Reprinted
March 31, 2021

ENGROSSED
HOUSE BILL No. 1421

DIGEST OF HB 1421 (Updated March 30, 2021 3:41 pm - DI 104)

Citations Affected: IC 4-6; IC 5-10; IC 16-18; IC 16-21; IC 16-24.5; IC 27-1; noncode.

Synopsis: Various health care matters. 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. 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
(Continued next page)

Effective: Upon passage; March 1, 2021 (retroactive); July 1, 2021.

Schaibley, Heaton, Lauer, Cook
(SENATE SPONSORS — BROWN L, CHARBONNEAU, ZAY)

January 14, 2021, read first time and referred to Committee on Public Health. Reassigned to Committee on Financial Institutions and Insurance.
February 11, 2021, amended, reported — Do Pass.
February 17, 2021, read second time, amended, ordered engrossed.
February 18, 2021, engrossed.
February 22, 2021, read third time, passed. Yeas 90, nays 0.

SENATE ACTION
March 1, 2021, read first time and referred to Committee on Health and Provider Services.
March 11, 2021, amended, reported favorably — Do Pass.
March 30, 2021, read second time, amended, ordered engrossed.

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Medicare and Medicaid Services as in effect on January 1, 2021, if: (1) the federal Hospital Price Transparency Rule is repealed; or (2) federal enforcement of the federal Hospital Price Transparency Rule is stopped. Prohibits the inclusion in a health provider contract of any provision that would: (1) prohibit the disclosure of health care service claims data, including for use in 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.

Reprinted
March 31, 2021

First Regular Session of the 122nd General Assembly (2021)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2020 Regular Session of the General Assembly.

ENGROSSED
HOUSE BILL No. 1421

A BILL FOR AN ACT to amend the Indiana Code concerning health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 4-6-3-3, AS AMENDED BY P.L.137-2007, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 3. If the attorney general has reasonable cause to believe that a person may be in possession, custody, or control of documentary material, or may have knowledge of a fact that is relevant to an investigation conducted to determine if a person is or has been engaged in a violation of IC 4-6-9, IC 4-6-10, IC 13-14-10, IC 13-14-12, IC 13-24-2, IC 13-30-4, IC 13-30-5, IC 13-30-8, IC 23-7-8, IC 24-1-2, IC 24-5-0.5, IC 24-5-7, IC 24-5-8, IC 24-9, IC 25-1-7, **IC 27-1-37-8,** IC 32-34-1, or any other statute enforced by the attorney general or is or has been engaged in a criminal violation of IC 13, only the attorney general may issue in writing, and cause to be served upon the person or the person's representative or agent, an investigative demand that requires that the person served do any combination of the following:

(1) Produce the documentary material for inspection and copying or reproduction.

(2) Answer under oath and in writing written interrogatories.

(3) Appear and testify under oath before the attorney general or the attorney general's duly authorized representative.

SECTION 2. IC 5-10-8-7, AS AMENDED BY P.L.217-2017, SECTION 53, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 7. (a) The state, excluding state educational institutions, may not purchase or maintain a policy of group insurance, except:

(1) life insurance for the state's employees;

(2) long term care insurance under a long term care insurance policy (as defined in IC 27-8-12-5), for the state's employees; or

(3) an insurance policy that provides coverage that supplements coverage provided under a United States military health care plan.

(b) With the consent of the governor, the state personnel department may establish self-insurance programs to provide group insurance other than life or long term care insurance for state employees and retired state employees. The state personnel department may contract with a private agency, business firm, limited liability company, or corporation for administrative services. A commission may not be paid for the placement of the contract. The department may require, as part of a contract for administrative services, that the provider of the administrative services offer to an employee terminating state employment the option to purchase, without evidence of insurability, an individual policy of insurance.

(c) Notwithstanding subsection (a), with the consent of the governor, the state personnel department may contract for health services for state employees through one (1) or more prepaid health care delivery plans.

