SENATE BILL No. 296

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15-44.5; IC 25-1-9.5-8.

Synopsis: Health matters. Removes requirements of cost sharing in the healthy Indiana plan. Removes requirements concerning prescribing a drug to a patient receiving services through telemedicine when the individual has not been previously examined by the prescriber.

Effective: July 1, 2021.

Breaux

January 11, 2021, read first time and referred to Committee on Health and Provider Services.

Introduced

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.

SENATE BILL No. 296

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 12-15-44.5-3.5, AS ADDED BY P.L.30-2016, SECTION 28, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 3.5. (a) The plan must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage, including coverage of a long acting, nonaddictive medication assistance treatment drug if the drug is being prescribed for the treatment of substance abuse.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Comprehensive disease management.

(9) Home health services, including case management.

(10) Urgent care center services.

(11) Preventative care services.

(12) Family planning services:

(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and

(B) not including abortion or abortifacients.

(13) Hospice services.

(14) Substance abuse services.

(15) Pregnancy services.

(16) A service determined by the secretary to be required by federal law as a benchmark service under the federal Patient Protection and Affordable Care Act.

(b) The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(c) The plan may provide vision services and dental services. ~~only to individuals who regularly make the required monthly contributions for the plan as set forth in section 4.7(c) of this chapter.~~

(d) The benefit package offered in the plan:

(1) must be benchmarked to a commercial health plan described in 45 CFR 155.100(a)(1) or 45 CFR 155.100(a)(4); and

(2) may not include a benefit that is not present in at least one (1) of these commercial benchmark options.

(e) The office shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The office shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

(f) The plan shall, at no cost to the individual, provide payment of preventative care services described in 42 U.S.C. 300gg-13 for an individual who participates in the plan.

(g) The plan shall, at no cost to the individual, provide payments of not more than five hundred dollars ($500) per year for preventative care services not described in subsection (f). Any additional preventative care services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan.

SECTION 2. IC 12-15-44.5-4.7, AS AMENDED BY P.L.152-2017, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 4.7. (a) To participate in the plan, an individual

must apply for the plan on a form prescribed by the office. The office may develop and allow a joint application for a household.

~~(b) A pregnant woman is not subject to the cost sharing provisions of the plan. Subsections (c) through (g) do not apply to a pregnant woman participating in the plan.~~

~~(c) An applicant who is approved to participate in the plan does not begin benefits under the plan until a payment of at least:~~

~~(1) one-twelfth (1/12) of the annual income contribution amount; or~~

~~(2) ten dollars ($10);~~

~~is made to the individual's health care account established under section 4.5 of this chapter for the individual's participation in the plan. To continue to participate in the plan, an individual must contribute to the individual's health care account at least two percent (2%) of the individual's annual household income per year or an amount determined by the secretary that is based on the individual's annual household income per year, but not less than one dollar ($1) per month. The amount determined by the secretary under this subsection must be approved by the United States Department of Health and Human Services and must be budget neutral to the state as determined by the state budget agency.~~

~~(d) If an applicant who is approved to participate in the plan fails to make the initial payment into the individual's health care account, at least the following must occur:~~

~~(1) If the individual has an annual income that is at or below one hundred percent (100%) of the federal poverty income level, the individual's benefits are reduced as specified in subsection (e)(1).~~

~~(2) If the individual has an annual income of more than one hundred percent (100%) of the federal poverty income level, the individual is not enrolled in the plan.~~

~~(e) If an enrolled individual's required monthly payment to the plan is not made within sixty (60) days after the required payment date, the following, at a minimum, occur:~~

~~(1) For an individual who has an annual income that is at or below one hundred percent (100%) of the federal income poverty level, the individual is:~~

~~(A) transferred to a plan that has a material reduction in benefits, including the elimination of benefits for vision and dental services; and~~

~~(B) required to make copayments for the provision of services that may not be paid from the individual's health care account.~~

~~(2) For an individual who has an annual income of more than one~~

~~hundred percent (100%) of the federal poverty income level, the individual shall be terminated from the plan and may not reenroll in the plan for at least six (6) months.~~

~~(f) The state shall contribute to the individual's health care account the difference between the individual's payment required under this section and the plan deductible set forth in section 4.5(c) of this chapter.~~

~~(g)~~ **(b)** A member shall remain enrolled with the same managed care organization during the member's benefit period. A member may change managed care organizations as follows:

(1) Without cause:

(A) ~~before making a contribution or~~ before finalizing enrollment; ~~in accordance with subsection (d)(1);~~ or

(B) during the annual plan renewal process.

(2) For cause, as determined by the office.

SECTION 3. IC 12-15-44.5-4.9, AS AMENDED BY P.L.114-2018, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 4.9. (a) An individual who is approved to participate in the plan is eligible for a twelve (12) month plan period if the individual continues to meet the plan requirements specified in this chapter.

(b) If an individual chooses to renew participation in the plan, the individual is subject to an annual renewal process at the end of the benefit period to determine continued eligibility for participating in the plan. If the individual does not complete the renewal process, the individual may not reenroll in the plan for at least six (6) months.

(c) This subsection applies to participants who consistently made the required payments in the individual's health care account. If the individual receives the qualified preventative services recommended to the individual during the year, the individual is eligible to have the individual's unused share of the individual's health care account at the end of the plan period, determined by the office, matched by the state and carried over to the subsequent plan period to reduce the individual's required payments. If the individual did not, during the plan period, receive all qualified preventative services recommended to the individual, only the nonstate contribution to the health care account may be used to reduce the individual's payments for the subsequent plan period.

