2024 Indiana Legislative Healthcare Summary

March 20, 2024

The 2024 Legislative Session began on January 8 and concluded on March 8. A total of 739 bills (443 bills in the House and 296 bills in the Senate) were introduced. Of those introduced, 172 bills passed by the Indiana General Assembly, resulting in an overall passage percentage rate of 23%.

This report summarizes EFI priority and other key healthcare legislation that passed into law.

2024 Accomplishments of the Employers' Forum of Indiana

1. Through SEA 9, EFI successfully advocated for language requiring health care entities with total assets of at least $10,000,000 to give notice of a merger or acquisition to the Indiana Attorney General's Office 90 days prior to the date of the merger or acquisition.
2. Another one of EFI's top priorities for the session was strengthening data transparency. HEA 1259 incorporates language originally in HB 1327, which includes the following provisions: requiring contracts with TPAs, PBMs, or prepaid health care delivery plans to provide that the plan sponsor has ownership of claims data; allowing for contract holders, plan sponsors (or FSSA or SPD) to request an unfettered audit of a PBM, TPA (or MCO or prepaid health care delivery plan) once a year to include what was submitted and paid to providers/pharmacies via the 837/835 electronic file transactions; requirements for specific information that must be included in the audit if requested; and prohibitions on fees and certain conditions related to requesting an audit.
3. HEA 1332 is a larger insurance matters bill that contained provisions amending language from SEA 8 (2023) relating to rebates at the point of sale. There was a potential amendment in the House Insurance committee which would have removed the employers' ability to determine how to distribute and share savings. We opposed this amendment, and it was ultimately not included in the bill.
4. HEA 1385 was introduced to address the crisis ground ambulance/EMS providers. Originally, the bill required a health plan operator to provide payment to a nonparticipating ambulance service provider at a rate not to exceed the rates set or approved by contract or ordinance by the county or municipality in which the services originated, at 500% of Medicare, or at the nonparticipating ambulance provider's billed charges were, whichever is less. After EFI and others expressed concern of the 500% of Medicare rate, this was reduced to a 400% of Medicare cap. The latest version of the bill also exempted the state health plan as well as EMS operated by hospital systems.

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EFI Priority Legislation

Senate Enrolled Acts

1. **SEA 9 Notice of Health Care Entity Mergers (Senators Chris Garten, Ed Charbonneau, Liz Brown)**
    - **A.** Effective Date: July 1, 2024.
    - **B.** 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.
    - **C.** 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.
    - **D.** Defines "health care entity" as any of the following:
        - **i.** Any organization or business that provides diagnostic, medical, surgical, dental treatment, or rehabilitative care.
        - **ii.** An insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1), except for the following types of coverage:
            - **a.** Accident only, credit, dental, vision, long term care, or disability income insurance.
            - **b.** Coverage issued as a supplement to liability insurance.
            - **c.** Automobile medical payment insurance.
            - **d.** A specified disease policy.
            - **e.** A policy that provides indemnity benefits not based on any expense incurred requirements, including a plan that provides coverage for:
                - **a.** hospital confinement, critical illness, or intensive care; or
                - **b.** gaps for deductibles or copayments.
            - **f.** Worker's compensation or similar insurance.
            - **g.** A student health plan.
            - **h.** A supplemental plan that always pays in addition to other coverage.
        - **iii.** A health maintenance organization (as defined in IC 27-13-1-19).
        - **iv.** A pharmacy benefit manager (as defined in IC 27-1-24.5-12).
        - **v.** An administrator (as defined in IC 27-1-25-1).
        - **vi.** 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 (subsections (1) – (5) on pages 2 – 3 of the bill).
        - **vii.** This term does NOT include the Medicaid program or the Medicare program.

