EMPLOYERS' FORUM OF INDIANA
Addressing the challenges of the local healthcare marketplace

2024 Indiana Healthcare Legislation

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EFI All-Stakeholder Webinar
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Core Team: Members & Roles

INTERNAL

Employers' Forum of Indiana CEO: analyze, explain, provide data to legislators; edit bill draft language; testify and coordinate testimony; respond to data requests from legislative leadership; inform employer policy committee; communicate with ally organizations

Employers' Forum of Indiana Policy Committee: comprised only of Forum employers, convene regularly to discuss and approve Forum policy agenda; provide recommendations for bill edits; provide Forum position on healthcare bills

Hallowell Consulting: provide government affairs and lobbying services, schedule meetings with legislative leadership; explain policy priorities to leadership; monitor / lobby legislators on key bills; provide weekly updates to EFI policy committee

EXTERNAL

Legislative Leadership: work with lead bill authors and champions of healthcare affordability

Brain Trust: seek advise from national recognized economists, academics, forensic accountants, and attorneys

Hoosiers for Affordable Healthcare: meet with leadership to explain data findings and advocate for evidence-based policy

Policy making is akin to sausage making…

Disgusting process…

tasty in the end…

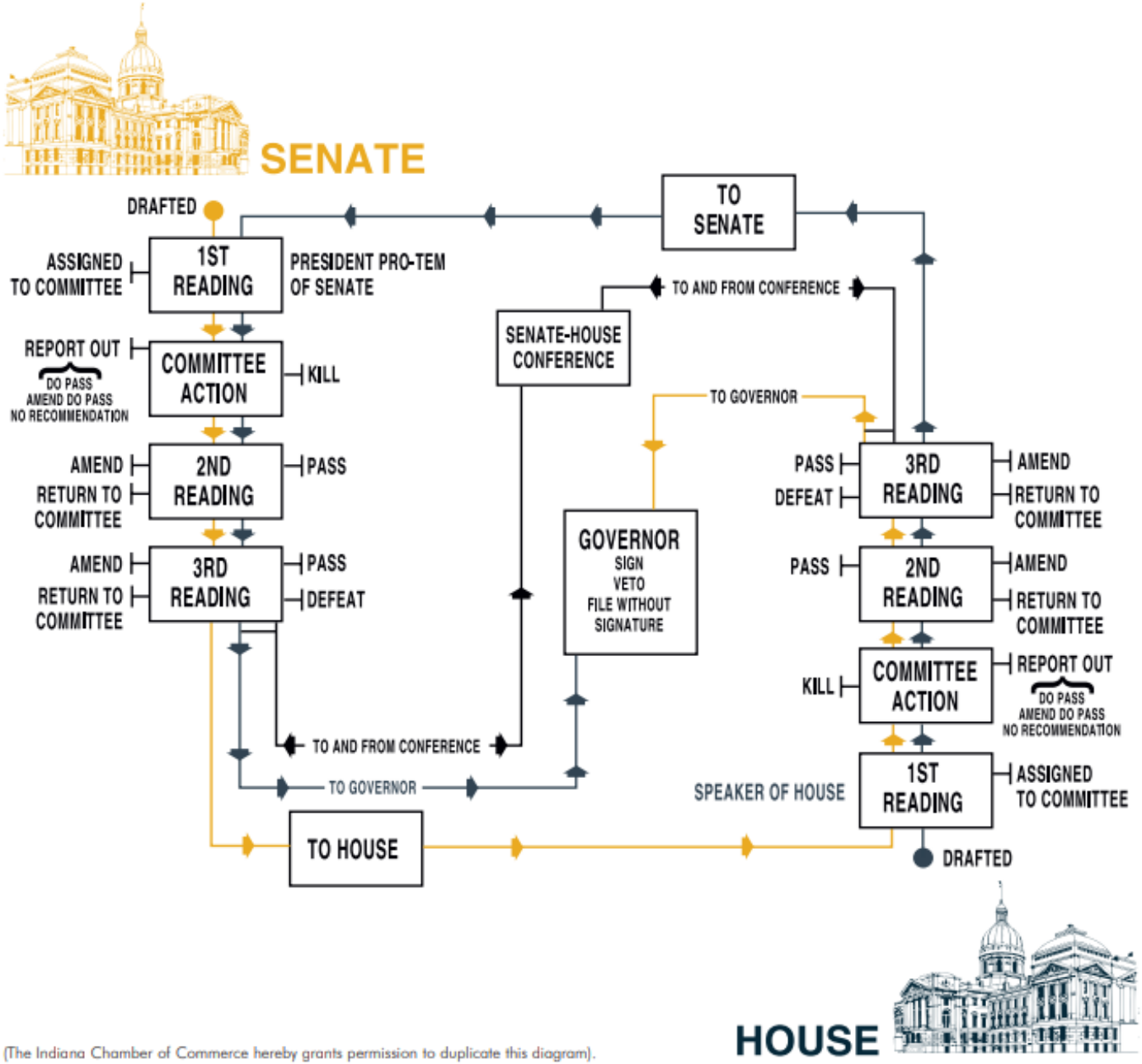
but incredibly unhealthy and exhausting!

