Reprinted
April 13, 2021

ENGROSSED
SENATE BILL No. 325

DIGEST OF SB 325 (Updated April 12, 2021 7:21 pm - DI 137)

Citations Affected: IC 16-18; IC 16-21; IC 16-24.5; IC 27-1; IC 27-2.

Synopsis: Hospitals. Provides that if a woman who is in premature labor presents to a hospital, the hospital must inform the woman of the hospital's capabilities of treating the born alive infant and managing a high risk pregnancy. Requires a hospital to provide: (1) a medical screening examination; and (2) any needed stabilizing treatment; to an infant who is born alive or a woman who is in premature labor. Requires the hospital to provide certain information to the parents of a born alive infant and a woman in premature labor. Provides that a hospital that violates the requirements is subject to certain penalties. Provides that certain health care providers are subject to the standards of practices for the provider's licensed or certified profession. Prohibits a hospital from permitting the administration of a specialty drug on its premises unless certain requirements regarding the dispensation and
(Continued next page)

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

Busch, Charbonneau
(HOUSE SPONSORS — MANNING, PRESCOTT)

January 11, 2021, read first time and referred to Committee on Health and Provider Services.
February 18, 2021, amended, reported favorably — Do Pass.
February 22, 2021, read second time, amended, ordered engrossed.
February 23, 2021, engrossed. Read third time, passed. Yeas 47, nays 0.

HOUSE ACTION

March 4, 2021, read first time and referred to Committee on Public Health.
April 8, 2021, amended, reported — Do Pass.
April 12, 2021, read second time, amended, ordered engrossed.

Digest Continued

transportation of the specialty drug are met. Provides that a health plan and a hospital may not enter into an agreement regarding the dispensation and reimbursement for specialty drugs unless certain requirements are met. 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. Requires an ambulatory outpatient surgical center and urgent care facility to post certain pricing information on the center's Internet web site by December 31, 2021. Removes hospitals from certain state statutory health care services price disclosure posting requirements. 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. Provides that if the federal Hospital Price Transparency Rule (federal rule) is repealed or stopped, a hospital shall continue to post pricing information in compliance with the federal rule as the federal rule was in effect on January 1, 2021. Requires a pharmacy to report to the state insurance commissioner, on a quarterly basis, the total amount of rebates received by the pharmacy during the previous quarter. Requires a prescription drug manufacturer to make certain reports to the state insurance commissioner regarding federally approved prescription drugs sold in or into the state by the manufacturer. 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.

Reprinted
April 13, 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
SENATE BILL No. 325

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 16-18-2-37.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 37.9. "Born alive", for purposes of IC 16-21-2-17, has the meaning set forth in IC 16-21-2-17(a).**

SECTION 2. IC 16-18-2-75.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 75.5. "Contracted pharmacy", for purposes of IC 16-21-16.5, has the meaning set forth in IC 16-21-16.5-2.**

SECTION 3. IC 16-18-2-167.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 167.5. "Health plan", for purposes of IC 16-21-16.5, has the meaning set forth in IC 16-21-16.5-3.**

SECTION 4. IC 16-18-2-179, AS AMENDED BY P.L.99-2007, SECTION 154, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 179. (a) "Hospital", except as

provided in subsections (b) through (g), means a hospital that is licensed under IC 16-21-2.

(b) "Hospital", for purposes of IC 16-21, means an institution, a place, a building, or an agency that holds out to the general public that it is operated for hospital purposes and that it provides care, accommodations, facilities, and equipment, in connection with the services of a physician, to individuals who may need medical or surgical services. The term does not include the following:

(1) Freestanding health facilities.

(2) Hospitals or institutions specifically intended to diagnose, care, and treat the following:

(A) Individuals with a mental illness (as defined in IC 12-7-2-117.6).

(B) Individuals with developmental disabilities (as defined in IC 12-7-2-61).

(3) Offices of physicians where patients are not regularly kept as bed patients.

(4) Convalescent homes, boarding homes, or homes for the aged.

(c) "Hospital", for purposes of IC 16-22-8, has the meaning set forth in IC 16-22-8-5.

(d) "Hospital", for purposes of IC 16-23.5, has the meaning set forth in IC 16-23.5-1-9.

(e) "Hospital" or "tuberculosis hospital", for purposes of IC 16-24, means an institution or a facility for the treatment of individuals with tuberculosis.

(f) "Hospital", for purposes of IC 16-34, means a hospital (as defined in subsection (b)) that:

(1) is required to be licensed under IC 16-21-2; or

(2) is operated by an agency of the United States.

(g) "Hospital", for purposes of IC 16-41-12, has the meaning set forth in IC 16-41-12-6.

(h) "Hospital", for purposes of IC 16-21-16 and IC 16-21-16.5, has the meaning set forth in IC 16-21-16-1.

SECTION 5. 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 16-24.5-1, has the meaning set forth in IC 16-21-17-0.3(a).**

SECTION 6. IC 16-18-2-336.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 336.5. "Specialty drug", for purposes of IC 16-21-16 and IC 16-21-16.5, has the meaning set**

forth in IC 16-21-16-2.

SECTION 7. IC 16-18-2-336.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 336.6. "Specialty drug agreement", for purposes of IC 16-21-16.5, has the meaning set forth in IC 16-21-16.5-4.**

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 16-24.5-1, has the meaning set forth in IC 16-21-17-0.3(b).**

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 16-21-2-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 17. (a) As used in this section, "born alive" means the complete expulsion or extraction from the infant's mother, at any stage of development or gestational age, of an infant who after the expulsion or extraction:**

(1) breathes;

(2) has a beating heart or pulsation of the umbilical cord; or

(3) has a definite movement of voluntary muscles;

regardless of whether the umbilical cord has been cut or whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion.