E. Defines "merger" as any change of ownership, including an acquisition or transfer of assets, or the purchase of stock effectuated by a merger agreement.
F. The notice of such merger or acquisition must include the following from each health care entity:
    i. Business address and federal tax number.
    ii. Name and contact information of a representative of the health care entity concerning the merger or acquisition.
    iii. Description of the health care entity.
    iv. Description of the merger or acquisition, including the anticipated timeline.
    v. A copy of any materials that have been submitted to a federal or state agency concerning the merger or acquisition.
    vi. The notice must be certified by a public notary.
G. The Attorney General's Office must keep all nonpublic information confidential and may not release it to the public.
H. No later than 45 days after the submission of the notice, the Attorney General's Office:
    i. shall review the information submitted with the notice; and
    ii. may analyze in writing any antitrust concerns with the merger or acquisition.
        a. The Attorney General's Office shall provide any written analysis to the person that submitted the notice.
I. The Attorney General's Office may issue a civil investigation demand under IC 4-6-3 to a health care entity that has submitted notice for additional information.
J. Any information received or produced by the Attorney General's Office under IC 25-1-8.5(4) is confidential.

Click here to read the latest version of the bill.

2. SEA 132 Professions and Professional Services (Senators Liz Brown, Ed Charbonneau, Dr. Tyler Johnson)

A. Effective Date: July 1, 2024.
B. Authorizes FSSA to implement a risk based managed care program for certain Medicaid recipients.
    i. "Covered population" means all Medicaid recipients who are eligible to participate in the federal Medicare program and receives nursing facility services, or
        a. is at least 60 years of age;
        b. blind, aged, or disabled; and

c. receiving services through one of the following:
    a. The aged and disabled Medicaid waiver.
    b. A risk based managed care program for aged, blind, or disabled individuals who are not eligible to participate in the federal Medicare program.
    c. The state Medicaid plan.

C. Requires the office of Medicaid policy and planning 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.

D. 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.

E. Amends statutes concerning Medicaid provider agreements, health insurance reimbursement agreements, and Medicare supplement insurance to specify that a 15-day period consists of 15 business days.

F. 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.
    i. This is later changed to a "may" provision in HEA 1259.

G. Removes an expired provision concerning hospital fiscal reports.

H. 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.

I. Makes changes in the law concerning health facility administrators, including eliminating the requirement that a health facility administrator display the individual's license in a prominent location in the individual's principal office and providing that a particular course of study for administrators in training is not mandatory.

J. Specifies:
    i. the manner in which certain nurse applicants may demonstrate English proficiency;
    ii. that a graduate of a foreign nursing school must pass a specified examination; and
    iii. additional credentialing verification assessment organizations for certain nurse applicants.

K. 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 dental plan.

i. "Contracting entity" means a dental carrier, a TPA, or another person that enters into a provider network contract with providers for the delivery of dental services in the ordinary course of business.
ii. "Covered individual" means an individual who is entitled to dental services or coverage of dental services through a provider network contract.
iii. "Dental carrier" means any of the following:
    a. An insurer that issues a policy of accident and sickness insurance that covers dental services.
    b. A health maintenance organization that provides, or provides coverage for, dental services.
    c. An entity that provides dental services or arranges for dental services to be provided but is not itself a provider.
iv. "Dental plan" means any of the following:
    a. A policy issued by an insurer (as defined in IC 27-1-2-3(x)) that provides coverage for dental services.
    b. A contract under which a health maintenance organization (as defined in IC 27-13-1-19) provides or covers dental services.
    c. A preferred provider plan (as defined in IC 27-8-11(g)) that provides or covers dental services.
    d. The term does not include the following:
        a. A policy providing comprehensive coverage described in Class 1(b) and Class 2(a) of IC 27-1-5-1.
        b. Accident only, Medicare supplement, long term care, or disability income insurance.
        c. Coverage issued as a supplement to liability insurance.
        d. Automobile medical payment insurance.
        e. A specified disease policy.
        f. Worker's compensation or similar insurance.
        g. A student health plan.
        h. A supplemental plan that always pays in addition to other coverage.
v. "Dental service" means any service provided by a dentist within the scope of the dentist's licensure under IC 25-14.
    a. Does not include a service delivered by a provider that is billed as a medical expense.
vi. "Health insurer" means an insurer that issues policies of accident and sickness insurance (as defined in IC 27-8-5-1) or a health maintenance organization (as defined in IC 27-13-1-19).