How Does a Bill Become Law?

Bills may originate in either the Senate or House of Representatives of the General Assembly. The exception is revenue-raising bills which must be introduced in the House of Representatives.

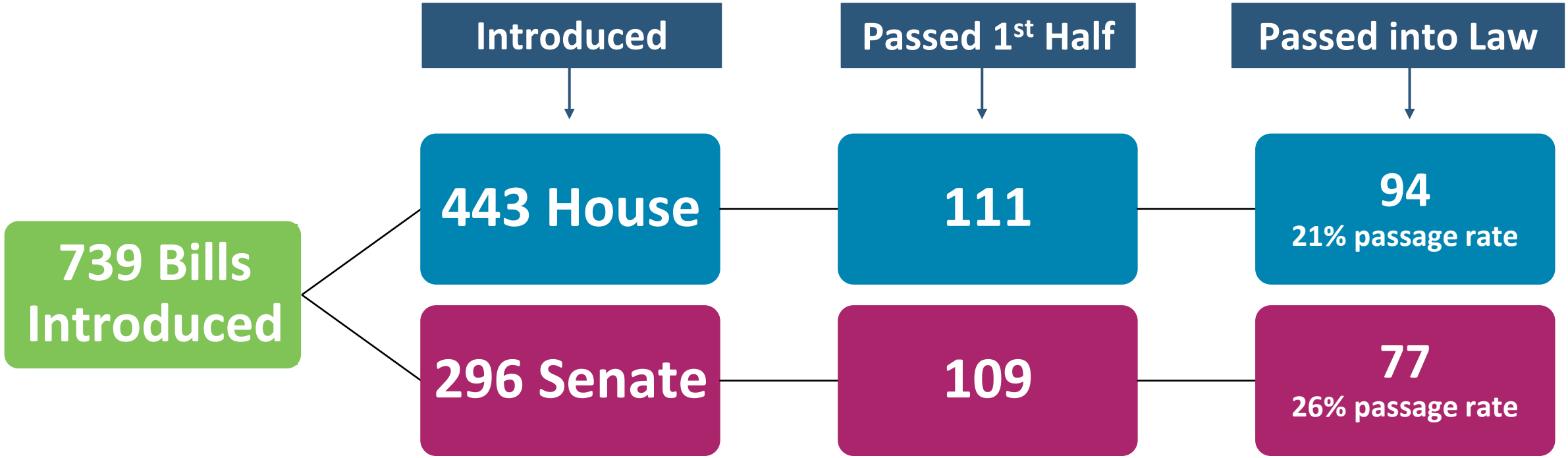
Learn more:

- Indiana Chamber: How a Bill Becomes a Law
- State House: How a Bill Becomes Law



(The Indiana Chamber of Commerce hereby grants permission to duplicate this diagram).