(b) If a woman who is in premature labor presents to a hospital, the hospital must inform the woman of the hospital's capabilities of treating the born alive infant and managing a high risk pregnancy. If the hospital does not have the capability to treat the premature born alive infant or the ability to manage a high risk pregnancy, the hospital must provide the woman options to get to a hospital with the appropriate level of care under the perinatal level of care designation established under IC 16-21-13.

(c) A hospital must provide:

(1) a medical screening examination; and

(2) any needed stabilizing treatment;

to an infant who is born alive, including born prematurely or with a disability, or a woman who is in premature labor.

(d) After a hospital has provided a medical screening examination under subsection (c)(1), the hospital must inform:

(1) a parent of the born alive infant of the:

(A) infant's treatment options; and

(B) hospital's determination of the appropriate level of care under the perinatal level of care designation established under IC 16-21-13; and

(2) the woman who is in premature labor of the:

(A) woman's treatment options; and

(B) hospital's determination of the appropriate level of care under the perinatal level of care designation established under IC 16-21-13.

(e) Subject to the requirements under the federal Emergency Medical Treatment and Labor Act, a hospital shall determine what perinatal level of care under IC 16-21-13 is appropriate for the born alive infant and mother and arrange for transport consistent with requirements adopted under IC 16-21-13-5.

(f) A hospital that violates this section is subject to the penalties under IC 16-21-3-1.

(g) A health care provider who is:

(1) licensed or certified under IC 25;

(2) employed or under contract with a hospital; and

(3) responsible for providing treatment or an examination to a born alive infant or woman with a high risk pregnancy under this chapter;

is subject to the standards of practice under IC 25-1-9. A health care provider who violates the standards of practice is subject to disciplinary sanctions under IC 25-1-9-9.

SECTION 11. IC 16-21-9-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 3.5. (a) This section does not apply to the following:**

(1) A nonprofit critical access hospital that is not:

(A) part of a hospital system; or

(B) an affiliate of a hospital or hospital system.

(2) A county hospital that is established and operated under IC 16-22.

(b) Before December 31 of each year, a nonprofit hospital shall hold a public forum in which the nonprofit hospital, including the nonprofit hospital's board of directors, shall:

(1) obtain feedback from the community about the nonprofit hospital's performance in the previous year;

(2) discuss the pricing of health services provided at the nonprofit hospital; and

(3) discuss the contributions made by the nonprofit hospital to the community, including uncompensated care, charitable contributions, and any other charitable assistance programs.

(c) At least fourteen (14) days before the forum held under subsection (b), the nonprofit hospital shall post on the nonprofit hospital's Internet web site the following:

(1) A printed notice that:

(A) is designed, lettered, and featured on the Internet web site so as to be conspicuous to and readable by any individual with normal vision who visits the Internet web site;

(B) states the date, time, and location of the public forum to be held under subsection (b); and

(C) states that the purpose of the public forum is to provide members of the community with an opportunity to:

(i) comment on the nonprofit hospital's performance in the previous year;

(ii) discuss the pricing of health services provided at the nonprofit hospital; and

(iii) discuss the contributions made by the hospital to the community, including uncompensated care, charitable contributions, and any other charitable assistance programs.

(2) The following information relating to the subjects to be discussed at the public forum held under subsection (b):

(A) The nonprofit hospital's Indiana specific income statement for the previous calendar year that is prepared according to generally accepted accounting principles.

(B) Information concerning:

(i) the nonprofit hospital's pricing of health services in comparison to the amounts of reimbursement for the health services under the Medicare program;

(ii) the rationale for any pricing of health services by the nonprofit hospital that is higher than the corresponding reimbursement for the health services under the Medicare program; and

(iii) any increase in the nonprofit hospital's pricing of health services that occurred in the previous year.

(d) The public forum requirement under this section may 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.

SECTION 12. IC 16-21-16 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 16. Administration of Specialty Drugs

Sec. 1. As used in this chapter, "hospital" means a hospital licensed under IC 16-21-2, a county hospital under IC 16-22, and a municipal hospital under IC 16-23, and includes all outpatient facilities in a hospital's network.

Sec. 2. As used in this chapter, "specialty drug" means a prescription drug that is:

(1) prescribed to an individual with a chronic, complex, rare, or life threatening medical condition;

(2) available in injectable, infusion, inhalable, implantable, or oral form; and

(3) usually administered by a medical professional.

Sec. 3. A hospital shall not permit the administration of a specialty drug on the hospital's premises unless the specialty drug is:

(1) dispensed by a third party pharmacy and delivered directly and safely to the hospital; or

(2) dispensed by a pharmacy located within the hospital or another facility in the hospital's network.

SECTION 13. IC 16-21-16.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 16.5. Specialty Drug Agreements

Sec. 1. This chapter applies to a specialty drug agreement between a hospital and a health plan regarding reimbursement for specialty drugs that is entered into, amended, or renewed after the effective date of this chapter.

Sec. 2. As used in this chapter, "contracted pharmacy" means a pharmacy that has an agreement with a health plan to dispense specialty drugs.

Sec. 3. As used in this chapter, "health plan" means the following:

(1) A state employee health plan (as defined in IC 5-10-8-7).

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

(3) An individual contract (as defined in IC 27-13-1-21) and a group contract (as defined in IC 27-13-1-16).

(4) Any other plan or program that provides payment, reimbursement, or indemnification to a covered individual for

the cost of prescription drugs.