vii. "Person" means an individual, a corporation, a limited liability company, a partnership, or any other legal entity.

viii. "Provider" means a dentist licensed under IC 25-14 or a dental office through which one or more dentists licensed under IC 25-14 provide dental services.

a. Does not include a physician organization or physician hospital organization that leases or rents the network of the physician organization of physician hospital organization network to a third party.

ix. "Provider network contract" means a contract between a contracting entity and one or more providers that establishes a network through which the providers: provide dental services to covered individuals, are compensated for providing the dental services, and that specifies the rights and responsibilities of the contracting entity and the providers concerning the network.

x. "Third party" means a person that enters into a contract with a contracting entity or another third party to gain access to:

a. a provider network contract;

b. dental services provided pursuant to a provider network contract; or

c. contractual discounts provided pursuant to a provider network contract.

d. The term does not include an employer or another group or entity for which the contracting entity provides administrative services.

L. Provides that 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 the conditions are satisfied.

i. When a provider network contract is entered into or renewed, or when there are material modifications to a provider network contract relevant to granting access to a third party:

a. any provider that is a party to the provider network contract must be allowed to choose not to participate in the third-party access; or

b. if third party access is to be provided through the acquisition of the provider network by a health insurer, any provider that is a party to the provider network contract must be allowed to enter into a contract directly with the health insurer that acquired the provider network.

ii. The provider network contract must specifically authorize the contracting entity to enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

iii. If the contracting entity seeking to grant a third-party access is a dental carrier, a provider that is a party to the provider network contract must have

chosen to participate in third party access at the time the provider network contract was entered into or renewed.

iv. If the contracting entity seeking to grant a third-party access is a health insurer, the provider network contract must contain a third-party access provision specifically granting third party access to the provider network.

v. If the contracting entity seeking to grant a third-party access is a dental carrier, the provider network contract must state that the provider has a right to choose not to participate in the third-party access.

vi. The third party being granted access must agree to comply with all the terms of the provider network contract.

vii. The contracting entity seeking to grant third party access must identify to each provider that is a party to the provider network contract, in writing or electronic form, all third parties in existence as of the date on which the provider network contract is entered into or renewed.

viii. The contracting entity granting third party access must identify, in a list on its website that is updated at least once every 90 days, all third parties to which third party access has been granted.

ix. If third party access as is to be granted through the sale or leasing of the network established by the provider network contract, the contracting entity must notify all providers that are parties to the provider network contract of the leasing or sale of the network at least 30 days before the sale or lease of the network takes effect.

x. The contracting entity seeking to grant third party access to contractual discounts must require each third party to identify the source of the discount on all remittance advice or explanations of payment under which a discount is taken. (Does not apply to electronic transactions mandated by HIPAA).

M. 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:

i. Medicaid established under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.);

ii. the children's health insurance program established under Title XXI of the federal Social Security Act (42 U.S.C. 1397aa-1397mm); or

iii. Medicare Advantage.

N. 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 provider network contract because the provider chose not to participate in third party access.

O. 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 cease and desist order, to impose a civil penalty upon the person and suspend or revoke the person's certificate of authority.
   i. Civil penalty may not be more than $10,000 for each day of the violation.

P. 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.
   i. 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.
   ii. An assignment of benefits does not affect or limit the dental carrier's obligation to pay the benefits.

Q. 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.

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

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

Click here to read the latest version of the bill.

House Enrolled Acts

3. **HEA 1259 Health Care Matters (Representative (Dr.) Brad Barrett)**
   A. Effective Date: Upon Passage (as noted), otherwise July 1, 2024.
   B. 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, including the following:
      i. Posttraumatic stress disorder, with a focus on treating the disorder in combat veterans and first responders.
      ii. Anxiety.
      iii. Depression.
      iv. Bipolar disorder.

v. Chronic pain.
vi. Migraines.
vii. Alcohol use disorder.
viii. Tobacco use disorder.