(d) The state personnel department shall adopt rules under IC 4-22-2 to establish long term and short term disability plans for state employees (except employees who hold elected offices (as defined by IC 3-5-2-17)). The plans adopted under this subsection may include any provisions the department considers necessary and proper and must:

(1) require participation in the plan by employees with six (6) months of continuous, full-time service;

(2) require an employee to make a contribution to the plan in the form of a payroll deduction;

(3) require that an employee's benefits under the short term disability plan be subject to a thirty (30) day elimination period and that benefits under the long term plan be subject to a six (6) month elimination period;

(4) prohibit the termination of an employee who is eligible for benefits under the plan;

(5) provide, after a seven (7) day elimination period, eighty percent (80%) of base biweekly wages for an employee disabled by injuries resulting from tortious acts, as distinguished from passive negligence, that occur within the employee's scope of state employment;

(6) provide that an employee's benefits under the plan may be reduced, dollar for dollar, if the employee derives income from:

(A) Social Security;

(B) the public employees' retirement fund;

(C) the Indiana state teachers' retirement fund;

(D) pension disability;

(E) worker's compensation;

(F) benefits provided from another employer's group plan; or

(G) remuneration for employment entered into after the disability was incurred.

(The department of state revenue and the department of workforce development shall cooperate with the state personnel department to confirm that an employee has disclosed complete and accurate information necessary to administer this subdivision.);

(7) provide that an employee will not receive benefits under the plan for a disability resulting from causes specified in the rules; and

(8) provide that, if an employee refuses to:

(A) accept work assignments appropriate to the employee's medical condition;

(B) submit information necessary for claim administration; or

(C) submit to examinations by designated physicians;

the employee forfeits benefits under the plan.

(e) This section does not affect insurance for retirees under IC 5-10.3 or IC 5-10.4.

(f) The state may pay part of the cost of self-insurance or prepaid health care delivery plans for its employees.

(g) A state agency may not provide any insurance benefits to its employees that are not generally available to other state employees, unless specifically authorized by law.

(h) The state may pay a part of the cost of group medical and life coverage for its employees.

(i) To carry out the purposes of this section, a trust fund may be established. The trust fund established under this subsection is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be

transferred, assigned, or otherwise removed from the trust fund established under this subsection by the state board of finance, the budget agency, or any other state agency. Money in a trust fund established under this subsection does not revert to the state general fund at the end of any state fiscal year. The trust fund established under this subsection consists of appropriations, revenues, or transfers to the trust fund under IC 4-12-1. Contributions to the trust fund are irrevocable. The trust fund must be limited to providing prefunding of annual required contributions and to cover OPEB liability for covered individuals. Funds may be used only for these purposes and not to increase benefits or reduce premiums. The trust fund shall be established to comply with and be administered in a manner that satisfies the Internal Revenue Code requirements concerning a trust fund for prefunding annual required contributions and for covering OPEB liability for covered individuals. All assets in the trust fund established under this subsection:

(1) are dedicated exclusively to providing benefits to covered individuals and their beneficiaries according to the terms of the health plan; and

(2) are exempt from levy, sale, garnishment, attachment, or other legal process.

The trust fund established under this subsection shall be administered by the state personnel department. The expenses of administering the trust fund shall be paid from money in the trust fund. Notwithstanding IC 5-13, the treasurer of state shall invest the money in the trust fund not currently needed to meet the obligations of the trust fund in the same manner as money may be invested by the public employees' retirement fund under IC 5-10.3-5. However, the trustee may not invest the money in the trust in equity securities. The trustee shall also comply with the prudent investor rule set forth in IC 30-4-3.5. The trustee may contract with investment management professionals, investment advisors, and legal counsel to assist in the investment of the trust and may pay the state expenses incurred under those contracts from the trust. Interest that accrues from these investments shall be deposited in the trust fund.

(j) Nothing in this section prohibits the state personnel department from directly contracting with health care providers for health care services for state employees.

SECTION 3. IC 16-18-2-92.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 92.3. (a) "De-identified maximum negotiated charge", for purposes of**

IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(a).

(b) "De-identified minimum negotiated charge", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(b).

SECTION 4. IC 16-18-2-96.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 96.1. "Discounted cash price", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(c).**

SECTION 5. IC 16-18-2-153.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 153.8. "Gross charge", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(d).**

SECTION 6. IC 16-18-2-194.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 194.7. "Item or service", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(e).**

SECTION 7. IC 16-18-2-272.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 272.5. "Payer-specific negotiated charge", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(f).**

SECTION 8. IC 16-18-2-337.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 337.5. "Standard charge", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(g).**

SECTION 9. IC 16-18-2-375.5 IS REPEALED [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]. ~~Sec. 375.5. "Weighted average negotiated charge", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.5.~~

SECTION 10. IC 16-21-17-0.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 0.3. (a) As used in this chapter, "de-identified maximum negotiated charge" means the highest charge that an ambulatory outpatient surgical center has negotiated with any third party payer for an item or service.**

(b) As used in this chapter, "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.