Bill Passage Stats



2024 Forum Policy Priorities

✓ Indicates language appeared in some form in 2024 **introduced** legislation in HB1327 (died) and ended up in HB1259, SB 9, HB 1377

PRIMARY PRIORITIES:

1. **Strengthen data transparency**
   - ☑ Establish that all employers own their data.
   - ☑ Prohibit employer audit restrictions in TPA, insurer, PBM contracts, and in contracts with any of their affiliates, subsidiaries, or organizations with whom they have partnerships, i.e. data warehouses.
   - ☑ Assure fair fees for claims data access by TPAs, insurers, PBMs, and with any of their affiliates, subsidiaries, or organizations with whom they have partnerships.
   - ☑ Prohibit PBM and TPA/insurer spread pricing.
   - ❑ Add state penalties to match federal penalties for hospital and insurer non-compliance with price transparency.
2. **Strengthen anti-trust laws**
   - ☑ Create a Merger, Acquisition, and Closure (MAC) board or a Merger, Acquisition, Closure, and Expansion (MACE) board.
   - ❑ Capture insurer, PBM, and provider OWNERSHIP AND PARTNERSHIP information.

2024 Forum Policy Priorities

✓ Indicates language appeared in all or in part in 2024 introduced legislation

PRIMARY PRIORITIES CONTINUED:

3. 2023 legislative follow-ups

SEA 7 Considerations

- ❑ Clarify that physician contracts that auto renew are considered new contracts. Consider expanding to all providers, including advanced practice registered nurses, registered nurses, and physician assistants, and others.
- ☑ Prohibit TPA/insurers from charging a "carveout fee" to employers if they wish NOT to purchase an alternate service(s) offered by the TPA/insurer.
- ☑ Monitor bills aimed at rolling back progress made in 2023.

HEA 1004 Considerations

- ❑ Redefine "office setting".
- ☑ Edit in Chapter 37.6, Section 15(a)(5) under value-based healthcare reimbursement arrangements: "Any other health care reimbursement arrangement in which the health care. provider accepts at ~~most~~ ***[least]*** ten percent (10%) of the downside risk."
- ❑ Define "price" so the 285% benchmark reflects hospital facility-fees only.

SEA 8 Considerations

- ❑ Consider adding PBMs back into chapters 49 and 50.

2024 Forum Policy Priorities

✓ Indicates language appeared in some form in 2024 introduced legislation in HB 1327 (bill died) and ended up in HB 1259, HB 1200, SB 257

PRIMARY PRIORITIES CONTINUED:

- ❑ 4. Prohibit provider contracts from containing anti-tiering, anti-steering, and all-or-none clauses.
- ☑ 5. Require PBMs, TPAs and employee benefit consultants/brokers to act as a fiduciary for their employer clients.
- ❑ 6. Require hospitals to provide acquisition price and commercial price transparency for meds.
- ☑ 7. Require the state employee health plan to implement reference-based pricing, i.e., 200% of Medicare.
- ❑ 8. Require TPA/insurers to establish select Site Neutral payments, i.e. hospital on-campus labs.

2024 Forum Policy Priorities

✓ Indicates language appeared in some form in 2024 **introduced** legislation in HB 1327 (bill died) and ended up in HB 1259, HB 1309, HB 1377, HB 1385

SECONDARY PRIORITIES:

1. HEA 1004 Considerations:
   - ❑ Edit hospital price benchmark from 285% to 260% of Medicare.
   - ❑ Add penalties if hospitals do not meet price target of 260% of Medicare.

✓ 2. Establish minimum criteria for hospitals to maintain their state tax-exempt status.

❑ 3. Require all non-profit hospitals to submit their IRS Schedule H of Form 990 with the audited financial statements that they already submit to the Indiana State Department of Health.

✓ 4. Prohibit ground ambulance surprise billing to patients – take patient out of the middle.

❑ 5. Establish behavioral health in-network access requirements.

❑ 6. Consider having the Indiana Department of Insurance improve their insurance rate review process to include an affordability standard, if not already established.

✓ 7. Support policies that improve PBM, TPA, insurer transparency and efficiency.