Sec. 4. As used in this chapter, "specialty drug agreement" means an agreement between a health plan and a hospital regarding how specialty drugs are reimbursed by the health plan depending on where the specialty drugs are dispensed.

Sec. 5. A health plan and a hospital may not enter into a specialty drug agreement that requires the hospital to obtain specialty drugs from a contracted pharmacy to be reimbursed, or limits reimbursement based on a contract pharmacy's price schedule for the specialty drugs, unless the following requirements are met:

(1) The health plan must provide the hospital with written notice that it would like to enter into a specialty drug agreement.

(2) The health plan must allow for not less than ninety (90) days after the health plan provides the notice described in subdivision (1) for the health plan and the hospital to engage in negotiations regarding the specialty drug agreement.

(3) If the health plan and the hospital are unable to reach an agreement in the period described in subdivision (2), the health plan may request a review by the state department of the terms of the proposed specialty drug agreement. The state department shall consult with the office of the secretary of family and social services in reviewing the proposed specialty drug agreement. The state department shall render a decision within sixty (60) days of its receipt of a request for review approving or rejecting the terms of the proposed specialty drug agreement. The state department shall approve the proposed specialty drug agreement if it determines the terms of the proposed specialty drug agreement would benefit the population's health outcomes, health care access, and quality of health care. The state department shall consider the following in its review of the proposed specialty drug agreement:

(A) The quality and price of hospital and health care services provided to Indiana residents, including the demonstration of population health improvement of the region serviced and the extent to which medically underserved populations have access to and are projected to use specialty drugs.

(B) The preservation of sufficient health care services within the geographic area to ensure public access to acute

care.

(C) The cost efficiency of services, resources, and equipment provided or used by the hospital that is a party to the proposed specialty drug agreement.

(D) Employment.

(E) Economic impact.

(4) The state department's decision in subdivision (3) may be appealed by either the health plan or the hospital under IC 4-21.5.

(5) The specialty drug agreement must include provisions to ensure there will be no waste of specialty drugs greater than what would be expected if the specialty drugs were dispensed at the hospital.

Sec. 6. A specialty drug agreement between a health plan and a hospital that is a covered entity authorized to participate in the federal 340B Drug Pricing Program under Section 340(B)(a)(4) of the federal Public Health Service Act (42 U.S.C. 256b(a)(4)) may not require specialty drugs dispensed as part of the 340B program to be dispensed by a contracted pharmacy.

SECTION 14. 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, "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 nonphysician practitioners, including professional charges.

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

(b) 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 15. 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 16. 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~~ **December** 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~~ **required under 45 CFR Part 180** 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 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 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.~~

(2) The standard charges, which include the following, as defined by 45 CFR 180.20:

(A) The gross charge.

(B) The payer-specific negotiated charge.

(C) The de-identified minimum negotiated charge.

(D) The de-identified maximum negotiated charge.

(E) The discounted cash price.

(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 required under 45 CFR Part 180 and in effect on January 1, 2021.

SECTION 17. IC 16-21-17-2, AS ADDED BY P.L.50-2020, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: Sec. 2. (a) The information displayed on the Internet web site must be in an easy to read, understandable format, and include the ~~negotiated charge~~ **standard charges** as described in section 1 of this chapter for each service. ~~by provider type.~~

(b) ~~A hospital and~~ An ambulatory outpatient surgical center shall update the information on the Internet web site on an annual basis.

SECTION 18. 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~~ **December** 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 **and shoppable** services that are provided by the urgent care facility **or group of facilities under common ownership.**

(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)~~ **(1)** A description of the service.

~~(3) 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 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.~~

(2) The standard charges, which include the following, as defined by 45 CFR 180.20:

(A) The gross charge.

(B) The payer-specific negotiated charge.

(C) The de-identified minimum negotiated charge.

(D) The de-identified maximum negotiated charge.

(E) The discounted cash price.

SECTION 19. IC 16-24.5-1-3, AS ADDED BY P.L.50-2020, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: Sec. 3. (a) The information displayed on the Internet web site must be in an easy to read, understandable format, and include the ~~negotiated charge~~ **standard charges** as described in section 2 of this chapter for each service. ~~by provider type.~~

(b) An urgent care facility shall update the information on the Internet web site on an annual basis.

SECTION 20. IC 27-1-24.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]:

Chapter 24.7. Disclosure of Prescription Drug Pricing Information

Sec. 1. As used in this chapter, "manufacturer" means a person engaged in manufacturing, preparing, propagating, compounding, or processing a prescription drug.

Sec. 2. As used in this chapter, "prescription drug" means a controlled substance or a legend drug (as defined in IC 16-18-2-199).

Sec. 3. As used in this chapter, "wholesale acquisition cost" means a manufacturer's list price for a prescription drug when sold to a wholesaler or a direct purchaser in the United States, not including any discounts, rebates, or other reductions in price.

Sec. 4. (a) Beginning January 1, 2022, a manufacturer shall submit a report to the commissioner not later than the fifteenth day of January, April, July, and October of each year. The report must provide the current wholesale acquisition cost for each of the manufacturer's prescription drugs that is:

(1) approved by the federal Food and Drug Administration; and

(2) sold in or into the state by that manufacturer.

(b) The commissioner shall publish the information submitted in the reports required by subsection (a) on an Internet web site. The web site must be accessible through a dedicated link on the home page of the department's Internet web site or by a separate, easily identifiable Internet web site address.

Sec. 5. (a) If the wholesale acquisition cost of a prescription drug increases:

(1) sixty percent (60%) or more over the preceding five (5) calendar years; or

(2) for a prescription drug with a wholesale acquisition cost of seventy dollars ($70) or more for a thirty (30) day supply, fifteen percent (15%) or more over the preceding twelve (12) months;

the manufacturer shall submit a report to the commissioner not later than thirty (30) days after the increase.