(c) As used in this chapter, "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.

(d) As used in this chapter, "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.

(e) As used in this chapter, "item or service" means 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:

(1) Supplies.

(2) Procedures.

(3) Use of the facility and other facility fees.

(4) Services of employed physicians and non-physician practitioners, including professional charges.

(5) Anything that an ambulatory outpatient surgical center has established as a standard charge.

(f) As used in this chapter, "payer-specific negotiated charge" means the charge that a hospital has negotiated with a third party payer for an item or service.

(g) As used in this chapter, "standard charge" means the regular rate established by the ambulatory outpatient surgical center for an item or service provided to a specific group of paying patients. The term includes the following:

(1) Gross charge.

(2) Payer-specific negotiated charge.

(3) De-identified minimum negotiated charge.

(4) De-identified maximum negotiated charge.

(5) Discounted cash price.

SECTION 11. IC 16-21-17-0.5 IS REPEALED [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]. ~~Sec. 0.5. As used in this chapter, "weighted average negotiated charge" means the amount determined in STEP SIX of the following formula with respect to a particular procedure:~~

~~STEP ONE: For each insurer with whom the hospital or an ambulatory outpatient surgical center negotiates a charge for a particular procedure, determine the percentage of the hospital's~~

~~patients or the ambulatory outpatient surgical center's patients insured by the insurer in the previous calendar year rounded to a whole percentage.~~

~~STEP TWO: Multiply each percentage determined under STEP ONE by one hundred (100) and express the results as whole numbers so that the sum of the percentage points determined under STEP ONE is one hundred (100).~~

~~STEP THREE: For a particular procedure, determine the amount of the negotiated charge for the procedure for each insurer described in STEP ONE.~~

~~STEP FOUR: For each insurer described in STEP ONE, multiply the STEP THREE amount determined for a particular procedure by the result determined under STEP TWO for that insurer.~~

~~STEP FIVE: For a particular procedure, determine the sum of the amounts determined under STEP FOUR for all of the insurers described in STEP ONE with respect to that procedure.~~

~~STEP SIX: For a particular procedure, determine the quotient of:~~

~~(A) the sum determined under STEP FIVE for that procedure; divided by~~

~~(B) one hundred (100).~~

SECTION 12. IC 16-21-17-1, AS AMENDED BY P.L.93-2020, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: Sec. 1. (a) Not later than ~~March 31, 2021, a hospital and~~ **December 31, 2021,** an ambulatory outpatient surgical center shall post on the Internet web site of the ~~hospital or~~ ambulatory outpatient surgical center pricing and other information specified in this chapter for the following:

(1) For as many of the seventy (70) shoppable services specified in the final rule of the Centers for Medicare and Medicaid Services published in 84 FR 65524 that are provided by the ~~hospital or~~ ambulatory outpatient surgical center.

(2) In addition to the services specified in subdivision (1):

(A) the thirty (30) most common services that are provided by the ~~hospital or~~ ambulatory outpatient surgical center not included in subdivision (1); **or**

(B) if the ambulatory outpatient surgical center offers less than thirty (30) services not included under subdivision (1), all of the services provided by the ambulatory outpatient surgical center.

(b) The following information, to the extent applicable, must be included on the Internet web site by ~~a hospital and~~ an ambulatory outpatient surgical center for the shoppable and common services

described in subsection (a):

(1) A description of the shoppable and common service.

(2) The ~~weighted average negotiated~~ **standard** charge per service per provider type for each of the following categories:

(A) Any nongovernment sponsored health benefit plan or insurance plan provided by a health carrier in which the provider is in the network.

(B) Medicare, including fee for service and Medicare Advantage.

(C) Self-pay without charitable assistance from the ~~hospital or~~ ambulatory outpatient surgical center.

(D) Self-pay with charitable assistance from the ~~hospital or~~ ambulatory outpatient surgical center.

(E) Medicaid, including fee for service and risk based managed care.