Forum Priority Polices That Passed into Law noted with ★

- HEA 1259 (language from HB 1327)
- SEA 9
- HEA 1332
- HEA 1385

HEA 1259 – Health Care Matters

https://iga.in.gov/legislative/2024/bills/house/1259/details

- **Effective Date: Upon Passage (as noted), otherwise July 1, 2024.**

- Requires a contract with a TPA, PBM, or prepaid health care delivery plan to provide that the **plan sponsor has ownership of the claims data**.
- Allows a contract holder to request an **audit of a PBM** one time per calendar year, no earlier than 6 months after a previously requested audit.
  - **If requested by the contract holder, the audit shall** include the following data specific to the contract holder:
    - **Rebate amounts secured on prescription drugs**, whether product specific or general rebates, that were provided by a PBM. The information must identify the prescription drugs by therapeutic category.
    - **Pharmaceutical and device claims received by the PBM.**

HEA 1259 – Health Care Matters: Related to PBMs

- The forms or transaction may be modified as necessary to comply with the HIPAA or to redact a trade secret.
  - "Trade secret" means information, including a formula, pattern, compilation, program, device, method, technique, or process that:
  - derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from its disclosure or use; and
  - is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.
- **Pharmaceutical and device claims payments or electronic funds transfer or remittance advice notices provided by the PBM, including the 837 and 835 transaction files.** The files may be modified as necessary to comply with HIPAA or to redact a trade secret.
- **Any other revenue and fees derived by the PBM from the contract, including all direct and indirect remuneration from pharmaceutical manufacturers**, regardless of whether the remuneration is classified as a rebate, fee, or another term.

HEA 1259 – Health Care Matters: Related to PBMs

- A **PBM may not impose** the following:
  - **Fees** for requesting an audit or selecting an auditor other than an auditor designated by the PBM.
  - Conditions that would restrict a contract holder's right to conduct an audit, including restrictions on the:
    - **time period of the audit;**
    - **number of claims analyzed;**
    - **type of analysis conducted;**
    - **data elements used in the analysis; or**
    - **selection of the auditor**
- A PBM shall disclose, upon request from a contract holder to the contract holder, the actual amounts directly or indirectly **paid by the PBM to the pharmacist or pharmacy for the drug and for pharmacist services** related to the drug.

HEA 1259 – Health Care Matters: Related to PBMs

- A PBM shall provide notice to a contract holder contracting with the PBM of any consideration, including direct or indirect **remuneration, that the PBM receives from a pharmaceutical manufacturer or group purchasing organization** for formulary placement of any other reason.
- A contract entered into, issued, **amended or renewed after June 30, 2024**, may not contain a provision that violates these provisions.
- A PMB shall obtain any information requested in an audit from a group purchasing organization or other partner entity of the PBM and confirm receipt of a request for an audit to the contract holder no later than 10 business days after the request.
- Information provided in an audit must be provided in compliance with HIPAA.

HEA 1259 – Health Care Matters: Related to TPAs

- Provides that the **plan sponsor owns the claims data relating to the contract**.
  - A plan sponsor's ownership of the claims data may not be construed to require the PBM or TPA to disclose a trade secret.
  - Any claims data provided must be provided in accordance with HIPAA.
- Allows a plan sponsor that contracts with a **TPA,** FSSA that contracts with an MCO to provide services to a Medicaid recipient, or the state personnel department (SPD) that contracts with a prepaid health care delivery plan to provide group health coverage for state employees **to request an audit one time in a calendar year and not earlier than 6 months after a previously requested audit.**
  - If requested by the plan sponsor, FSSA, or SPD, the **audit shall include full disclosure** of the following data specific to the plan sponsor, FSSA or SPD:
    - **Claims data.**
    - **Claims received by the TPA**, MCO, or prepaid health care delivery plan.
    - **Claims payments, electronic funds transfer, or remittance advice notices provided by the TPA,** managed care organization, or prepaid health care delivery plan. Includes 837 and 835 e-transactions.
    - **Any fees charged to the plan sponsor**, FSSA, or SPD related to plan administration and claims processing, including renegotiation fees, access fees, repricing fees, or enhanced review fees.

HEA 1259 – Health Care Matters: Related to TPAs

- A TPA, MCO, or prepaid health care delivery plan **may not impose**:
  - **fees for requesting an audit or selecting an auditor other than an auditor** designated by the TPA, MCO, or prepaid health care delivery plan; or
  - conditions that would **restrict** a party's right to conduct an audit under this section, including restrictions on the:
    - **time period of the audit;**
    - **number of claims analyzed;**
    - **type of analysis conducted;**
    - **data elements used in the analysis; or**
    - **selection of an auditor.**

- A TPA, MCO, or prepaid healthcare delivery plan shall <u>confirm receipt of a request</u> for an audit under this section to the plan sponsor, FSSA, or SPD no later than 10 business days after the information is requested.