(d) For individuals participating in the plan who, in the past, did not make consistent payments into the individual's health care account while participating in the plan, but:

(1) had a balance remaining in the individual's health care

account; and

(2) received all of the required preventative care services;

the office may elect to offer a discount on ~~the individual's required payments to~~ the individual's health care account for the subsequent benefit year. The amount of the discount under this subsection must be related to the percentage of the health care account balance at the end of the plan year but not to exceed a fifty percent (50%) discount of the required contribution.

(e) If an individual is no longer eligible for the plan, does not renew participation in the plan at the end of the plan period, or is terminated from the plan for nonpayment of a required payment, the office shall, not more than one hundred twenty (120) days after the last date of the plan benefit period, refund to the individual the amount determined under subsection (f) of any funds remaining in the individual's health care account as follows:

(1) An individual who is no longer eligible for the plan or does not renew participation in the plan at the end of the plan period shall receive the amount determined under STEP FOUR of subsection (f).

(2) An individual who is terminated from the plan due to nonpayment of a required payment shall receive the amount determined under STEP SIX of subsection (f).

The office may charge a penalty for any voluntary withdrawals from the health care account by the individual before the end of the plan benefit year. The individual may receive the amount determined under STEP SIX of subsection (f).

(f) The office shall determine the amount payable to an individual described in subsection (e) as follows:

STEP ONE: Determine the total amount paid into the individual's health care account under this chapter.

STEP TWO: Determine the total amount paid into the individual's health care account from all sources.

STEP THREE: Divide STEP ONE by STEP TWO.

STEP FOUR: Multiply the ratio determined in STEP THREE by the total amount remaining in the individual's health care account.

STEP FIVE: Subtract any nonpayments of a required payment.

STEP SIX: Multiply the amount determined under STEP FIVE by at least seventy-five hundredths (0.75).

SECTION 4. IC 12-15-44.5-10, AS AMENDED BY P.L.30-2016, SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 10. (a) The secretary has the authority to provide benefits to individuals eligible under the adult group described in 42

CFR 435.119 only in accordance with this chapter.

(b) The secretary may negotiate and make changes to the plan, except that the secretary may not negotiate or change the plan that would do the following:

~~(1)~~ ~~Reduce the following:~~

~~(A) Contribution amounts below the minimum levels set forth in section 4.7 of this chapter.~~

~~(B) Deductible amounts below the minimum amount established in section 4.5(c) of this chapter.~~

~~(2)~~ ~~Remove or reduce the penalties for nonpayment set forth in section 4.7 of this chapter.~~

~~(3)~~ **(1)** Revise the use of the health care account requirement set forth in section 4.5 of this chapter.

~~(4)~~ **(2)** Include noncommercial benefits or add additional plan benefits in a manner inconsistent with section 3.5 of this chapter.

~~(5) Allow services to begin:~~

~~(A) without the payment established or required by; or~~

~~(B) earlier than the time frames otherwise established by; section 4.7 of this chapter.~~

~~(6)~~ **(3)** Reduce financial penalties for the inappropriate use of the emergency room below the minimum levels set forth in section 5.7 of this chapter.

~~(7)~~ **(4)** Permit members to change health plans without cause in a manner inconsistent with section 4.7(g) of this chapter.

~~(8)~~ **(5)** Operate the plan in a manner that would obligate the state to financial participation beyond the level of state appropriations or funding otherwise authorized for the plan.

(c) The secretary may make changes to the plan under this chapter if the changes are required by federal law or regulation.

SECTION 5. IC 25-1-9.5-8, AS AMENDED BY P.L.52-2020, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 8. (a) A prescriber may issue a prescription to a patient who is receiving services through the use of telemedicine if the patient has not been examined previously by the prescriber in person if the following conditions are met:

(1) The prescriber has satisfied the applicable standard of care in the treatment of the patient.

(2) The issuance of the prescription by the prescriber is within the prescriber's scope of practice and certification.

(3) The prescription:

(A) meets the requirements of subsection (b); and

(B) is not for an opioid. However, an opioid may be prescribed

if the opioid is a partial agonist that is used to treat or manage opioid dependence.

(4) The prescription is not for an abortion inducing drug (as defined in IC 16-18-2-1.6).

(5) If the prescription is for a medical device, including an ophthalmic device, the prescriber must use telemedicine technology that is sufficient to allow the provider to make an informed diagnosis and treatment plan that includes the medical device being prescribed. However, a prescription for an ophthalmic device is also subject to the conditions in section 13 of this chapter.

(b) Except as provided in subsection (a), a prescriber may issue a prescription for a controlled substance (as defined in IC 35-48-1-9) to a patient who is receiving services through the use of telemedicine, even if the patient has not been examined previously by the prescriber in person, if the following conditions are met:

(1) The prescriber maintains a valid controlled substance registration under IC 35-48-3.

(2) The prescriber meets the conditions set forth in 21 U.S.C. 829 et seq.

~~(3) The patient has been examined in person by a licensed Indiana health care provider and the licensed health care provider has established a treatment plan to assist the prescriber in the diagnosis of the patient.~~

~~(4) The prescriber has reviewed and approved the treatment plan described in subdivision (3) and is prescribing for the patient pursuant to the treatment plan.~~

~~(5)~~ **(3)** The prescriber complies with the requirements of the INSPECT program (IC 25-26-24).

(c) A prescription for a controlled substance under this section must be prescribed and dispensed in accordance with IC 25-1-9.3 and IC 25-26-24.