(b) The report required in subsection (a) must contain the following information:

(1) The name of the prescription drug.

(2) Whether the prescription drug is a brand name drug or a generic drug.

(3) The effective date of the change in the wholesale acquisition cost.

(4) The aggregate, company-level research and development costs for the prior calendar year.

(5) The name of each of the manufacturer's prescription drugs that were approved by the federal Food and Drug Administration in the previous five (5) calendar years.

(6) The name of each of the manufacturer's prescription drugs that lost patent exclusivity in the United States in the previous five (5) calendar years.

(7) A statement of rationale describing the factors that caused the increase in the wholesale acquisition cost.

(c) The quality and types of information provided by a manufacturer under this section must be consistent with the quality and types of information the manufacturer provides in its annual consolidated report to the federal Securities and Exchange Commission or any other public disclosure.

(d) Not later than sixty (60) days after the commissioner receives a report under subsection (a), the commissioner shall publish the information contained in the report on the Internet web site described in section 4(b) of this chapter.

Sec. 6. A manufacturer shall notify the commissioner in writing if it is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold for a specialty drug under the Medicare Part D program. The manufacturer shall provide the written notice not later than three (3) calendar days following the release of the prescription drug in the commercial

market. A manufacturer may make the notification pending approval of the federal Food and Drug Administration if commercial availability is expected within three (3) calendar days following the approval.

Sec. 7. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 21. IC 27-1-24.9 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]:

Chapter 24.9. Disclosure of Rebates Received by Pharmacies

Sec. 1. As used in this chapter, "pharmacy" has the meaning set forth in IC 27-1-24.5-11.

Sec. 2. As used in this chapter, "prescription drug" means a controlled substance or legend drug (as defined in IC 16-18-2-199).

Sec. 3. As used in this chapter, "rebate" means a discount or other price concession that is:

(1) based on the use of a prescription drug; and

(2) paid by a manufacturer or a third party to a pharmacy.

Sec. 4. (a) Beginning January 1, 2022, a pharmacy shall submit a report to the commissioner not later than the fifteenth of January, April, July, and October of each year. The report must provide the total amount of rebates received by the pharmacy during the previous quarter.

(b) The commissioner shall publish on the department's Internet web site the information submitted in the reports required by subsection (a). The web site on which the information is published must be accessible by a dedicated link on the home page of the department's Internet web site or by a separate, easily identifiable Internet web site address.

Sec. 5. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 22. IC 27-2-26 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]:

Chapter 26. Public Forums by Health Carriers

Sec. 1. As used in this chapter, "health carrier" means the following entities:

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

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

Sec. 2. (a) Before December 31, a health carrier shall hold a public forum in which the health carrier shall:

(1) obtain feedback from the community about the health carrier's performance in the previous year; and

(2) discuss the premiums (as defined in IC 27-1-2-3(w)) charged by the health carrier.

(b) The public forum required under subsection (a) may 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.

Sec. 3. At least fourteen (14) days before the public forum required by this chapter is held, the health carrier shall post on the health carrier's Internet web site the following:

(1) A printed notice that:

(A) is designed, lettered, and featured on the Internet web site in a manner that is conspicuous to and readable by any individual with normal vision who visits the Internet web site;

(B) states the date, time, and location of the public forum; and

(C) states that the purpose of the public forum is to provide members of the community with an opportunity to:

(i) comment on the health carrier's performance in the previous year; and

(ii) discuss the premiums (as defined in IC 27-1-2-3(w)) charged by the health carrier.

(2) The following information concerning the subjects to be discussed at the public forum:

(A) The health carrier's Indiana based profits, if the health carrier is publicly traded.

(B) The premiums (as defined in IC 27-1-2-3(w)) charged by the health carrier.

(C) The health carrier's strategy to lower health care costs.

(D) Any increase in the health carrier's premiums, on average statewide, that occurred in the previous year for each health carrier.

(E) Annual audited financial reports, if required under IC 27-1-3.5-6 and if the health carrier is publicly traded.

SECTION 23. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 325, 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:

Replace the effective date in SECTION 1 with "[EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]".

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. 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).".

Page 1, line 3, strike "a hospital".

Page 1, line 4, strike "and".

Page 1, line 5, strike "hospital or".

Page 1, line 12, reset in roman "thirty (30)".

Page 1, line 12, delete "two hundred thirty (230)".

Page 1, line 13, strike "hospital or".

Page 1, line 15, delete "The" and insert "**Subject to subsection (e),** the".

Page 1, line 16, strike "a hospital and".

Page 2, line 10, strike "hospital or".

Page 2, line 12, strike "hospital or".

Page 2, delete lines 16 through 22, begin a new paragraph and insert:

"**(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.

(e) A hospital complies with this section by posting the information by either of the following means:

(1) As specified in subsection (b).

(2) As set forth in the final rule of the federal Centers for Medicare and Medicaid Services published by 84 FR 65524 and in effect on January 1, 2021.

SECTION 3. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 325 as introduced.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 10, Nays 0.

SENATE MOTION

Madam President: I move that Senate Bill 325 be amended to read as follows:

Page 2, line 28, delete "Subject to subsection (e), the" and insert "The".

Page 3, delete lines 18 through 23.

(Reference is to SB 325 as printed February 19, 2021.)

