# SB 38

Reporting by pharmacy benefit managers. Requires pharmacy benefit managers to report annually specified information to the commissioner of the department of insurance. Requires the commissioner to post the information on the department of insurance’s Internet web site.

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# HB 1116

Drug information reporting. Requires prescription drug manufacturers, health insurance issuers, pharmacy benefits managers, and wholesale drug distributors (reporting entities) to report certain information to the department of insurance (department), including increases in the wholesale acquisition cost of brand name drugs and generic drugs, the introduction into the United States of a new drug, and spending on prescription drugs before enrollee cost sharing for each of the top 25 prescription drugs and drug groups. Requires reporting entities to pay an annual assessment to support the operational costs incurred by the department in connection with the reporting. Requires a reporting entity to certify under the penalty of perjury that a required report is accurate. Authorizes the insurance commissioner to impose a civil penalty on a reporting entity that fails to comply with a reporting requirement. Requires the department to annually prepare and make available on its web site a report on emerging trends in prescription drug prices. Requires the department to keep confidential and protect from public disclosure all information submitted by reporting entities.

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# HB 1042

Pharmacy benefit managers. Requires a pharmacy benefit manager to obtain a license issued by the department of insurance and sets forth requirements of the pharmacy benefit manager. Provides for the commissioner of the department of insurance to adopt rules to specify licensure, financial standards, and reporting requirements that apply to a pharmacy benefit manager. Sets forth requirements and prohibitions of a pharmacy benefit manager. Allows a party that has contracted with a pharmacy benefit manager to request an audit of compliance at least one time per year. Makes violations of the chapter concerning pharmacy benefit

managers an unfair or deceptive act or practice in the business of insurance. Allows a pharmacy benefit manager 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.

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# HB 1005

Health and insurance matters. Establishes the importation of prescription drugs program (program) for the importation of prescription drugs to be administered by the state department of health (state department). Requires the state department to apply to the federal government for approval of the program. Sets forth requirements for the vendor of the program. Sets requirements for suppliers, importers, and wholesale drug distributors of the program. Requires the state department to submit reports to the governor and the general assembly concerning the program. Establishes for participants in the program an international export pharmacy permit and wholesale drug distributor permit administered by the Indiana board of pharmacy.Provides that a facility is an off-campus location of a hospital if: (1) the operations of the facility are directly or indirectly owned or controlled by, or affiliated with, the hospital; (2) the facility provides services that are organizationally and functionally integrated with the services of the hospital; and (3) the facility provides preventive services, diagnostic services, treatment services, or emergency services. Requires hospitals, ambulatory surgical outpatient centers, and urgent care facilities to post certain health care services pricing information by billing code on the hospital's Internet web site and sets forth requirements. Requires: (1) a provider facility (including a hospital) in which a nonemergency health care service will be performed; or (2) a practitioner (including a physician) who will perform a nonemergency health care service; upon request from the individual for whom the nonemergency health care service has been ordered, scheduled, or referred, to provide a good faith estimate of the price for the nonemergency health care service not more than three business days after receiving the individual's request. Requires a provider facility or practitioner to include the address of the service facility location to obtain reimbursement for a commercial claim for health care services. Requires a health carrier (including an insurer or a health maintenance organization) to provide to an individual who is entitled to coverage from the health carrier, not more than three business days after the individual requests the information, a good faith estimate of: (1) the amount of the cost of the nonemergency health care service that the health carrier will pay for or reimburse to the covered individual; or (2) the extent and nature of the ordered nonemergency health care

service a covered individual is entitled to receive. Requires the department of insurance to submit a request for information and a request for proposal concerning the establishment and implementation of an all payer claims data base and sets forth requirements. Provides that if a health carrier provides coverage to the individual through a network plan, the health carrier shall inform the individual whether the provider facility in which the nonemergency health care service will be provided and the practitioners who will provide the nonemergency health care service are included in the health carrier's network plan. Requires provider facilities to post signs in waiting rooms and to provide Internet web site notices about the availability of estimates of the amount the patient will be charged for medical services. Requires practitioners to provide notice about the availability of estimates of the amount the patient will be charged for medical services when the practitioner has ordered, scheduled, or referred the individual for a nonemergency health care service. Requires health carriers to provide Internet web site notices about the availability of good faith estimates of coverage for nonemergency health care services. Provides penalties for noncompliance by provider facilities, practitioners, and health carriers. Requires an insurance producer to disclose commission information. Prohibits health provider contracts and contracts between a provider and a pharmacy benefits manager from including provisions that prohibit the disclosure of health care service claims data to employers providing the health coverage and makes a violation an unfair and deceptive act. Provides that a fully credentialed provider shall be reimbursed by an insurer or health maintenance organization for eligible services provided at an in-network hospital if certain conditions are met.