(c) If:

(1) the federal Hospital Price Transparency Rule is repealed; or

(2) federal enforcement of the federal Hospital Price Transparency Rule is stopped;

the state health commissioner shall notify the legislative council of the occurrence referred to in subdivision (1) or (2) in an electronic format under IC 5-14-6.

(d) This subsection takes effect when the legislative council receives a notification from the state health commissioner under subsection (c). A hospital shall post pricing information in compliance with the federal Hospital Price Transparency Rule of the federal Centers for Medicare and Medicaid Services as published at 84 FR 65524 and in effect on January 1, 2021.

SECTION 13. IC 16-24.5-1-2, AS AMENDED BY P.L.93-2020, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: Sec. 2. (a) Not later than March 31, 2021, an urgent care facility shall post on the Internet web site of the urgent care facility pricing and other information specified in this chapter for the fifteen (15) most common services that are provided by the urgent care facility.

(b) The following information, to the extent applicable, must be included on the Internet web site by an urgent care facility for the fifteen (15) most common services described in subsection (a):

(1) The number of times each service is provided by the urgent care facility.

(2) A description of the service.

(3) The ~~weighted average negotiated~~ **standard** charge per service per provider type for each of the following categories:

(A) Any nongovernment sponsored health benefit plan or insurance provided by a health carrier in which the provider is in the network.

(B) Medicare, including fee for service and Medicare Advantage.

(C) Self-pay without charitable assistance from the urgent care facility.

(D) Self-pay with charitable assistance from the urgent care facility.

(E) Medicaid, including fee for service and risk based managed care.

SECTION 14. IC 27-1-37-0.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 0.2. As used in this chapter, "affiliate" means any person who, directly or indirectly through one (1) or more intermediaries, controls, is controlled by, or is under common control with, the person to whom affiliation is attributed.**

SECTION 15. IC 27-1-37-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 1.5. (a) As used in this chapter, "health carrier" means an entity:**

(1) that is subject to IC 27 and the administrative rules adopted under IC 27; and

(2) that enters into a contract to:

(A) provide health care services;

(B) deliver health care services;

(C) arrange for health care services; or

(D) pay for or reimburse any of the costs of health care services.

(b) The term includes the following:

(1) An insurer, as defined in IC 27-1-2-3(x), that issues a policy of accident and sickness insurance, as defined in IC 27-8-5-1(a).

(2) A health maintenance organization, as defined in IC 27-13-1-19.

(3) An administrator (as defined in IC 27-1-25-1(a)) that is licensed under IC 27-1-25.

(4) A state employee health plan offered under IC 5-10-8.

(5) A short term insurance plan (as defined by IC 27-8-5.9-3).

(6) Any other entity that provides a plan of health insurance, health benefits, or health care services.

(c) The term does not include:

(1) an insurer that issues a policy of accident and sickness insurance;

(2) a limited service health maintenance organization (as defined in IC 27-13-34-4); or

(3) an administrator;

that only provides coverage for, or processes claims for, dental or vision care services.

SECTION 16. IC 27-1-37-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 3. As used in this chapter, "health provider contract" means an agreement with a provider **or a health provider facility** relating to terms and conditions of reimbursement for health care services provided to an individual under:

(1) an employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.);

(2) a policy of accident and sickness insurance (as defined in IC 27-8-5-1);

(3) a contract with a health maintenance organization;

(4) a self-insurance program established under IC 5-10-8-7(b); or

(5) a prepaid health care delivery plan entered into under IC 5-10-8-7(c).

SECTION 17. IC 27-1-37-3.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 3.2. As used in this chapter, "health provider facility" means any of the following:**

(1) A hospital, as defined in IC 16-18-2-179(a).

(2) A hospital system.

(3) An affiliate of a hospital or hospital system.

SECTION 18. IC 27-1-37-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 3.5. As used in this chapter, "hospital system" means:**

(1) a parent corporation of at least one (1) hospital and any entity affiliated with the parent corporation through ownership, governance, or membership; or

(2) a hospital and any entity affiliated with the hospital through ownership, governance, or membership.

SECTION 19. IC 27-1-37-7, AS AMENDED BY P.L.93-2020, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 7. (a) This section applies to health provider

contracts entered into or renewed after June 30, 2020.