BUSCH

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 325, 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 1, delete lines 1 through 17, begin a new paragraph and insert:

"SECTION 1. IC 16-18-2-37.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 37.9. "Born alive", for purposes of IC 16-21-2-17, has the meaning set forth in IC 16-21-2-17(a).**

SECTION 2. 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 16-24.5-1, has the meaning set forth in IC 16-21-17-0.3(a).**

SECTION 3. 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 16-24.5-1, has the meaning set forth in IC 16-21-17-0.3(b).**

SECTION 4. 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 5. IC 16-21-2-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 17. (a) As used in this section, "born alive" means the complete expulsion or extraction from the infant's mother, at any stage of development or gestational age, of an infant who after the**

expulsion or extraction:

(1) breathes;

(2) has a beating heart or pulsation of the umbilical cord; or

(3) has a definite movement of voluntary muscles;

regardless of whether the umbilical cord has been cut or whether the expulsion or extraction occurs as a result of natural or induced labor, cesarean section, or induced abortion.

(b) If a woman who is in premature labor presents to a hospital, the hospital must inform the woman of the hospital's capabilities of treating the born alive infant and managing a high risk pregnancy. If the hospital does not have the capability to treat the premature born alive infant or the ability to manage a high risk pregnancy, the hospital must provide the woman options to get to a hospital with appropriate capabilities.

(c) A hospital must provide:

(1) a medical screening examination; and

(2) any needed stabilizing treatment;

to an infant who is born alive, including born prematurely or with a disability, or a woman who is in premature labor.

(d) After a hospital has provided a medical screening examination under subsection (c)(1), the hospital must inform the:

(1) parents of the born alive infant of the:

(A) infant's treatment options and probable outcomes; and

(B) hospital's treatment capabilities; and

(2) woman who is in premature labor of the:

(A) woman's treatment options and probable outcomes; and

(B) hospital's treatment capabilities.

(e) If a hospital does not have the capability to provide care for the infant who is born alive, including born prematurely or with a disability, or manage a woman's high risk pregnancy, the hospital:

(1) may not refuse transport of the infant or woman to another hospital with the capacity to provide the needed care; and

(2) shall arrange for the transport of the infant or woman to the other hospital, if:

(A) capable transport is available; and

(B) acceptance of the patient by the other hospital is confirmed.

(f) A hospital that violates this section is subject to the penalties under IC 16-21-3-1.

(g) A health care provider who is:

(1) licensed or certified under IC 25;

(2) employed or under contract with a hospital; and

(3) responsible for providing treatment or an examination to a born alive infant or woman with a high risk pregnancy under this chapter;

is subject to the standards of practice under IC 25-1-9. A health care provider who violates the standards of practice is subject to disciplinary sanctions under IC 25-1-9-9.

SECTION 6. IC 16-21-9-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: **Sec. 3.5. (a) This section does not apply to the following:**

(1) A nonprofit critical access hospital that is not:

(A) part of a hospital system; or

(B) an affiliate of a hospital or hospital system.

(2) A county hospital that is established and operated under IC 16-22.

(b) Before December 31 of each year, a nonprofit hospital shall hold a public forum in which the nonprofit hospital, including the nonprofit hospital's board of directors, shall:

(1) obtain feedback from the community about the nonprofit hospital's performance in the previous year;

(2) discuss the pricing of health services provided at the nonprofit hospital; and

(3) discuss the contributions made by the nonprofit hospital to the community, including uncompensated care, charitable contributions, and any other charitable assistance programs.

(c) At least fourteen (14) days before the forum held under subsection (b), the nonprofit hospital shall post on the nonprofit hospital's Internet web site the following:

(1) A printed notice that:

(A) is designed, lettered, and featured on the Internet web site so as to be conspicuous to and readable by any individual with normal vision who visits the Internet web site;

(B) states the date, time, and location of the public forum to be held under subsection (b); and

(C) states that the purpose of the public forum is to provide members of the community with an opportunity to:

(i) comment on the nonprofit hospital's performance in the previous year;

(ii) discuss the pricing of health services provided at the nonprofit hospital; and

(iii) discuss the contributions made by the hospital to the community, including uncompensated care, charitable contributions, and any other charitable assistance programs.

(2) The following information relating to the subjects to be discussed at the public forum held under subsection (b):

(A) The nonprofit hospital's Indiana specific income statement for the previous calendar year that is prepared according to generally accepted accounting principles.

(B) Information concerning:

(i) the nonprofit hospital's pricing of health services in comparison to the amounts of reimbursement for the health services under the Medicare program;

(ii) the rationale for any pricing of health services by the nonprofit hospital that is higher than the corresponding reimbursement for the health services under the Medicare program; and

(iii) any increase in the nonprofit hospital's pricing of health services that occurred in the previous year.

(d) The public forum requirement under this section may be held through an interactive real time audio and video meeting that is accessible to the community through the Internet.

SECTION 7. 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, "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 nonphysician practitioners, including professional charges.

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

(b) 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 8. 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 2, delete lines 1 through 12.

Page 2, line 15, after "than" strike "March" and insert "**December**".

Page 2, line 22, strike "published in 84 FR 65524" and insert "**required under 45 CFR Part 180**".

Page 2, line 24, delete "(1)," and insert "(1):

(A)".

Page 2, line 27, delete "(1)." and insert "(1); **or**

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

center.".

Page 2, strike lines 33 through 39.

Page 2, line 40, strike "(C) Self-pay without charitable assistance from the".

Page 2, strike line 41.

Page 2, line 42, strike "(D) Self-pay with charitable assistance from the".

Page 3, strike lines 1 through 3.

Page 3, between lines 3 and 4, begin a new line block indented and insert:

"**(2) The standard charges, which include the following, as defined by 45 CFR 180.20:**

(A) The gross charge.

(B) The payer-specific negotiated charge.

(C) The de-identified minimum negotiated charge.