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# HB 1332

Ambulatory surgical centers. Provides that ambulatory surgical centers may be reimbursed in an amount not to exceed 275% of the ambulatory surgical center's Medicare reimbursement rate. Provides that the payment to an ambulatory surgical center for a medical device under worker's compensation may not exceed the invoice amount plus 3%. Increases benefits for injuries and disablements by 2% each year for three years, beginning on July 1, 2020. Provides that a medical service facility may be reimbursed in an amount not to exceed 200% of the medical service facility's Medicare reimbursement rate.

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# SB 3

Health care provider billing. Prohibits billing a patient who receives emergency services: (1) from an out of network provider; and (2) at specified facilities that are in network; for amounts that exceed the cost paid by the patient's insurance plus any deductibles, copayments, and coinsurance amounts. Requires certain health care providers to provide, upon request from the patient, a good faith estimate to the patient for the cost of care at least five business days before a health care service or procedure is provided. Sets forth requirements of the good faith estimate. Requires the patient to acknowledge in writing receipt of the estimate and indicate whether to proceed with the service or procedure.

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# HB 1230

Health care provider billing requirements. Requires a hospital or ambulatory outpatient surgical center to provide a patient written notice before a service may be provided if the provider who is to provide the service is out of the patient's health plan network. Requires the patient to acknowledge receipt of the notice and either agree or decline to receive the service from an out of network provider. Specifies options if the patient declines to receive the services from an out of network provider. Includes transportation services as an included service for purposes of the notice and excludes emergency services.

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# HB 1335

Health care costs. Requires a hospital or ambulatory outpatient surgical center to provide each patient, patient's guardian, or patient's health care representative with a good faith estimate (estimate) of all charges and fees associated with certain medical procedures and services. Requires an estimate to be provided to a patient upon: (1) the patient's discharge from the hospital or ambulatory outpatient surgical center; or (2) the conclusion of a medical examination or procedure. Specifies that an estimate is not a legally binding contract or estimate concerning the: (1) allowable; (2) total; or (3) final; cost for a medical examination, procedure, or other service. Requires a revised estimate to be provided not later than 30 days

after the date specified on an original estimate. Prohibits a hospital or ambulatory outpatient surgical center from charging a fee for the service of providing an estimate to a patient. Provides that a contract or contract provision may not prohibit a hospital or ambulatory outpatient surgical center from providing an estimate to a patient when required. Defines certain terms.

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# SB 243

Physicians who leave an employer. Provides that a physician noncompete agreement, to be enforceable, must contain the following provisions: (1) A provision requiring the physician's employer to provide the physician with a copy of any notice that: (A) concerns the physician's departure; and (B) was sent to a patient seen or treated by the physician during the two years preceding the termination of the physician's employment or expiration of the departing physician's contract. (2) A provision requiring the physician's employer to provide current or last known contact and location information to a patient seen or treated by the physician during the two years preceding the termination of the physician's employment or expiration of the physician's contract. (3) A provision providing 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 prohibiting the providing of medical records to the physician in a format differing from the format used to create or store the medical record during the ordinary course of business. Provides for information and notification that an employer must give to: (1) a physician who leaves the employment of the provider; and (2) certain patients who request the physician's contact information. Allows a person or entity responsible for copying or transferring a medical record to charge a reasonable fee.

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# HB 1421

Provides that the state employee health plan statute does not prohibit the state personnel department from directly contracting with health care providers for health care services for state employees. Defines "health carrier" for purposes of the law on health provider contracts.

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. Prohibits the inclusion in a health provider contract of any provision that would: (1) prohibit the disclosure of health care service claims data for purposes of using price transparency tools, including the all payer claims data base; (2) limit the ability of a health carrier or 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; or (3) limit the ability of a health carrier or health provider facility to disclose out-of-pocket costs to an insured or an enrollee. Requires the department of insurance to issue a report to: (1) the legislative council; and (2) the interim study committees on financial institutions and insurance and public health, behavioral health, and human services; setting forth its suggestions for revising the department’s administrative rules to reduce the regulatory costs incurred by employers seeking to provide health coverage for their employees through multiple employer welfare arrangements. Urges the legislative council to assign to an appropriate interim study committee the task of studying the rising cost and prices of health care services in Indiana. Requires the legislative services agency to conduct a study of market concentration in the health insurance industry, the hospital industry, the professions of licensed health care practitioners, the retail pharmaceutical industry, and the pharmacy benefit manager industry.