the requirement that a practitioner provide a good faith estimate of the amount the practitioner intends to charge for a health care service. Requires that the communication by a provider facility and a practitioner to a patient about the patient’s right to request a good faith estimate be conspicuous and be provided by at least

three of eight specified potential means. Provides that the written notice that a practitioner provides to an individual about a scheduled or ordered nonemergency health care service must state that a good faith estimate of cost need not be provided if the service is scheduled to be performed within five business days of the date of the patient's request. Provides that certain written statements must be in "conspicuous" type instead of in type at least as large as 14 point type. Requires a practitioner or facility to provide a written explanation if the charge for a health care service exceeds the practitioner's or facility's good faith estimate by the greater of: (1) $100; or (2) 5%. Revises the content of the written statement that an out of network practitioner providing health care services at an in network facility must give to a covered individual in order to be reimbursed more for the health care services than allowed according to the rate established by the covered individual's network plan. Provides that a practitioner can comply with the requirement to provide a good faith estimate of the amount that the practitioner intends to charge a covered individual by complying with the requirements of the new federal No Surprises Act (Act). Provides that a health carrier may satisfy certain requirements concerning good faith estimates by complying with the Act.

SB 325

Hospitals. Requires certain nonprofit hospitals to hold an annual public forum for the purposes of: (1) obtaining feedback from the community about the nonprofit hospital's performance in the previous year; (2) discussing the pricing of health services provided at the nonprofit hospital; and (3) discussing the contributions made by the nonprofit hospital to the community. Requires a nonprofit hospital, at least 14 days before the public forum, to post on the nonprofit hospital's Internet web site: (1) a notice stating the date, time, location, and purposes of the public forum; and (2) information relating to the subjects to be discussed at the public forum. Allows the public forum to be held, either all or in part, through an interactive real time audio and video meeting that is accessible to the community through the Internet. Changes the date that ambulatory outpatient surgical centers are required to begin posting certain pricing information from March 31, 2021, to December 31, 2021. Specifies that the pricing information posted is the standard charge rather than the weighted average negotiated charge and sets forth what is included in the standard charge. Specifies that if an ambulatory outpatient surgical center offers less than 30 additional services, the center is required to post all of the services the center provides. Requires a hospital to post pricing information in compliance with the federal Hospital Price Transparency Rule of the Centers for Medicare and Medicaid Services as in effect on January 1, 2021, if: (1) the federal Hospital

Price Transparency Rule is repealed; or (2) federal enforcement of the federal Hospital Price Transparency Rule is stopped. Requires a health carrier to hold an annual public forum. Specifies information to be discussed at the health carrier public forum and information to be disclosed before the forum. Makes conforming changes.

HB 1231

Prescription price. Requires a retail pharmacy, before dispensing a prescription, to inform an insured patient of the cost of the drug or device without insurance or an applicable discount, if the cost of the drug or device is less than the copayment cost to the patient using the insurance or an applicable discount.

HB 1219

Requires a state employee health plan, a policy of accident and sickness insurance, a health maintenance organization contract, an employee welfare benefit plan, or any other health plan that is compliant with federal law to only offer health plans that do not require a covered individual to: (1) pay a deductible; or (2) pay more than the amount of the copayment or coinsurance specified in the plan's summary of benefits and coverage; with respect to a prescription drug. Prohibits a state employee health plan, a policy of accident and sickness insurance, or a health maintenance organization contract from requiring an insured to pay a cost sharing requirement of more than $250 for a 30 day supply of an individual prescription drug. Requires a state employee health plan, a policy of accident and sickness insurance, and a health maintenance organization contract to include any amounts paid by a covered individual or on behalf of a covered individual when calculating the covered individual's cost sharing requirement. Provides that the cost sharing requirement for a prescription drug under a state employee health plan, a policy of accident and sickness insurance, or a health maintenance organization contract will be calculated at the point of sale and based on a price that is reduced by an amount equal to at least 75% of all rebates received by the insurer in connection with the dispensing or administration of the prescription drug.

HB 1207

Pharmacy matters. 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. Adds advanced practice registered nurses and physician assistants to the list of out-of-state providers whose prescriptions a pharmacist has a duty to honor. Allows a prescription for a patient to be transferred electronically or by facsimile by a pharmacy to another pharmacy if the pharmacies do not share a common data base. Provides that aggregated information compiled from annual reports of pharmacy benefit managers to the insurance commissioner is not confidential except for information that would reveal a specific pharmacy benefit manager's proprietary information. Requires: (1) a state employee health plan; and (2) an insurer-provided health plan that complies with the federal Affordable Care Act; to establish a procedure under which the amount paid by a covered individual for a covered prescription drug purchased outside of the health plan will offset the covered individual's deductible. Requires an insurer, when removing a prescription drug from the insurer's formulary or changing the cost sharing requirements applying to the prescription drug, to give an insured for whom the drug has been prescribed 60 days notice of the insurer's action and provide an appeal process through which the insured may request an extension of coverage for the drug through the end of the insured's plan year.

HB 1209

Reimbursement for emergency medical services. 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: (1) rendered by an emergency medical services provider organization; (2) within the emergency medical services provider organization's scope of practice; (3) performed or provided as advanced life support services; and (4) performed or provided during a response initiated through the 911 system.

HB 1372

Various insurance matters. Requires a state employee health plan, a policy of accident and sickness insurance, and a health maintenance organization contract to provide coverage for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS), including treatment with intravenous immunoglobulin therapy. Makes changes in the law concerning the permissible investments of life insurance companies and casualty, fire, and marine insurance companies. Provides that an insurance administrator may pay claims via electronic payment. Exempts an individual from the prelicensing course, state license examination, and continuing education requirements for licensed independent adjusters if the individual holds a current claims certification issued by a national or state claims association whose certification program meets certain conditions. Provides that a multiple employer welfare arrangement may be established through an interlocal cooperation agreement. Adopts the insurance data security model law, which requires certain holders of an insurance license, authority, or registration to maintain an information security program and meet other requirements.