HEA 1259 – Health Care Matters: Related to PBMs & TPAs

- A contract that is entered into, **issued, amended or renewed after June 30, 2024**, may not contain a provision that violates these provisions.
- A violation of these provisions is an unfair or deceptive act or practice in the business of insurance.
- The department may also adopt rules to set forth fines for a violation.

HEA 1259 – Health Care Matters

not relevant to the Forum's priority agenda but part of this bill

- Establishes the therapeutic psilocybin research fund, administered by DMHA, to provide financial assistance to research institutions in Indiana to study the use of psilocybin to treat mental health and other medical conditions

- Requires the research institution that receives a grant to conduct a clinical study to prepare and submit a report to the interim study committee on public health, behavioral health, and human services, IDOH, and DMHA.

- Allows, rather than requires, IDOH to grant an extension to a hospital for the filing of certain reports.

SEA 9 – Notice of Health Care Entity Mergers

https://iga.in.gov/legislative/2024/bills/senate/9/details

- **Effective Date: July 1, 2024**
- Requires a **health care entity that is involved in a merger or acquisition** with another health care entity with total assets (including combined entities and holdings) of at **least $10,000,000 to provide written notice to the Indiana Attorney General's Office 90 days prior to the date of the merger or acquisition**.
- Defines "acquisition" as any agreement, arrangement, or activity the consummation of which results in a person acquiring directly or indirectly the control of another person.

SEA 9 – Notice of Health Care Entity Mergers

- Defines **“health care entity”** as any of the following:
  - Any organization or business that provides diagnostic, medical, surgical, dental treatment, or rehabilitative care.
  - An insurer that issues a policy of accident and sickness insurance.
  - A health maintenance organization.
  - A pharmacy benefit manager.
  - An administrator.
  - A **private equity** partnership, regardless of where the private equity partnership is located, seeking to enter into a merger or acquisition with an entity described above.
  - This term does **NOT** include the Medicaid program or the Medicare program.

SEA 9 – Notice of Health Care Entity Mergers

- Defines **"merger"** as any change of ownership, including an acquisition or transfer of assets, or the purchase of stock effectuated by a merger agreement.
- The notice of such merger or acquisition **must include the following** from each health care entity:
  - Business address and federal tax number.
  - Name and contact information of a representative of the health care entity concerning the merger or acquisition.
  - Description of the health care entity.
  - Description of the merger or acquisition, including the anticipated timeline.
  - A copy of any materials that have been submitted to a federal or state agency concerning the merger or acquisition.
  - The notice must be certified by a public notary.

SEA 9 – Notice of Health Care Entity Mergers

- The AG's Office **must keep all nonpublic information confidential** and may not release it to the public.
- **No later than 45 days after the submission** of the notice, the AG's Office:
  - shall review the information submitted with the notice; and
  - may analyze in writing any antitrust concerns with the merger or acquisition.
    - The AG's Office shall provide any written analysis to the person that submitted the notice.
- The AG's Office may issue a civil investigation demand to a health care entity that has submitted notice for additional information.
- Any information received or produced by the AG's Office is confidential.

HEA 1332 – Insurance Matters

https://iga.in.gov/legislative/2024/bills/house/1332/details

- **Effective Date: July 1, 2024** (unless otherwise noted).
- Amends the law on **individual prescription drug rebates** and the law on group prescription drug rebates to authorize **DOI to adopt rules for the enforcement** of those laws and to specify that a violation of either of those laws is an unfair or deceptive act or practice in the business of insurance.
- **Requires an insurer to only offer to plan sponsors the following plans:**
  - A plan that **applies 100% of the rebates to reduce premiums** for all covered individuals equally.
  - A plan that calculates defined cost sharing for **covered individuals of the plan sponsor at the point of sale based on a price that is reduced by an amount equal to at least 85% of all the rebates** received or estimated to be received by the insurer.

