**INDIANA ACADEMY OF FAMILY PHYSICIANS**
**ANNUAL REPORT OF THE COMMISSION ON LEGISLATION**

**Indianapolis, IN** **July 20, 2018**

**Richard Feldman, MD**

Although a short session of the General Assembly, this was one of the busiest and most intense sessions for the IAFP that I can remember. There were a number of important bills that were tracked and addressed to help ensure that they not pass, and others that we supported into law. Your legislative team worked diligently to protect the interests of family physicians and our patients. Thanks to John Hammond and the rest our legislative team at Ice Miller for all their efforts this year. I always received excellent thoughtful recommendations and guidance. Also thanks to Missy Lewis and our commission members who actively participated in the development of our positions. We were well served again this year. Special thanks to Anne Doran at Ice Miller with whom I worked closely this session.

Our legislative commission met during the session to set priorities and define specific positions on bills that we were following. We worked effectively on issues with other organizations and communicated and coordinated closely with the ISMA on several particular bills. Additionally, the IAFP held another successful legislative reception during the session.

Once again this year, I was privileged to be appointed as a lay member to the Interim Study Committee on Public Health, Behavioral Health, and Human Services of the Indiana General Assembly. The next Interim Committee should be most interesting this year.

I personally testified on a number of bills and participated in working through a number of other bills with other stakeholders. Please see the legislative summary attached to this report for details of the bills of interest to the IAFP. I would like to also provide some explanation on the following:

HB 1302 was a very contentious bill which would have allowed Advanced Practice Registered Nurses to practice and prescribe independently in Indiana. The APRN's position was to grant independent prescribing after about a year and a half (in hours) of physician collaboration. Along with the ISMA, we strongly opposed this measure as written. The author held a meeting with the APRN lobbyist, the IAFP and the ISMA to see if any compromise could be reached. The APRN's showed little interest in compromising, the ISMA was flatly against the legislation on any basis, and our attempts to compromise were rejected by the APRN's. Our compromise was based mostly on a 3 year direct on-site (shoulder-to shoulder) physician supervision/collaboration requirement. Ultimately, the author of the bill and the House Public Health Chairwoman decided not to hear the bill. I believe the independent practice/prescribing for nurse practitioners legislation will be raised again next year.

SB 221 included language that would have required physicians to check INSPECT before prescribing any opioid or benzodiazepine medications to a patient (each script). I testified in the Senate expressing that this would be burdensome to family physicians and would be most burdensome to physicians who do not utilize an EMR or do not have internet access. (There is an ongoing state initiative for the integration of INSPECT with the EMR through grant money that will potentially make checking INSPECT faster and more efficient). Although the IAFP is in favor of prescribing physicians enrolling in INSPECT and checking INSPECT, the legislative team felt that checking for every prescription was overkill, would discourage some physicians from appropriately prescribing, and affect patient access for pain medication. Along with the help of the ISMA we were able to get an amendment included that would only require checking every 90 days when the patient has a

controlled substance contract with the provider. Exactly how these requirements will be interpreted and implemented in practice are yet to be defined. Family physicians will not have to comply until 2021.

SB225 will require (beginning in 2019) two hours of CME on opioid prescribing and abuse every two years. We supported this bill along with all health care stakeholder organizations including the ISMA. This was a very reasonable bill with minimum requirements and a sunset date. It could have been much worse, and to oppose this legislation given the mood of the legislature regarding opioid prescribing would not have been a good political position to take.

SB 398 would have created onerous regulations for office-based buprenorphine prescribing and would have created requirements close to the rigor of methadone clinics. This came primarily from the Attorney General's Office who is concerned with "Suboxone Mills". This was really misguided legislation opposed by the State Health Commissioner, addiction specialists, and the ISMA. We and others met with the AG's office that really was willing to listen to concerns and amiable to changes in the bill. Amendments were proposed that made the bill much better, and I proposed to exclude physicians prescribing in the office setting when treating 30 patients or less. The AG's office accepted this suggestion. Despite the work on the bill, the Chair of the Senate Health & Provider Services Committee chose not to hear the bill and instead sent it to a summer study committee for review. This was a great result for a nasty bill.

SB52 will legalize CBD oil (actually full spectrum hemp extract) with THC content of 0.3 percent or less. There are absolutely no euphoric effects at this level. This was a great bipartisan effort and the IAFP was very supportive of the measure. I actively worked with several legislators on the bill and testified in both the house and senate committees. There is a lack of good scientific studies (like many herbal supplements) because of the DEA's schedule 1 classification that severely hampers research. Although anecdotal, the testimony from physicians and patients was powerful and compelling. I have received emails from both physicians and patients that were also equally impressive in response to my Indianapolis Star column. As a harmless herbal supplement our position is that if patients feel that it helps them, there is no reason for it to be illegal.