(D) The de-identified maximum negotiated charge.

(E) The discounted cash price.".

Page 3, line 17, delete "published at 84 FR 65524" and insert "**required under 45 CFR Part 180**".

Page 3, between lines 17 and 18, begin a new paragraph and insert:

"SECTION 10. IC 16-21-17-2, AS ADDED BY P.L.50-2020, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: Sec. 2. (a) The information displayed on the Internet web site must be in an easy to read, understandable format, and include the ~~negotiated charge~~ **standard charges** as described in section 1 of this chapter for each service. ~~by provider type.~~

(b) ~~A hospital and~~ An ambulatory outpatient surgical center shall update the information on the Internet web site on an annual basis.

SECTION 11. 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~~ **December** 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 **and shoppable** services that are provided by the urgent care facility **or group of facilities under common ownership.**

(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)~~ **(1)** A description of the service.

~~(3) 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 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.~~

(2) The standard charges, which include the following, as defined by 45 CFR 180.20:

(A) The gross charge.

(B) The payer-specific negotiated charge.

(C) The de-identified minimum negotiated charge.

(D) The de-identified maximum negotiated charge.

(E) The discounted cash price.

SECTION 12. IC 16-24.5-1-3, AS ADDED BY P.L.50-2020, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE MARCH 1, 2021 (RETROACTIVE)]: Sec. 3. (a) The information displayed on the Internet web site must be in an easy to read, understandable format, and include the ~~negotiated charge~~ **standard charges** as described in section 2 of this chapter for each service. ~~by provider type.~~

(b) An urgent care facility shall update the information on the Internet web site on an annual basis.

SECTION 13. IC 27-2-26 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]:

Chapter 26. Public Forums by Health Carriers

Sec. 1. (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.

Sec. 2. (a) Before December 31, a health carrier shall hold a public forum in which the health carrier shall:

(1) obtain feedback from the community about the health carrier's performance in the previous year; and

(2) discuss the premiums (as defined in IC 27-1-2-3(w)) charged by the health carrier.

(b) The public forum required in subsection (a) must be held in the municipality where the health carrier's principal office (as defined in IC 27-1-2-3(l)) is located.

Sec. 3. At least fourteen (14) days before the public forum required by this chapter is held, the health carrier shall post on the health carrier's Internet web site the following:

(1) A printed notice that:

(A) is designed, lettered, and featured on the Internet web site in a manner that is conspicuous to and readable by any individual with normal vision who visits the Internet web site;

(B) states the date, time, and location of the public forum; and

(C) states that the purpose of the public forum is to provide members of the community with an opportunity to:

(i) comment on the health carrier's performance in the previous year; and

(ii) discuss the premiums (as defined in IC 27-1-2-3(w)) charged by the health carrier.

(2) The following information concerning the subjects to be discussed at the public forum:

(A) The health carrier's Indiana based profits.

(B) The premiums (as defined in IC 27-1-2-3(w)) charged by the health carrier.

(C) The health carrier's strategy to lower health care costs.

(D) Any increase in the health carrier's premiums, on average statewide, that occurred in the previous year for each health carrier.

(E) The health carrier's Indiana specific income statement for the previous calendar year that is prepared according to generally accepted accounting principles.

(F) Annual audited financial reports, if required under IC 27-1-3.5-6.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 325 as reprinted February 23, 2021.)

BARRETT

Committee Vote: yeas 12, nays 0.

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 325 be amended to read as follows:

Page 4, line 27, delete "held" and insert "**held, either all or in part,**".

Page 8, delete lines 28 through 42, begin a new paragraph and insert:

"**Sec. 1. As used in this chapter, "health carrier" means the following entities:**

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

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

Page 9, delete lines 1 through 7.

Page 9, delete lines 14 through 16, begin a new paragraph and

insert:

"**(b) The public forum required under subsection (a) may 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.**".

Page 9, line 35, delete "profits." and insert "**profits, if the health carrier is publicly traded.**".

Page 9, delete line 42, begin a new line double block indented and insert:

"**(E) Annual audited financial reports, if required under IC 27-1-3.5-6 and if the health carrier is publicly traded.**".

Page 10, delete lines 1 through 4.

(Reference is to ESB 325 as printed April 8, 2021.)

MANNING

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 325 be amended to read as follows:

Page 2, line 20, delete "appropriate capabilities." and insert "**the appropriate level of care under the perinatal level of care designation established under IC 16-21-13.**".

Page 2, line 27, delete "inform the:" and insert "**inform:**".

Page 2, line 28, delete "parents" and insert "**a parent**".

Page 2, line 29, delete "options and probable outcomes;" and insert "**options;**".

Page 2, line 30, delete "treatment capabilities;" and insert "**determination of the appropriate level of care under the perinatal level of care designation established under IC 16-21-13;**".

Page 2, line 31, after "(2)" insert "**the**".

Page 2, line 32, delete "options and probable outcomes;" and insert "**options;**".

Page 2, line 34, delete "treatment capabilities." and insert "**determination of the appropriate level of care under the perinatal level of care designation established under IC 16-21-13.**".

Page 2, delete lines 35 through 42, begin a new paragraph and insert:

"**(e) Subject to the requirements under the federal Emergency Medical Treatment and Labor Act, a hospital shall determine what**

perinatal level of care under IC 16-21-13 is appropriate for the born alive infant and mother and arrange for transport consistent with requirements adopted under IC 16-21-13-5.".

Page 3, delete lines 1 through 3.

(Reference is to ESB 325 as printed April 8, 2021.)