HEA 1332 – Insurance Matters

not relevant to the Forum's priority agenda but part of this bill

- Adds to the law on the regulation of insurance holding company systems provisions concerning liquidity stress testing according to the framework established by the National Association of Insurance Commissioners.
- Requires an insurer to mail a written notice of nonrenewal to an insured at least 60 days before the anniversary date of the policy if the coverage is provided to a municipality or county entity.
  - Does not apply to worker's compensation insurance.
- Provides that if a party to a health provider contract intends to terminate the contractual relationship with another party to the health provider contract, the terminating party must provide written notice to the other party of the decision to terminate the contractual relationship no less than 90 days before the health provider contract terminates.

HEA 1332 – Insurance Matters

not relevant to the Forum's priority agenda but part of this bill

- Establishes the insurance producer education and continuing education commission with appointments from the DOI commissioner.
- Repeals the insurance producer education and continuing education advisory council.
- Repeals the law requiring an alien or foreign insurance company to annually submit to DOI a condensed statement of its assets and liabilities and requiring DOI to publish the statement in a newspaper.

HEA 1385 – Emergency Medical Services

https://iga.in.gov/legislative/2024/bills/house/1385/details

- **Effective Date: January 1, 2025**, for all provisions except those related to the community cares initiative grant pilot program (July 1, 2024).
- Establishes the community cares initiative grant pilot program for the purpose of assisting in the costs of starting or expanding mobile integrated health care programs and mobile crisis teams in Indiana.
- Requires a health plan operator to provide payment to a nonparticipating ambulance service provider for **ambulance service** provided to a covered individual:
  - at a rate not to exceed the rates set or approved, by contract or ordinance, by the county or municipality in which the ambulance service originated;
  - at the rate of **400% of the published rate for ambulance services established under the Medicare law for the same ambulance service provided in the same geographic area; or**
  - **according to the nonparticipating ambulance provider's billed charges**;
  - **whichever is less.**

HEA 1385 – Emergency Medical Services

- Does not apply to the Medicaid program or ambulance services owned or operated by a **health system (or the state employee health plan).**
- Provides that if a health plan operator makes payment to a **nonparticipating ambulance service provider in compliance with these requirements:**
  - **the payment shall be considered payment in full**, except for any copayment, coinsurance, deductible, and other cost sharing amounts that the health plan requires the covered individual to pay; and
  - the nonparticipating ambulance service provider **is prohibited from billing the covered individual for any additional amount.**

HEA 1385 – Emergency Medical Services

- Provides that the copayment, coinsurance, deductible, and other cost sharing amounts that a covered individual is required to pay in connection with ambulance service provided by a **nonparticipating ambulance service provider shall not exceed what the individual would be required to pay (for those shared costs) if the ambulance service had been provided by a participating ambulance service provider.**

- Requires a health plan operator that receives a clean claim from a nonparticipating ambulance service provider to remit payment directly to the nonparticipating ambulance service provider no more than 30 days after receiving the clean claim.
  - "Clean claim" means a claim for payment for ambulance service that is submitted to a health plan by an ambulance services provider and about which there is no defect, impropriety, or particular circumstance requiring special treatment that may prevent or delay payment.
  - The health plan operator may not send the payment to the covered individual.

HEA 1385 – Emergency Medical Services

- Provides that if a claim received by a health plan operator for ambulance service provided by a nonparticipating ambulance service provider is not a clean claim, the health plan operator, no more than 30 days after receiving the claim, shall:
  - remit payment; or
  - send a written notice that:
    - acknowledges the date of receipt of the claim; and
    - either explains why the health plan operator is declining to pay the claim or states that additional information is needed for a determination whether to pay the claim.

EMPLOYERS' FORUM OF INDIANA

Addressing the challenges of the local healthcare marketplace

Other Healthcare Legislation Which Was NOT a Priority for the Forum but is Worthwhile to Know About

- HEA 1302
- SEA 132
- SEA 215
- SEA 273
- HEA 1058
- HEA 1426

Other Health Care Legislation

HEA 1302 – Emergency Medical Services

https://iga.in.gov/legislative/2024/bills/house/1302/details

- **Effective date: July 1, 2024.**
- Provides that **no later than July 15, 2024**, the county executive shall provide the department of homeland security (DHS) certain information relating to each emergency medical services (EMS) provider in the county, including the following:
  - Each EMS provider that provides services in the county.
  - Each EMS provider in the county that provides services to an adjacent county.
  - The funding source for each EMS provider described above.
  - The level of care provided by each EMS provider in the county, including the description of the basic life support (BLS) services and advanced life support (ALS) services.