(b) A health provider contract, including a contract with a pharmacy benefit manager or a health facility, may not contain a provision that prohibits the disclosure of health care service claims data to:

(1) employers providing the coverage; **or**

(2) beginning July 1, 2021, another person for use in the all payer claims data base established by IC 27-1-44.5.

However, any disclosure of claims data must comply with health privacy laws, including the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(c) A violation of this section constitutes an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

SECTION 20. IC 27-1-37-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 8. (a) This section applies to a health provider contract entered into, amended, or renewed after June 30, 2021.**

(b) A health provider contract, including a contract with a pharmacy benefit manager, may not contain a provision that does any of the following:

(1) 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 (as defined in IC 27-8-5.8-3) or enrollee (as defined in IC 27-13-1-12), or to the treating health provider facility or physician of the insured or enrollee.

(2) Limits the ability of either the health carrier or the health provider facility to disclose out-of-pocket costs to an insured (as defined in IC 27-8-5.8-3) or an enrollee (as defined in IC 27-13-1-12).

(c) Any provision of a health provider contract that includes a provision described in subsection (b) in violation of this section is severable and the provision in violation is null and void. The remaining provisions of the health provider contract, excluding the provision in violation of this section, remain in effect and are enforceable.

(d) The attorney general may issue a civil investigative demand to obtain information from a party of, or pertaining to, a health provider contract and compliance of this section.

SECTION 21. [EFFECTIVE UPON PASSAGE] **(a) Before September 1, 2021, the department of insurance shall issue a report to:**

(1) the legislative council; and

(2) the interim study committees on:

(A) financial institutions and insurance; and

(B) public health, behavioral health, and human services;

established by IC 2-5-1.3-4;

setting forth suggestions for revising the rules adopted under IC 27-1-34-9 to reduce the regulatory costs incurred by employers seeking to provide health coverage for their employees through multiple employer welfare arrangements. The report must be submitted in an electronic format under IC 5-14-6.

(b) This SECTION expires January 1, 2022.

SECTION 22. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Financial Institutions and Insurance, to which was referred House Bill 1421, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 2, delete lines 4 through 42.

Delete pages 3 through 5.

Page 6, delete lines 1 through 23.

Page 9, delete lines 17 through 42.

Delete page 10.

Page 11, delete lines 1 through 20, begin a new paragraph and insert:

"SECTION 3. IC 16-21-17-0.5, AS ADDED BY P.L.93-2020, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: Sec. 0.5. As used in this chapter, "weighted average negotiated charge" means the amount determined in STEP SIX of the following formula with respect to a particular procedure:

STEP ONE: For each insurer with whom ~~the hospital or~~ an ambulatory outpatient surgical center negotiates a charge for a particular procedure, determine the percentage of the ~~hospital's patients or the~~ ambulatory outpatient surgical center's patients insured by the insurer in the previous calendar year rounded to a whole percentage.

STEP TWO: Multiply each percentage determined under STEP ONE by one hundred (100) and express the results as whole numbers so that the sum of the percentage points determined under STEP ONE is one hundred (100).

STEP THREE: For a particular procedure, determine the amount of the negotiated charge for the procedure for each insurer described in STEP ONE.

STEP FOUR: For each insurer described in STEP ONE, multiply the STEP THREE amount determined for a particular procedure by the result determined under STEP TWO for that insurer.

STEP FIVE: For a particular procedure, determine the sum of the amounts determined under STEP FOUR for all of the insurers described in STEP ONE with respect to that procedure.

STEP SIX: For a particular procedure, determine the quotient of:

(A) the sum determined under STEP FIVE for that procedure; divided by

(B) one hundred (100).

SECTION 4. IC 16-21-17-1, AS AMENDED BY P.L.93-2020, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: Sec. 1. (a) Not later than March 31, 2021, ~~a hospital and~~ an ambulatory outpatient surgical center shall post on the Internet web site of the ~~hospital or~~ ambulatory outpatient surgical center pricing and other information specified in this chapter for the following:

(1) For as many of the seventy (70) shoppable services specified in the final rule of the Centers for Medicare and Medicaid Services published in 84 FR 65524 that are provided by the ~~hospital or~~ ambulatory outpatient surgical center.

(2) In addition to the services specified in subdivision (1), the thirty (30) most common services that are provided by the ~~hospital or~~ ambulatory outpatient surgical center not included in subdivision (1).