C. Sets forth clinical study requirements.

D. Requires a 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.

E. Psilocybin sections (1 – 4) of the bill are Effective Upon Passage.

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

i. This amends language from HEA 1004 (2023) regarding an initial extension for hospital reporting requirements. SEA 132 required IDOH to grant an extension for "good cause". This language amends that provision and allows IDOH to grant an extension for good cause.

G. Removes the requirement that a clinical preceptor must have at least 18 months of experience as a licensed nurse.

H. Allows the majority of nursing program faculty to be part-time employees of an approved postsecondary educational institution or a hospital that conducts a nursing program.

I. Allows the holder of a student permit issued by the respiratory care committee to perform certain respiratory care procedures on certain child patients.

J. Provides that an individual who previously was employed to provide supervised surgical assistance in a health care facility may provide surgical assistance in a health care facility.

K. Defines "contract holder" as:

i. an individual or entity that offers health insurance coverage to its employees or members through a self-funded health benefit plan, including a self-funded health benefit plan that complies with ERISA;
ii. a health plan; or
iii. Medicaid or a managed care organization (as defined in IC 12-7-2-126.9) that provides services to a Medicaid recipient;
iv. that contracts with a PBM to provide services.

L. 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.

M. 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.

i. If requested by the contract holder, the audit shall include the following data specific to the contract holder:
   a. 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.
   b. Pharmaceutical and device claims received by the PBM on any of the following:
      a. The CMS-1500 form or its successor form.
      b. The HCFA-1500 form or its successor form.
      c. The HIPAAX12 837P electronic claims transaction for professional services, or its successor transaction.
      d. The HIPAA X12 837I institutional form or its successor form.
      e. The CMS-1450 form or its successor form.
      f. The UB-04 form or its successor form.
   c. The forms or transaction may be modified as necessary to comply with the HIPAA or to redact a trade secret (as defined in IC 24-2-3-2).
      a. "Trade secret" means information, including a formula, pattern, compilation, program, device, method, technique, or process, that:
         i. 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
         ii. is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.
   d. Pharmaceutical and device claims payments or electronic funds transfer or remittance advice notices provided by the PBM as ASC X12N 835 files or a successor format. The files may be modified as necessary to comply with HIPAA or to redact a trade secret (as defined in IC 24-2-3-2). If paper claims are provided, the PBM shall convert the paper claims to the ASCX12N835 electronic format or a successor format.
   e. 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.

ii. A PBM may not impose the following:

a. Fees for requesting an audit or selecting an auditor other than an auditor designated by the PBM.

b. Conditions that would restrict a contract holder's right to conduct an audit, including restrictions on the:

a. time period of the audit;
b. number of claims analyzed;
c. type of analysis conducted;
d. data elements used in the analysis; or
e. selection of the auditor as long as the auditor:

i. does not have a conflict of interest;
ii. meets a threshold for liability insurance specified in the contract between the parties;
iii. does not work on a contingent fee basis; and
iv. does not have a history of breaching nondisclosure agreements.

iii. 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.

iv. 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.

v. A contract entered into, issued, amended or renewed after June 30, 2024, may not contain a provision that violates these provisions.

vi. 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.

vii. Information provided in an audit must be provided in compliance with HIPAA.

N. Defines "plan sponsor" as an individual or entity that offers health insurance coverage to its employees or members through a self-funded health benefit plan, including a self-funded health benefit plan that complies with ERISA and a self-insurance program established under IC5-10-8-7(b).

O. Defines "third party administrator" as an individual or entity that performs administrative services for a self-funded health benefit plan, including a self-funded health benefit plan that complies with the ERISA and a self-insurance program established under IC5-10-8-7(b).

P. Provides that the plan sponsor owns the claims data relating to the contract.
- **i.** A plan sponsor's ownership of the claims data may not be construed to require the PBM or TPA to disclose a trade secret.
- **ii.** Any claims data provided must be provided in accordance with HIPAA.