HB1384 was the Chiropractor bill that extends their scope of practice among other things. This bill passed, but we were able to have their specific ability to order and interpret advanced diagnostic imaging on all areas of the human body removed. We felt this was inappropriate, and working outside of the committee setting we were successful in this regard.

SB340 was an abortion-related bill that requires extensive reporting of pregnancy termination complications. We opposed this bill as we felt compliance was onerous for physicians, especially in light of non-compliance being treated as a criminal violation. This requirement is not just for the immediate time period after the abortion but for some complications potentially anytime thereafter for any physician (not even involved with the abortion) who is treating the patient for the complication. This could be potentially many years down the road. Such inquiries by physicians with their patients may be very intrusive and create barriers in the doctor-patient relationship. This would include miscarriages that would have to be questioned to assure it was not an abortion. Women should not be placed on the defensive or made to feel guilty coming to the physician for advice or treatment. The list of complications is astonishingly long, some not necessarily a result of an abortion. Further, the reporting required is also extensive and the clinical and research value of reporting this information is very questionable. Although the IAFP does not specifically support or oppose legal abortions as a matter of policy, a woman's reproductive health should be a decision purely between a doctor and patient without undue government interference. Thanks to Ellyn Stecker for her assistance in interpreting the ramifications of this bill and closely following its progress.

I testified on legislation that would have raised the legal age for purchasing tobacco to 21. The bill passed committee but was quickly killed by being assigned to Ways and Means for that purpose. We will try again!

The scholarship fund created for Hoosier Marian University College of Osteopathic Medicine students was problematic and severely underutilized. The scholarships were the subject of an IAFP resolution two years ago. Consistent with the resolution, I actively worked last year for eliminating the underserved practice requirement while leaving the scholarship just to practicing primary care in Indiana. Working with Marian University, we were successful in removing the underserved practice requirement last session. In addition the scholarships were opened to out-of-state students (as a second priority) and also made available retroactively when the student decides to take the scholarship in the latter years of medical school (at a discounted amount). I conferred with Marian President Dan Elsener, Dean Don Sefcik, and Marian's lobbyist Lou Belch. I also had three meetings with Sen. Luke Kenley and our lobbyist talked with Chairman Tim Brown. All supported these changes and the bill passed. However the language passed last session was not quite right and inadvertently excluded the most recent graduating class and previous scholarships of present students. I worked directly with the House Republican Policy Office to have the needed corrective language included in a Higher Education Commission bill. This passed this session.

Finally, HB1143 (Prior Authorization) was a result of Dr. Bernie Emkes' resolution at last year's congress. This bill will provide for increased consistency, transparency, and accountability for insurance companies. We worked closely with the ISMA in support of this legislation. This legislation will require insurers to give more notice when they make PA changes. It gives clear guidance as to the documents needed for PA, the process flow and time frames for notification of approval or denial. It enables clinicians to take intermediate steps before a request is denied, and, if it is, insurers must cite specific reasons for denial rather than generalities. Finally, in all but a few situations, obtaining a PA will now guarantee payment for the authorized services. These are huge victories for physicians in Indiana, but we plan on continuing our efforts to chip away at administrative burdens that keep physicians from practicing medicine. Please see a portion of the final version of the bill reprinted and attached to this report for your information.

Your legislative team was successful in modifying last year's legislation that requires a referring provider to present in writing to the patient a disclaimer that a referral may be to an out-of- network provider and may result in higher costs to the patient. This is a problem with telephonic referrals when the patient is not present. We were able to amend SB 223 to include language that the notification can be verbal with certain documentation in the chart. That language is as follows:
*(c) A provider that makes a referral via telephone to a patient of record shall provide to the covered individual all of the following information:*
*(1) That an out of network provider may be called upon to render health care items or services to the covered individual during the course of treatment.*
*(2) That an out of network provider described in subdivision (1) is not bound by the payment provisions that apply to health care items or services rendered by a network provider under the covered individual's health plan.*
*(3) That the covered individual may contact the covered individual's health plan before receiving health care items or services rendered by an out of network provider described in subdivision (1):*
*(A) to obtain a list of network providers that may render the health care items or services; and*
*(B) for additional assistance.*
*(4) The provider shall note in the covered individual's medical chart:*
*(A) the name of the provider to whom the covered individual was referred; and*

*(B) that the referral was made via telephone.*

I want to again express my gratitude to the members of the legislative commission for their time, advice, and expertise. Thanks also to those IAFP members who volunteered their time as Physician of the Day and to those who generously gave to the IAFP Political Action Committee. Legislators continue to very much appreciate our presence in the Physician of the Day program.

