SB 448

Nonprofit hospital report. Requires a nonprofit hospital to annually report the policies, procedures, activities, or any other actions taken by the nonprofit hospital in the preceding calendar year that were intended to make health care more affordable.

HB 1236

Prohibition on risk based managed care programs. Extends the prohibition against the inclusion of certain Medicaid recipients in: (1) risk based managed care programs; or (2) capitated managed care programs; from June 30, 2020, to June 30, 2021. Makes a technical correction.

HB 1146

Health care service cost. Requires provider facilities and certain health care practitioners to provide to patients the cost of scheduled health care services.

SB 453

Direct primary care services pilot programs. Requires the state personnel department to establish and implement a direct primary care pilot program for public employees. Sets forth requirements of the pilot program. Requires the state personnel department to prepare and submit an annual report to the general assembly evaluating the pilot program. Requires the office of the secretary of family and social services (office) to apply to the United States Department of Health and Human Services for a Medicaid waiver or Medicaid state plan amendment necessary to allow the office to implement a direct primary care services pilot program for Medicaid recipients. Sets forth requirements of the pilot program, participants,

and direct primary care services providers. Requires the office to submit a quarterly report to the general assembly containing specified information concerning the pilot program.

SB 421

Restrictions on copayments. Requires a state employee health plan, a policy of accident and sickness insurance, and a health maintenance organization contract to provide coverage without cost sharing for auto-injectable epinephrine that is prescribed to individuals less than 18 years of age. Requires an insurer to cap the total amount an insured is required to pay for a 30 day supply of a prescription insulin drug at an amount not to exceed $50, regardless of the amount or type of insulin prescribed to the insured.

SB 282

Health insurance reimbursement rates. Requires an insurer to provide notice to the department of insurance not later than 270 days prior to reducing a reimbursement rate paid to a contracted provider. Requires the department of insurance to hold a public hearing on the proposed reduction not later than 60 days after it is provided notice by the insurer. Requires an insurer proposing a reduction to attend the hearing and present evidence regarding: (1) the proposed change in the reimbursement rate; (2) the insurer’s rationale for the proposed reduction; (3) the network adequacy; and (4) the procedure and timeline that will be used to notify contracted providers of the proposed reduction.

SB 160

Requires a policy of accident and sickness insurance, a health maintenance organization contract, 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. Requires 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 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 85% of all rebates received by the insurer in connection with the dispensing or administration of the prescription drug.

HB 1176

First steps program. Provides that: (1) a health benefits plan; or (2) an employee health plan; may not require authorization for services specified in a covered individual's individualized family service plan once the individualized family service plan is signed by a physician. Provides that: (1) a health plan information card issued: (A) to an insured by an insurer for a policy of accident and sickness insurance; or (B) to an enrollee by a health maintenance organization (HMO); must indicate the type of health plan that is providing the health benefits and services under the insurance policy or HMO contract; and (2) these requirements apply only to a health plan information card issued: (A) initially to a new insured or new enrollee; or (B) to an insured or enrollee at the time of the insured's or enrollee's policy or contract renewal; after July 1, 2020. Provides that: (1) the electronic database by which an issuer of a policy of accident and sickness insurance, or an administrator of a self insured plan, allows an insured or a provider to verify the coverage or benefits of an insured must indicate: (A) whether health benefits and services under the policy of accident and sickness insurance are provided by the issuer of the policy or by a third party administrator; and (B) whether the policy of accident and sickness insurance is subject to state or federal regulation; and (2) the electronic database by which by which an HMO, or an administrator of benefits and health care services under an HMO contract, allows an enrollee or a provider to verify the coverage or benefits of an enrollee must indicate: (A) whether benefits and health care services under the HMO contract are provided by the HMO or by a third party administrator; and (B) whether the HMO contract is a self funded or fully funded plan. Requires the department of insurance to adopt rules to ensure compliance with certain provisions added by the bill.

HB 1115

Physician noncompete agreements. Requires an enforceable physician noncompete agreement to contain the following provisions: (1) A provision that requires the employer of the physician to provide the physician with a copy of any notice: (A) concerning the physician's departure; and (B) sent to any patient seen or treated by the departing physician during the two year period preceding the termination of the physician's employment or expiration of the departing physician's contract, as applicable. (2) A provision that requires the physician's employer to, in good faith, provide current or last known contact and location information to a patient seen or treated by the physician during the two year period preceding the termination of the physician's employment or expiration of the physician's contract. (3) A provision that provides the physician whose employment has terminated or whose contract has expired with the option to purchase a complete and final release from the terms of an enforceable noncompete agreement at a reasonable price. (4) A provision that prohibits medical records from being provided to the physician in a format that differs from the format used to create or store the medical record during the routine and ordinary course of business. Allows the person or entity responsible for copying or transferring a medical record to charge a reasonable fee for the service.

SB 15

Pharmacy benefit managers. Requires a pharmacy benefit manager that is not licensed as an administrator to be registered with the board of pharmacy. Specifies requirements for registration, renewal, conduct, appeals, and annual reporting by pharmacy benefit managers. Repeals certain provisions regulating pharmacy benefit managers doing business in Indiana.