Q. Allows a plan sponsor that contracts with a TPA, FSSA that contracts with a managed care organization (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.
- **i.** 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:
  - **a.** Claims data.
  - **b.** Claims received by the TPA, MCO, or prepaid health care delivery plan on any of the following:
    a. The CMS-1500 form or its successor form.
    b. The HCFA-1500 form or its successor form.
    c. The HIPAAX12 837P electronic claims transaction for professional services, or its successor transaction.
    d. The HIPAA X12 837I institutional form or its successor form.
    e. The CMS-1450 form or its successor form.
    f. The UB-04 form or its successor form.
  - **c.** The forms or transaction may be modified as necessary to comply with HIPAA or to redact a trade secret.
  - **d.** Claims payments, electronic funds transfer, or remittance advice notices provided by the TPA, managed care organization, or prepaid health care delivery plan as ASC X12N 835 files or a successor format. The files may be modified only as necessary to comply with the HIPAA or to redact a trade secret.
    a. If paper claims are provided, the TPA, MCO, or prepaid health care delivery plan shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.
  - **e.** 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.

R. A TPA, MCO, or prepaid health care delivery plan may not impose:
- **i.** 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

ii. conditions that would restrict a party's right to conduct an audit under this section, including restrictions on the:
    a. time period of the audit;
    b. number of claims analyzed;
    c. type of analysis conducted;
    d. data elements used in the analysis; or
    e. selection of an auditor as long as the auditor:
        a. does not have a conflict of interest;
        b. meets a threshold for liability insurance specified in the contract between the parties;
        c. does not work on a contingent fee basis; and
        d. does not have a history of breaching nondisclosure agreements.

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

T. Information provided in an audit under this section must be provided in accordance with HIPAA.

U. A contract that is entered into, issued, amended, or renewed after June 30, 2024, may not contain a provision that violates these provisions.

V. A violation of these provisions is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

W. The department may also adopt rules under IC 4-22-2 to set forth fines for a violation.

X. Voids a provision in the Indiana Administrative Code relating to physician referrals for acupuncture services.

Click here for the latest version of the bill.

4. HEA 1332 Insurance Matters (Representative Martin Carbaugh)

A. Effective Date: July 1, 2024 (unless otherwise noted).

B. Establishes the insurance producer education and continuing education commission with appointments from the DOI commissioner.

C. Repeals the insurance producer education and continuing education advisory council.

D. 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.

E. 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.
F. Amends the law on insurance administrators to set forth certain circumstances under which an insurance administrator is required to apply to Indiana for a license.
G. 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.
    i. Does not apply to worker's compensation insurance.
H. 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.
I. 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.
J. Requires an insurer to only offer to plan sponsors the following plans:
    i. A plan that applies 100% of the rebates to reduce premiums for all covered individuals equally.
    ii. 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 of the rebates received or estimated to be received by the insurer.
K. Changes the date of applicability for provisions regarding a notice of material change from after June 30, 2024, to after June 30, 2025. (Effective June 30, 2024).
L. Amends the property and casualty insurance guaranty association law concerning the allocation, transfer, or assumption by one insurer of a policy that was issued by another insurer.

Click here for the latest version of the bill.

5. **HEA 1385 Emergency Medical Services (Representative (Dr.) Brad Barrett)**
    A. Effective Date: January 1, 2025, for all provisions except those related to the community cares initiative grant pilot program (July 1, 2024).

B. 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.
  - **i.** Administered by DMHA.
  - **ii.** A county, city, or town that operates a mobile integrated healthcare program or mobile crisis team is eligible to participate in the pilot program.
  - **iii.** Establishes the community cares initiative fund.
  - **iv.** Requires reporting back on the program from DMHA to the legislative council before December 1 of each year.