**Please refer to the legislative summary (attached) for further details on the bills that we followed.**

*HOUSE ENROLLED ACT No. 1143*
*AN ACT to amend the Indiana Code concerning insurance.*
*Be it enacted by the General Assembly of the State of Indiana:*
*SECTION 1. IC 5-10-8-19 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]:*
*Sec. 19.*
*A self-insurance program established under section 7(b) of this chapter to provide health care coverage shall comply with the prior authorization requirements that apply to a health plan under IC 27-1-37.5.*

*SECTION 2. IC 27-1-37.5 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2018]:*
*Chapter 37.5. Health Care Service Prior Authorization*
*Sec. 1.*
*(a) Except as provided in sections 10, 11, 12, and 13 of this chapter, this chapter applies beginning September 1, 2018.*
*(b) This chapter does not apply to a step therapy protocol exception procedure under IC 27-8-5-30 or IC 27-13-7-23.*
*(c) This chapter does not apply to a health plan that is offered by a local unit public employer under a program of group health insurance provided under IC 5-10-8-2.6.*
*Sec. 2. As used in this chapter, "covered individual" means an individual who is covered under a health plan.*
*Sec. 3. As used in this chapter, "CPT code" refers to the medical billing code that applies to a specific health care service, as published in the Current Procedural Terminology code set maintained by the American Medical Association.*
*Sec. 4.*
*(a) As used in this chapter, "health care service" means a health care related service or product rendered or sold by a health care provider within the scope of the health care provider's license or legal authorization, including hospital, medical, surgical, mental health, and substance abuse services or products.*
*(b) The term does not include the following:*
*(1) Dental services.*
*(2) Vision services.*
*(3) Long term rehabilitation treatment.*
*(4) Pharmaceutical services or products.*
*Sec. 5.*
*(a) As used in this chapter, "health plan" means any of the following that provides coverage for health care services:*
*(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in IC 27-8-5-2.5(a).*
*(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).*

*(b) The term includes a person that administers any of the following:*
*(1) A policy described in subsection (a)(1).*
*(2) A contract described in subsection (a)(2).*
*(3) A self-insurance program established under IC 5-10-8-7(b) to provide health care coverage.*
*Sec. 6. As used in this chapter, "participating provider" refers to the following:*
*(1) A health care provider that has entered into an agreement with an insurer under IC 27-8-11-3.*
*(2) A participating provider (as defined in IC 27-13-1-24).*
*Sec. 7. As used in this chapter, "prior authorization" means a practice implemented by a health plan through which coverage of a health care service is dependent on the covered individual or health care provider obtaining approval from the health plan before the health care service is rendered. The term includes prospective or utilization review procedures conducted before a health care service is rendered.*
*Sec. 8. As used in this chapter, "urgent care situation" means a situation in which a covered individual's treating physician has determined that the covered individual's condition is likely to result in:*
*(1) adverse health consequences or serious jeopardy to the covered individual's life, health, or safety; or*
*(2) due to the covered individual's psychological state, serious jeopardy to the life, health, or safety of another individual; unless treatment of the covered individual's condition for which prior authorization is sought occurs earlier than the period generally considered by the medical profession to be reasonable to treat routine or non-life threatening conditions.*
*Sec. 9.*
*(a) A health plan shall make available to participating providers on the health plan's Internet web site or portal the applicable CPT code for the specific health care services for which prior authorization is required.*
*(b) A health plan shall make available to participating providers, on the health plan's Internet web site or portal, a list of the health plan's prior authorization requirements, including specific information that a provider must submit to establish a complete request for prior authorization. This subsection does not prevent a health plan from requiring specific additional information upon review of the request for prior authorization.*
*(c) A health plan shall, not less than forty-five (45) days before the prior authorization requirement becomes effective, disclose to a participating provider any new prior authorization requirement.*
*(d) A disclosure made under subsection (c) must:*
*(1) be sent via electronic or United States mail and conspicuously labeled "Notice of Changes to Prior Authorization Requirements"; and*
*(2) specifically identify the location on the health plan's Internet web site or portal of the new prior authorization requirement. However, a health plan is considered to have met the requirements of this subsection if the health plan conspicuously posts the information required by this subsection, including the effective date of the new prior authorization requirement, on the health plan's Internet web site.*
*(e) A participating provider shall, not more than seven (7) days after the change is made, notify the health plan of a change in the participating provider's electronic or United States mail address.*
*Sec. 10.*
*(a) This section applies to a request for prior authorization delivered to a health plan after December 31, 2019.*
*(b) A health plan shall accept a request for prior authorization delivered to the health plan by a covered individual's health care.*

Submitted,

Richard Feldman, MD
Chairman

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