BARRETT

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 325 be amended to read as follows:

Page 1, between lines 4 and 5, begin a new paragraph and insert:

"SECTION 2. IC 16-18-2-75.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 75.5. "Contracted pharmacy", for purposes of IC 16-21-16.5, has the meaning set forth in IC 16-21-16.5-2.**

SECTION 3. IC 16-18-2-167.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 167.5. "Health plan", for purposes of IC 16-21-16.5, has the meaning set forth in IC 16-21-16.5-3.**

SECTION 4. IC 16-18-2-179, AS AMENDED BY P.L.99-2007, SECTION 154, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 179. (a) "Hospital", except as provided in subsections (b) through (g), means a hospital that is licensed under IC 16-21-2.

(b) "Hospital", for purposes of IC 16-21, means an institution, a place, a building, or an agency that holds out to the general public that it is operated for hospital purposes and that it provides care, accommodations, facilities, and equipment, in connection with the services of a physician, to individuals who may need medical or surgical services. The term does not include the following:

(1) Freestanding health facilities.

(2) Hospitals or institutions specifically intended to diagnose, care, and treat the following:

(A) Individuals with a mental illness (as defined in IC 12-7-2-117.6).

(B) Individuals with developmental disabilities (as defined in

IC 12-7-2-61).

(3) Offices of physicians where patients are not regularly kept as bed patients.

(4) Convalescent homes, boarding homes, or homes for the aged.

(c) "Hospital", for purposes of IC 16-22-8, has the meaning set forth in IC 16-22-8-5.

(d) "Hospital", for purposes of IC 16-23.5, has the meaning set forth in IC 16-23.5-1-9.

(e) "Hospital" or "tuberculosis hospital", for purposes of IC 16-24, means an institution or a facility for the treatment of individuals with tuberculosis.

(f) "Hospital", for purposes of IC 16-34, means a hospital (as defined in subsection (b)) that:

(1) is required to be licensed under IC 16-21-2; or

(2) is operated by an agency of the United States.

(g) "Hospital", for purposes of IC 16-41-12, has the meaning set forth in IC 16-41-12-6.

(h) "Hospital", for purposes of IC 16-21-16 and IC 16-21-16.5, has the meaning set forth in IC 16-21-16-1.".

Page 1, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 7. IC 16-18-2-336.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 336.5. "Specialty drug", for purposes of IC 16-21-16 and IC 16-21-16.5, has the meaning set forth in IC 16-21-16-2.**

SECTION 8. IC 16-18-2-336.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 336.6. "Specialty drug agreement", for purposes of IC 16-21-16.5, has the meaning set forth in IC 16-21-16.5-4.**".

Page 4, between lines 28 and 29, begin a new paragraph and insert:

"SECTION 14. IC 16-21-16 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 16. Administration of Specialty Drugs

Sec. 1. As used in this chapter, "hospital" means a hospital licensed under IC 16-21-2, a county hospital under IC 16-22, and a municipal hospital under IC 16-23, and includes all outpatient facilities in a hospital's network.

Sec. 2. As used in this chapter, "specialty drug" means a prescription drug that is:

(1) prescribed to an individual with a chronic, complex, rare,

or life threatening medical condition;

(2) available in injectable, infusion, inhalable, implantable, or oral form; and

(3) usually administered by a medical professional.

Sec. 3. A hospital shall not permit the administration of a specialty drug on the hospital's premises unless the specialty drug is:

(1) dispensed by a third party pharmacy and delivered directly and safely to the hospital; or

(2) dispensed by a pharmacy located within the hospital or another facility in the hospital's network.

SECTION 15. IC 16-21-16.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 16.5. Specialty Drug Agreements

Sec. 1. This chapter applies to a specialty drug agreement between a hospital and a health plan regarding reimbursement for specialty drugs that is entered into, amended, or renewed after the effective date of this chapter.

Sec. 2. As used in this chapter, "contracted pharmacy" means a pharmacy that has an agreement with a health plan to dispense specialty drugs.

Sec. 3. As used in this chapter, "health plan" means the following:

(1) A state employee health plan (as defined in IC 5-10-8-7).

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

(3) An individual contract (as defined in IC 27-13-1-21) and a group contract (as defined in IC 27-13-1-16).

(4) Any other plan or program that provides payment, reimbursement, or indemnification to a covered individual for the cost of prescription drugs.

Sec. 4. As used in this chapter, "specialty drug agreement" means an agreement between a health plan and a hospital regarding how specialty drugs are reimbursed by the health plan depending on where the specialty drugs are dispensed.

Sec. 5. A health plan and a hospital may not enter into a specialty drug agreement that requires the hospital to obtain specialty drugs from a contracted pharmacy to be reimbursed, or limits reimbursement based on a contract pharmacy's price schedule for the specialty drugs, unless the following requirements are met:

(1) The health plan must provide the hospital with written notice that it would like to enter into a specialty drug agreement.

(2) The health plan must allow for not less than ninety (90) days after the health plan provides the notice described in subdivision (1) for the health plan and the hospital to engage in negotiations regarding the specialty drug agreement.

(3) If the health plan and the hospital are unable to reach an agreement in the period described in subdivision (2), the health plan may request a review by the state department of the terms of the proposed specialty drug agreement. The state department shall consult with the office of the secretary of family and social services in reviewing the proposed specialty drug agreement. The state department shall render a decision within sixty (60) days of its receipt of a request for review approving or rejecting the terms of the proposed specialty drug agreement. The state department shall approve the proposed specialty drug agreement if it determines the terms of the proposed specialty drug agreement would benefit the population's health outcomes, health care access, and quality of health care. The state department shall consider the following in its review of the proposed specialty drug agreement:

(A) The quality and price of hospital and health care services provided to Indiana residents, including the demonstration of population health improvement of the region serviced and the extent to which medically underserved populations have access to and are projected to use specialty drugs.