C. Defines "health plan" as either a policy of accident and sickness insurance as defined in IC 27-8-5-1, but not including any insurance, plan, or policy set forth in IC 27-8-5-2.5(a) or an individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16) with a health maintenance organization that provides coverage for basic health care services (as defined in IC 27-13-1-4).
  - **i.** Does not include the state employee health plan.

D. Requires a health plan operator to provide payment to a nonparticipating ambulance service provider for ambulance service provided to a covered individual:
  - **i.** 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;
  - **ii.** 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
  - **iii.** according to the nonparticipating ambulance provider's billed charges;
  - **iv.** <u>whichever is less.</u>

E. Does not apply to the Medicaid program or ambulance services owned or operated by a health system (as defined in IC 16-18-2-168.5) that bill for ambulance services under the health system (or the state employee health plan).

F. Provides that if a health plan operator makes payment to a nonparticipating ambulance service provider in compliance with these requirements:
  - **i.** 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
  - **ii.** the nonparticipating ambulance service provider is prohibited from billing the covered individual for any additional amount.

G. 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 the copayment, coinsurance, deductible, and other cost sharing amounts that the

covered individual would be required to pay if the ambulance service had been provided by a participating ambulance service provider.

H. 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.
   - **i.** "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.
   - **ii.** The health plan operator may not send the payment to the covered individual.

I. 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:
   - **i.** remit payment; or
   - **ii.** send a written notice that:
     - **a.** acknowledges the date of receipt of the claim; and
     - **b.** 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.

J. Removes the requirement that a health plan operator negotiate rates and terms with any ambulance service provider willing to become a participating provider but retains the requirement that the state negotiate rates and terms with any ambulance service provider willing to become a participating provider.

Click here for the latest version of the bill.

Other Health Care Legislation

Senate Enrolled Acts

6. **SEA 215 Medicare Supplement Insurance (Senator Kyle Walker)**
   - **A.** Effective date: July 1, 2024.
   - **B.** 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.

i. Under current law, an issuer that makes a Medicare supplement policy or certificate available to persons at least 65 years of age is required only to make a Plan A policy or certificate available to individuals under 65 years of age, and is required to make the Plan A policy or certificate available to an individual under 65 years of age who is eligible for Medicare because of having a federally defined disability but is not required to make the Plan A policy or certificate available to an individual under 65 years of age who is eligible for Medicare because of having end stage renal disease.

C. 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:
   i. denying or conditioning the issuance or effectiveness of the individual's policy or certificate;
   ii. 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;
   iii. 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
   iv. issuing to the individual a policy or certificate that contains a waiting period or a preexisting condition limitation or exclusion.

D. Provides for the expiration of Code provisions that would be superseded by the new requirements applying to issuers of Medicare supplement policies or certificates (January 1, 2025).

Click here for the latest version of the bill.

7. SEA 273 Biomarker Testing Coverage (Senator Ed Charbonneau)

A. Effective date: July 1, 2024.

B. Requires a health plan (which includes a policy of accident and sickness insurance, a health maintenance organization contract, the Medicaid risk based managed care program, and a state employee 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.

i. Supporting medical and scientific evidence includes:
   a. labeled indications for a test approved or cleared by the US FDA;
   b. indicated tests for a drug approved by the United States FDA;
   c. a warning or precaution on the label of a drug approved by the United States FDA;
   d. a national coverage determination of the Centers for Medicare and Medicaid Services;
   e. a local coverage determination of a Medicare administrative contractor; or
   f. nationally recognized clinical practice guidelines or consensus statements.

C. Defines "biomarker" as a characteristic that is objectively measured and evaluated as an indicator of:
   i. normal biological processes;
   ii. pathogenic processes; or
   iii. pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered.
   iv. The term includes gene mutations, characteristics of genes, and protein expression.

D. "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. The term includes:
   i. single analyte tests;
   ii. multiplex panel tests;
   iii. protein expression; and
   iv. whole exome, whole genome, and whole transcriptome sequencing.

E. Requires the office of Medicaid policy and planning to provide biomarker testing as a Medicaid program service, and to apply to the United States Department of Health and Human Services for approval of any waiver necessary under the federal Medicaid program for the purpose of providing biomarker testing.