(b) The following information, to the extent applicable, must be included on the Internet web site by ~~a hospital and~~ an ambulatory outpatient surgical center for the shoppable and common services described in subsection (a):

(1) A description of the shoppable and common service.

(2) The weighted average negotiated charge per service per provider type for each of the following categories:

(A) Any nongovernment sponsored health benefit plan or insurance plan provided by a health carrier in which the provider is in the network.

(B) Medicare, including fee for service and Medicare Advantage.

(C) Self-pay without charitable assistance from the ~~hospital or~~ ambulatory outpatient surgical center.

(D) Self-pay with charitable assistance from the ~~hospital or~~ ambulatory outpatient surgical center.

(E) Medicaid, including fee for service and risk based managed care.

(c) If:

(1) the federal Hospital Price Transparency Rule is repealed; or

(2) federal enforcement of the federal Hospital Price Transparency Rule is stopped;

the state health commissioner shall notify the legislative council of the occurrence referred to in subdivision (1) or (2) in an electronic format under IC 5-14-6.

(d) This subsection takes effect when the legislative council

receives a notification from the state health commissioner under subsection (c). A hospital shall post pricing information in compliance with the federal Hospital Price Transparency Rule of the federal Centers for Medicare and Medicaid Services as published at 84 FR 65524 and in effect on January 1, 2021.".

Page 11, between lines 32 and 33, begin a new paragraph and insert:

"SECTION 6. IC 27-1-37-0.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 0.2. As used in this chapter, "affiliate" means any person who, directly or indirectly through one (1) or more intermediaries, controls, is controlled by, or is under common control with, the person to whom affiliation is attributed.**".

Page 12, between lines 22 and 23, begin a new paragraph and insert:

"SECTION 8. IC 27-1-37-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 3. As used in this chapter, "health provider contract" means an agreement with a provider **or a health provider facility** relating to terms and conditions of reimbursement for health care services provided to an individual under:

(1) an employee welfare benefit plan (as defined in 29 U.S.C. 1002 et seq.);

(2) a policy of accident and sickness insurance (as defined in IC 27-8-5-1);

(3) a contract with a health maintenance organization;

(4) a self-insurance program established under IC 5-10-8-7(b); or

(5) a prepaid health care delivery plan entered into under IC 5-10-8-7(c).

SECTION 9. IC 27-1-37-3.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 3.2. (a) As used in this chapter, "health provider facility" means any of the following:**

(1) A hospital, as defined in IC 16-18-2-179(a).

(2) A hospital system.

(3) An affiliate of a hospital or hospital system.

SECTION 10. IC 27-1-37-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 3.5. As used in this chapter, "hospital system" means:**

(1) a parent corporation of at least one (1) hospital and any entity affiliated with the parent corporation through ownership, governance, or membership; or

(2) a hospital and any entity affiliated with the hospital

through ownership, governance, or membership.".

Page 12, delete lines 39 through 42.

Page 13, delete lines 1 through 36, begin a new paragraph and insert:

"SECTION 12. IC 27-1-37-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 8. (a) This section applies to a health provider contract entered into, amended, or renewed after June 30, 2021.**

(b) A health provider contract, including a contract with a pharmacy benefit manager, may not contain a provision that does any of the following:

(1) 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 (as defined in IC 27-8-5.8-3) or enrollee (as defined in IC 27-13-1-12), or to the treating health provider facility or physician of the insured or enrollee.

(2) Limits the ability of either the health carrier or the health provider facility to disclose out-of-pocket costs to an insured (as defined in IC 27-8-5.8-3) or an enrollee (as defined in IC 27-13-1-12).

(c) Any provision of a health provider contract that includes a provision described in subsection (b) in violation of this section is severable and the provision in violation is null and void. The remaining provisions of the health provider contract, excluding the provision in violation of this section, remain in effect and are enforceable.

(d) The attorney general may issue a civil investigative demand to obtain information from a party of, or pertaining to, a health provider contract and compliance of this section.

SECTION 13. [EFFECTIVE UPON PASSAGE] **(a) Before September 1, 2021, the department of insurance shall issue a report to:**

(1) the legislative council; and

(2) the interim study committees on:

(A) financial institutions and insurance; and

(B) public health, behavioral health, and human services;

established by IC 2-5-1.3-4;

setting forth suggestions for revising the rules adopted under IC 27-1-34-9 to reduce the regulatory costs incurred by employers seeking to provide health coverage for their employees through multiple employer welfare arrangements. The report must be submitted in an electronic format under IC 5-14-6.