(B) The preservation of sufficient health care services within the geographic area to ensure public access to acute care.

(C) The cost efficiency of services, resources, and equipment provided or used by the hospital that is a party to the proposed specialty drug agreement.

(D) Employment.

(E) Economic impact.

(4) The state department's decision in subdivision (3) may be appealed by either the health plan or the hospital under IC 4-21.5.

(5) The specialty drug agreement must include provisions to ensure there will be no waste of specialty drugs greater than

what would be expected if the specialty drugs were dispensed at the hospital.

Sec. 6. A specialty drug agreement between a health plan and a hospital that is a covered entity authorized to participate in the federal 340B Drug Pricing Program under Section 340(B)(a)(4) of the federal Public Health Service Act (42 U.S.C. 256b(a)(4)) may not require specialty drugs dispensed as part of the 340B program to be dispensed by a contracted pharmacy.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 325 as printed April 8, 2021.)

CLERE

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 325 be amended to read as follows:

Page 8, between lines 23 and 24, begin a new paragraph and insert:

"SECTION 13. IC 27-1-24.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]:

Chapter 24.7. Disclosure of Prescription Drug Pricing Information

Sec. 1. As used in this chapter, "manufacturer" means a person engaged in manufacturing, preparing, propagating, compounding, or processing a prescription drug.

Sec. 2. As used in this chapter, "prescription drug" means a controlled substance or a legend drug (as defined in IC 16-18-2-199).

Sec. 3. As used in this chapter, "wholesale acquisition cost" means a manufacturer's list price for a prescription drug when sold to a wholesaler or a direct purchaser in the United States, not including any discounts, rebates, or other reductions in price.

Sec. 4. (a) Beginning January 1, 2022, a manufacturer shall submit a report to the commissioner not later than the fifteenth day of January, April, July, and October of each year. The report must provide the current wholesale acquisition cost for each of the manufacturer's prescription drugs that is:

(1) approved by the federal Food and Drug Administration; and

(2) sold in or into the state by that manufacturer.

(b) The commissioner shall publish the information submitted in the reports required by subsection (a) on an Internet web site. The web site must be accessible through a dedicated link on the home page of the department's Internet web site or by a separate, easily identifiable Internet web site address.

Sec. 5. (a) If the wholesale acquisition cost of a prescription drug increases:

(1) sixty percent (60%) or more over the preceding five (5) calendar years; or

(2) for a prescription drug with a wholesale acquisition cost of seventy dollars ($70) or more for a thirty (30) day supply, fifteen percent (15%) or more over the preceding twelve (12) months;

the manufacturer shall submit a report to the commissioner not later than thirty (30) days after the increase.

(b) The report required in subsection (a) must contain the following information:

(1) The name of the prescription drug.

(2) Whether the prescription drug is a brand name drug or a generic drug.

(3) The effective date of the change in the wholesale acquisition cost.

(4) The aggregate, company-level research and development costs for the prior calendar year.

(5) The name of each of the manufacturer's prescription drugs that were approved by the federal Food and Drug Administration in the previous five (5) calendar years.

(6) The name of each of the manufacturer's prescription drugs that lost patent exclusivity in the United States in the previous five (5) calendar years.

(7) A statement of rationale describing the factors that caused the increase in the wholesale acquisition cost.

(c) The quality and types of information provided by a manufacturer under this section must be consistent with the quality and types of information the manufacturer provides in its annual consolidated report to the federal Securities and Exchange Commission or any other public disclosure.

(d) Not later than sixty (60) days after the commissioner receives a report under subsection (a), the commissioner shall publish the information contained in the report on the Internet web site described in section 4(b) of this chapter.

Sec. 6. A manufacturer shall notify the commissioner in writing if it is introducing a new prescription drug to market at a wholesale acquisition cost that exceeds the threshold for a specialty drug under the Medicare Part D program. The manufacturer shall provide the written notice not later than three (3) calendar days following the release of the prescription drug in the commercial market. A manufacturer may make the notification pending approval of the federal Food and Drug Administration if commercial availability is expected within three (3) calendar days following the approval.

Sec. 7. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 325 as printed April 8, 2021.)

AUSTIN

HOUSE MOTION

Mr. Speaker: I move that Engrossed Senate Bill 325 be amended to read as follows:

Page 8, between lines 23 and 24, begin a new paragraph and insert:

"SECTION 13. IC 27-1-24.9 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]:

Chapter 24.9. Disclosure of Rebates Received by Pharmacies

Sec. 1. As used in this chapter, "pharmacy" has the meaning set forth in IC 27-1-24.5-11.

Sec. 2. As used in this chapter, "prescription drug" means a controlled substance or legend drug (as defined in IC 16-18-2-199).

Sec. 3. As used in this chapter, "rebate" means a discount or other price concession that is:

(1) based on the use of a prescription drug; and

(2) paid by a manufacturer or a third party to a pharmacy.

Sec. 4. (a) Beginning January 1, 2022, a pharmacy shall submit a report to the commissioner not later than the fifteenth of January, April, July, and October of each year. The report must provide the total amount of rebates received by the pharmacy during the previous quarter.

(b) The commissioner shall publish on the department's Internet

web site the information submitted in the reports required by subsection (a). The web site on which the information is published must be accessible by a dedicated link on the home page of the department's Internet web site or by a separate, easily identifiable Internet web site address.

Sec. 5. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.".

Renumber all SECTIONS consecutively.

(Reference is to ESB 325 as printed April 8, 2021.)

AUSTIN