Other Health Care Legislation

HEA 1302 – Emergency Medical Services

- The average response time for each EMS provider in the county disaggregated by nontransport EMS units and transport EMS units.
- Factors that result in a longer average response time in certain jurisdictions within the county disaggregated by nontransport EMS units and transport EMS units.
- Any information DHS, in consultation with the Indiana EMS commission determines is useful to include.

- No later than August 15, 2024, DHS, in consultation with the Indiana EMS commission, shall prepare and submit a report to the general assembly relating to the provision of EMS.
- Urges the legislative council to assign to the appropriate study committee the topic of improving the provision of EMS throughout Indiana.

Other Health Care Legislation

SEA 132 – Professions and Professional Services

https://iga.in.gov/legislative/2024/bills/senate/132/details

- **Effective Date: July 1, 2024.**

- Prohibits a TPA or another person from arranging for a dental provider to provide **dental services** for a dental plan that sets the amount of the fee for any dental services, unless they are covered services under the dental plan.

- Eliminates the requirement that a provider who is licensed in Indiana, physically located outside Indiana, but providing **telehealth services** to patients who are in Indiana, file a certification constituting a waiver of jurisdiction.

Other Health Care Legislation

SEA 132 – Professions and Professional Services

- Authorizes FSSA to implement a risk based managed care program for certain **Medicaid** recipients.
  - Requires the OMPP to convene a workgroup and, with managed care organizations, to conduct a claims submission testing period before the risk based managed care program is established.
  - Provides that, during the first 210 days after the risk based managed care program is implemented, a **provider** that experiences a financial emergency due to claims payment issues shall receive temporary emergency assistance from the managed care organizations with which the provider is contracted.
- Requires IDOH to grant a hospital an extension of time to file the **hospital's fiscal report** if the hospital shows good cause for the extension.
  - This is later changed to a "may" provision in HEA 1259.
  - Removes an expired provision concerning hospital fiscal reports.

Other Health Care Legislation

SEA 132 – Professions and Professional Services

- **A contracting entity may not grant a third party access to the provider network contract or to dental services or contractual discounts provided pursuant to the provider network contract unless certain conditions are satisfied.**
- Does not apply to a provider network contract for dental services provided to beneficiaries of health programs established or maintained by local, state, or federal government, such as:
  - Medicaid
  - the children's health insurance program
  - Medicare Advantage
- Prohibits a contracting entity from altering the rights or status under a provider network contract of a dental provider that chooses not to participate in third party access or rejecting a provider as a party to a network contract because the provider chose not to participate in third party access.

Other Health Care Legislation

SEA 132 – Professions and Professional Services

- Authorizes the insurance commissioner to issue a cease and desist order against a person that violates any of these prohibitions and, if the person violates the order, to impose a civil penalty and suspend or revoke the person's certificate of authority.
- Provides that if a covered individual assigns the covered individual's rights to benefits for dental services to the provider of the dental services, the dental carrier shall pay the benefits assigned by the covered individual to the provider of the dental services.
  - A dental carrier shall make a payment directly to the provider of the dental services and according to the same criteria and payment schedule under which the dental carrier would have been required to make the payment to the covered individual if the insured had not assigned the rights to the benefits.
  - An assignment of benefits does not affect or limit the dental carrier's obligation to pay the benefits.

Other Health Care Legislation

SEA 132 – Professions and Professional Services

- Prohibits the provider from billing the covered individual (except for a copayment, coinsurance, or a deductible amount) if the provider is in the dental carrier's network.

- Requires the Indiana state board of nursing to amend a specified administrative rule to conform with this act.

- Requires the medical licensing board to study certain rules concerning office-based setting accreditations and report to the general assembly.

Other Health Care Legislation

SEA 215 – Medicare Supplement Insurance

https://iga.in.gov/legislative/2024/bills/senate/215/details

- **Effective date: July 1, 2024.**
- Provides that after December 31, 2024, an issuer that makes a Medicare supplement policy or certificate available to persons at least 65 years of age must make the equivalent policy or certificate available to an individual under 65 years of age who is eligible for Medicare because of having a federally defined disability or end stage renal disease.