(b) This SECTION expires January 1, 2022.

SECTION 14. [EFFECTIVE UPON PASSAGE] **(a) The legislative council is urged to assign to an appropriate interim study committee the task of studying the rising cost and prices of health care services in Indiana. An interim study committee assigned a study under this SECTION shall consider:**

(1) how legislation enacted by the general assembly in recent sessions enhancing the transparency of the pricing of health care services has affected the marketplace; and

(2) additional steps that should be taken to lower health care prices, including market-driven solutions.

(b) This SECTION expires January 1, 2022.

SECTION 15. [EFFECTIVE UPON PASSAGE] **(a) The legislative services agency shall perform or commission the performance of a study of market concentration in Indiana in the following:**

(1) The health insurance industry.

(2) The hospital industry.

(3) The professions of licensed health care practitioners.

(4) The retail pharmaceutical industry.

(5) The pharmacy benefit manager industry.

(b) Before September 1, 2021, the legislative services agency shall present the findings of the study conducted under subsection (a) in an electronic format under IC 5-14-6 to the following:

(1) The combined interim study committees on:

(A) financial institutions and insurance; and

(B) public health, behavioral health, and human services; established by IC 2-5-1.3-4.

(2) The legislative council.

(3) The office of the governor.

(c) This SECTION expires January 1, 2022.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1421 as introduced.)

CARBAUGH

Committee Vote: yeas 13, nays 0.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1421 be amended to read as follows:

Page 6, delete lines 31 through 42.

Renumber all SECTIONS consecutively.

(Reference is to HB 1421 as printed February 11, 2021.)

SCHAIBLEY

HOUSE MOTION

Mr. Speaker: I move that House Bill 1421 be amended to read as follows:

Page 10, delete lines 8 through 25, begin a new paragraph and insert:

"SECTION 15. [EFFECTIVE UPON PASSAGE] **(a) The legislative services agency shall conduct a study of market concentration in Indiana in the following:**

(1) The health insurance industry.

(2) The hospital industry.

(3) The professions of licensed health care practitioners.

(4) The retail pharmaceutical industry.

(5) The pharmacy benefit manager industry.

(b) Before September 1, 2022, the legislative services agency shall present the findings of the study conducted under subsection (a) in an electronic format under IC 5-14-6 to the following:

(1) The combined interim study committees on:

(A) financial institutions and insurance; and

(B) public health, behavioral health, and human services; established by IC 2-5-1.3-4.

(2) The legislative council.

(3) The office of the governor.

(c) This SECTION expires January 1, 2022.".

Renumber all SECTIONS consecutively.

(Reference is to HB 1421 as printed February 11, 2021.)

AUSTIN

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1421, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 5, line 28, after "than" strike "March".

Page 5, line 29, strike "31, 2021,".

Page 5, line 29, after "and" insert "**December 31, 2021,**".

Page 5, line 37, delete "," and insert ":

(A)".

Page 5, line 40, delete "." and insert "; **or**

(B) if the ambulatory outpatient surgical center offers less than thirty (30) services not included under subdivision (1), all of the services provided by the ambulatory outpatient surgical center.".

Page 7, line 42, delete "(a)".

Page 8, line 21, delete "for purposes of".

Page 8, line 22, delete "using price transparency tools, including".

Page 9, delete lines 26 through 42.

Page 10, delete lines 1 through 12.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1421 Digest Correction as reprinted February 18, 2021.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 11, Nays 0.

SENATE MOTION

Madam President: I move that Engrossed House Bill 1421 be amended to read as follows:

Page 4, delete lines 39 through 42, begin a new paragraph and insert:

"SECTION 3. IC 16-18-2-92.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 92.3. (a)**

"De-identified maximum negotiated charge", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(a).

(b) "De-identified minimum negotiated charge", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(b).