F. Provides that coverage is not required for biomarker testing for screening purposes.

G. 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:
   i. approve or deny a request for prior authorization; and
   ii. notify the covered individual of the approval or denial;
   iii. 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.

H. 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:
  - **i.** The total number of patients who received biomarker testing.
  - **ii.** The total number of patients who received biomarker testing for each biomarker test type.
  - **iii.** The total amount of state funding expended for biomarker testing.
  - **iv.** The 10 most common conditions or treatments for which biomarker testing was ordered.
  - **v.** As a result of the biomarker testing, how many patients:
    - **a.** were placed on particular therapies;
    - **b.** avoided certain treatments; and
    - **c.** were subject to any other treatment impacts.
  - **vi.** Any other information requested by the budget committee.
  - **vii.** Each provider that receives state Medicaid funding under this section shall provide the information described.

Click here for the latest version of the bill.

House Enrolled Acts

8. HEA 1058 Breast Cancer Screening and Services (Representative Sharon Negele)

A. Effective date: July 1, 2024.

B. Specifies that coverage of breast cancer rehabilitative services and reconstructive surgery incident to a mastectomy includes chest wall reconstruction and aesthetic flat closure.

C. Requires a facility performing a mammography examination to provide:
  - **i.** an assessment of the patient's breast tissue density using specified classifications;
  - **ii.** written notice to the patient and the referring provider; and
  - **iii.** 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.

D. Requires the medical licensing board of Indiana to amend an administrative code rule to remove references to "high breast density" and to align with the breast tissue density classifications in this act.

Click here for the latest version of the bill.

9. HEA 1302 Emergency Medical Services (Representative Tim O'Brien)

- **A.** Effective date: July 1, 2024.
- **B.** 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:
  - **i.** Each EMS provider that provides services in the county.
  - **ii.** Each EMS provider in the county that provides services to an adjacent county.
  - **iii.** The funding source for each EMS provider described above.
  - **iv.** 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.
  - **v.** The average response time for each EMS provider in the county disaggregated by non-transport EMS units and transport EMS units.
  - **vi.** Factors that result in a longer average response time in certain jurisdictions within the county disaggregated by non-transport EMS units and transport EMS units.
  - **vii.** Any information DHS, in consultation with the Indiana EMS commission determines is useful to include.
- **C.** Provides that 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. The report must include the following:
  - **i.** A summary of the information provided to DHS described above.
  - **ii.** Any information DHS determines is necessary or useful to include.
  - **iii.** Any recommendations by DHS to improve EMS throughout Indiana.
- **D.** Urges the legislative council to assign to the appropriate study committee the topic of improving the provision of EMS throughout Indiana.

Click here for the latest version of the bill.

10. HEA 1426 Long Acting Reversible Contraceptives (Representative (Dr.) Rita Fleming)

- **A.** Effective date: July 1, 2024.
- **B.** Requires a hospital that operates a maternity unit to ensure that a woman who is:
  - **i.** giving birth in the hospital; and
  - **ii.** eligible for or receiving Medicaid assistance;

   iii. has the option, if not medically contraindicated, of having a long acting reversible subdermal contraceptive implanted after delivery and before the woman is discharged.

C. Allows a hospital to be exempt from the requirement if the hospital has a faith based objection.
D. Requires FSSA to reimburse the hospital for the following provided to a Medicaid recipient:
   i. A long-acting reversible subdermal contraceptive, including the cost of stocking the long acting reversible subdermal contraceptive.
   ii. Placement of the long acting reversible subdermal contraceptive.
E. Provides that the reimbursement must be separate from, and in addition to, the reimbursement for maternity services for the Medicaid recipient.
F. Sunsets the provisions being added in the bill on June 30, 2025.
G. Requires FSSA to develop a billing process that maximizes federal funding for purposes of the long acting reversible contraceptives reimbursement for a Medicaid recipient.

Click here for the latest version of the bill.