Other Health Care Legislation

SEA 215 – Medicare Supplement Insurance

- Provides that if an individual who is less than 65 years of age, who is eligible for Medicare because of having a federally defined disability or end stage renal disease, and who meets certain conditions as to application timeliness applies for a Medicare supplement policy or certificate, the issuer of the policy or certificate is prohibited from:
  - denying or conditioning the issuance or effectiveness of the individual's policy or certificate;
  - charging the individual a premium rate for a policy or certificate standardized as Plan A, B, or D that exceeds the premium rate the issuer charges an individual who is 65 years of age;
  - charging the individual a premium rate for any other standardized lettered policy or certificate that exceeds 200% of the premium rate the issuer charges an individual who is 65 years of age; or
  - issuing to the individual a policy or certificate that contains a waiting period or a preexisting condition limitation or exclusion.

Other Health Care Legislation

SEA 273 – Biomarker Testing Coverage

https://iga.in.gov/legislative/2024/bills/senate/273/details

- **Effective date: July 1, 2024.**
- Requires a health plan to provide coverage for biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition when biomarker testing is supported by medical and scientific evidence.
- Requires OMPP to provide biomarker testing as a Medicaid program service, and to apply to HHS for approval of any waiver necessary under the federal Medicaid program for the purpose of providing biomarker testing.
- Provides that if a prior authorization requirement applies to biomarker testing, the health plan or a third party acting on behalf of the health plan must:
  - approve or deny a request for prior authorization; and
  - notify the covered individual of the approval or denial;
  - in no more than 5 business days in the case of a nonurgent request or in not more than 48 hours in the case of an urgent request.

Other Health Care Legislation

SEA 273 – Biomarker Testing Coverage

- Before November 1, 2025, and before each November 1 thereafter, requires FSSA to report the following statewide aggregate information to the budget committee on Medicaid reimbursement rates provided for biomarker testing:
  - The total number of patients who received biomarker testing.
  - The total number of patients who received biomarker testing for each biomarker test type.
  - The total amount of state funding expended for biomarker testing.
  - The 10 most common conditions or treatments for which biomarker testing was ordered.
  - As a result of the biomarker testing, how many patients:
    - were placed on particular therapies;
    - avoided certain treatments; and
    - were subject to any other treatment impacts.
  - Any other information requested by the budget committee.

Other Health Care Legislation

HEA 1058 – Breast Cancer Screening and Services

https://iga.in.gov/legislative/2024/bills/house/1058/details

- **Effective date: July 1, 2024.**
- Specifies that coverage of breast cancer rehabilitative services and reconstructive surgery incident to a mastectomy includes chest wall reconstruction and aesthetic flat closure.
- Requires a facility performing a mammography examination to provide:
  - an assessment of the patient's breast tissue density using specified classifications;
  - written notice to the patient and the referring provider; and
  - concerning the notice to the patient, specified notification language depending on whether the facility determined the patient to have dense breast tissue or not dense breast tissue.

Other Health Care Legislation

HEA 1426 – Long Acting Reversible Contraceptives

https://iga.in.gov/legislative/2024/bills/house/1426/details

- **Effective date: July 1, 2024.**
- Requires a hospital that operates a maternity unit to ensure that a woman who is:
  - giving birth in the hospital; and
  - eligible for or receiving Medicaid assistance;
  - has the option, if not medically contraindicated, of having a long acting reversible subdermal contraceptive implanted after delivery and before the woman is discharged.
- Allows a hospital to be exempt from the requirement if the hospital has a faith based objection.

Other Health Care Legislation

HEA 1426 – Long Acting Reversible Contraceptives

- Requires FSSA to reimburse the hospital for the following provided to a Medicaid recipient:
  - A long acting reversible subdermal contraceptive, including the cost of stocking the long acting reversible subdermal contraceptive.
  - Placement of the long acting reversible subdermal contraceptive.
- Sunsets the provisions being added in the bill on June 30, 2025.
- Requires FSSA to develop a billing process that maximizes federal funding for purposes of the long acting reversible contraceptives reimbursement for a Medicaid recipient.

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THANK YOU!