SECTION 4. IC 16-18-2-96.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 96.1. "Discounted cash price", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(c).**

SECTION 5. IC 16-18-2-153.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 153.8. "Gross charge", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(d).**

SECTION 6. IC 16-18-2-194.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 194.7. "Item or service", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(e).**

SECTION 7. IC 16-18-2-272.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 272.5. "Payer-specific negotiated charge", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(f).**

SECTION 8. IC 16-18-2-337.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 337.5. "Standard charge", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.3(g).**

SECTION 9. IC 16-18-2-375.5 IS REPEALED [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]. ~~Sec. 375.5. "weighted average negotiated charge", for purposes of IC 16-21-17 and IC 16-21-24.5, has the meaning set forth in IC 16-21-17-0.5.~~

SECTION 10. IC 16-21-17-0.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: **Sec. 0.3. (a) As used in this chapter, "de-identified maximum negotiated charge" means the highest charge that an ambulatory outpatient surgical center has negotiated with any third party payer for an item or service.**

(b) As used in this chapter, "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.

(c) As used in this chapter, "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.

(d) As used in this chapter, "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.

(e) As used in this chapter, "item or service" means 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:

(1) Supplies.

(2) Procedures.

(3) Use of the facility and other facility fees.

(4) Services of employed physicians and non-physician practitioners, including professional charges.

(5) Anything that an ambulatory outpatient surgical center has established as a standard charge.

(f) As used in this chapter, "payer-specific negotiated charge" means the charge that a hospital has negotiated with a third party payer for an item or service.

(g) As used in this chapter, "standard charge" means the regular rate established by the ambulatory outpatient surgical center for an item or service provided to a specific group of paying patients. The term includes the following:

(1) Gross charge.

(2) Payer-specific negotiated charge.

(3) De-identified minimum negotiated charge.

(4) De-identified maximum negotiated charge.

(5) Discounted cash price.

SECTION 11. IC 16-21-17-0.5 IS REPEALED [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]. ~~Sec. 0.5. As used in this chapter, "weighted average negotiated charge" means the amount determined in STEP SIX of the following formula with respect to a particular procedure:~~

~~STEP ONE: For each insurer with whom the hospital or an ambulatory outpatient surgical center negotiates a charge for a~~

~~particular procedure, determine the percentage of the hospital's patients or the ambulatory outpatient surgical center's patients insured by the insurer in the previous calendar year rounded to a whole percentage.~~

~~STEP TWO: Multiply each percentage determined under STEP ONE by one hundred (100) and express the results as whole numbers so that the sum of the percentage points determined under STEP ONE is one hundred (100).~~

~~STEP THREE: For a particular procedure, determine the amount of the negotiated charge for the procedure for each insurer described in STEP ONE.~~

~~STEP FOUR: For each insurer described in STEP ONE, multiply the STEP THREE amount determined for a particular procedure by the result determined under STEP TWO for that insurer.~~

~~STEP FIVE: For a particular procedure, determine the sum of the amounts determined under STEP FOUR for all of the insurers described in STEP ONE with respect to that procedure.~~

~~STEP SIX: For a particular procedure, determine the quotient of:~~

~~(A) the sum determined under STEP FIVE for that procedure; divided by~~

~~(B) one hundred (100).~~".

Page 5, delete lines 1 through 25.

Page 6, line 8, strike "weighted average negotiated" and insert "**standard**".

Page 6, between lines 34 and 35, begin a new paragraph and insert:

"SECTION 13. IC 16-24.5-1-2, AS AMENDED BY P.L.93-2020, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: Sec. 2. (a) Not later than March 31, 2021, an urgent care facility shall post on the Internet web site of the urgent care facility pricing and other information specified in this chapter for the fifteen (15) most common services that are provided by the urgent care facility.

(b) The following information, to the extent applicable, must be included on the Internet web site by an urgent care facility for the fifteen (15) most common services described in subsection (a):

(1) The number of times each service is provided by the urgent care facility.

(2) A description of the service.

(3) The ~~weighted average negotiated~~ **standard** charge per service per provider type for each of the following categories:

(A) Any nongovernment sponsored health benefit plan or insurance provided by a health carrier in which the provider is

in the network.

(B) Medicare, including fee for service and Medicare Advantage.

(C) Self-pay without charitable assistance from the urgent care facility.

(D) Self-pay with charitable assistance from the urgent care facility.

(E) Medicaid, including fee for service and risk based managed care.".

Renumber all SECTIONS consecutively.

(Reference is to EHB 1421 as printed March 12, 2021.)

BROWN L