2025 LEGISLATIVE SESSION

HEALTH CARE RECAP

May 22, 2025

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

HALLOWELL
CONSULTING

The Team

INTERNAL

EFI Leadership: Act as a resource to legislators (provide data, studies, explain concepts, etc.); provide feedback and recommendations on legislative language; testify before committees; lead EFI policy committee; communicate with ally organizations

EFI Policy Committee: Determine legislative agenda; provide employer-based experiences and data; provide feedback on legislative language (the EFI policy committee is comprised only of EFI employers)

Hallowell Consulting: Provide government affairs and lobbying services; schedule meetings with legislators; work with EFI leadership to provide feedback and recommendations on legislative language; act as a resource to legislators; monitor legislation; provide weekly updates to EFI policy committee

EXTERNAL

Bill Authors: Carry legislation supporting EFI legislative agenda

Subject Matter Experts: Provide expertise in a given field to assist with feedback and recommendations on legislative language; testify before committees

Ally Organizations: Advocate for pro-employer health care policy

EFI's 2025 Legislative Agenda

First Priority

- ❑ Establish site neutral prices
  - ☑ Operationalize site of service legislation (2023)
- ❑ Prohibit spread pricing by pharmacy benefit managers and third-party administrators
- ☑ Establish a price ceiling as a percent of Medicare for hospital and ASC facility services*
- ☑ Create financial incentives for independent physicians
- ☑ Prohibit anticompetitive contract clauses in provider contracts
- ☑ Establish public ownership/partnership transparency for all health care entities
- ❑ Strengthen community benefit definition for nonprofit hospitals and health systems to maintain state tax exemption
- ❑ Require private equity merger and acquisition approval by the office of the attorney general
- ☑ Require fiduciary responsibility for third-party administrators and pharmacy benefit managers

KEY

Prices | Consolidation | Accountability

* A "soft" price ceiling for the "Big Five" nonprofit hospital systems only

EFI's 2025 Legislative Agenda

Second Priority

- ☑ Require providers to post actual prices, not price estimates
- ☐ Support improvement of price and quality transparency in the state's all-payer claims database (APCD)
- ☑ Codify the Federal Trade Commission's hospital noncompete final rule
- ☑ Repeal the state's certificate of public advantage (COPA) statute
- ☐ Require six-month hospital medical services pre-closure notification
- ☐ Require the office of the attorney general to provide public aggregate merger and acquisition numbers
- ☐ Establish minimum staffing requirement at nursing homes
- ☐ Establish an office of health care accountability

KEY

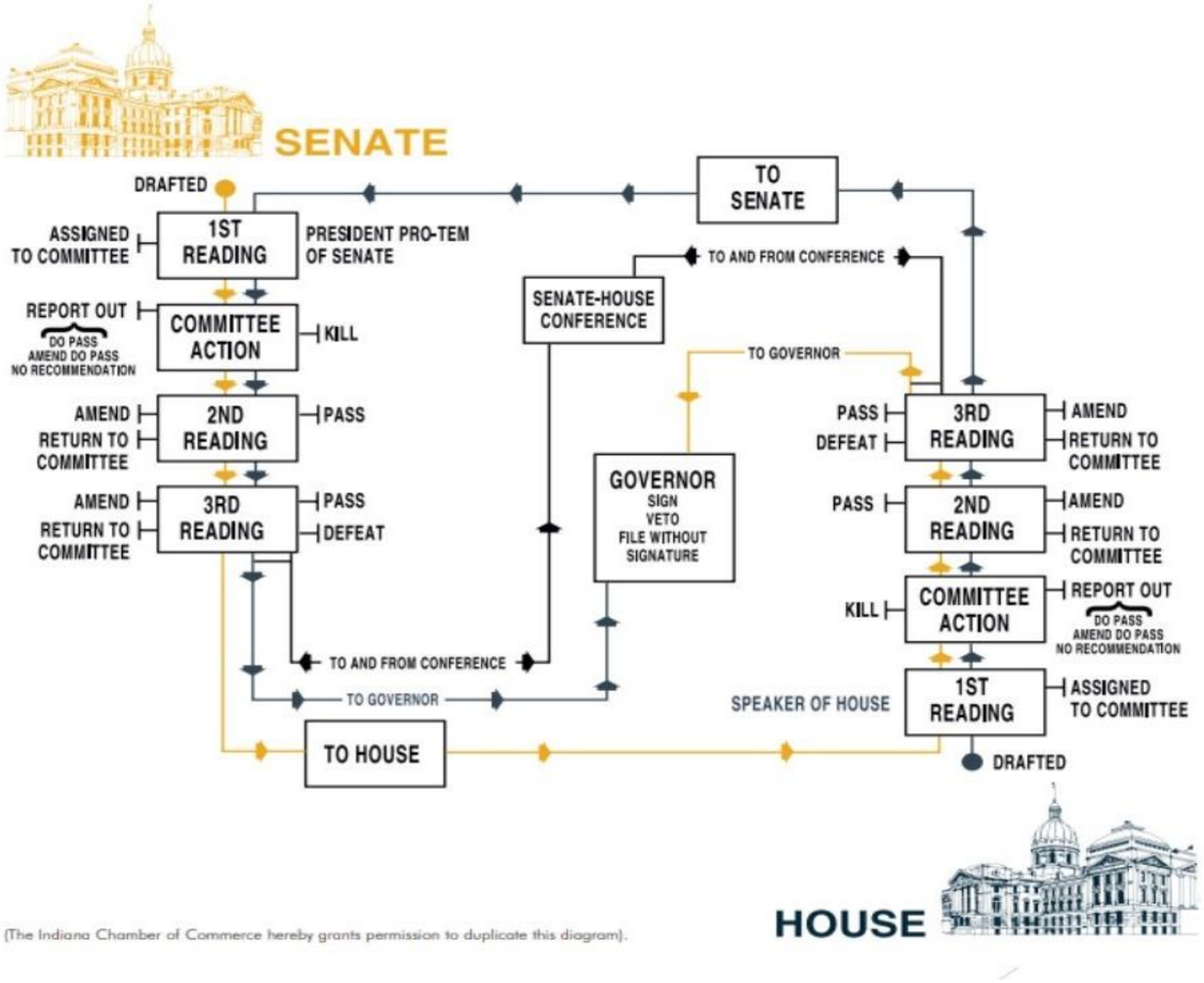
Prices | Consolidation | Accountability

How a Bill Becomes a 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
- Indiana General Assembly: How a Bill Becomes Law



Bill Passage Stats

	Introduced	Survived First Half	Survived Second Half	Survival Rate
House	708	178	140	20%
Senate	521	156	103	20%
TOTAL	**1,229**	**334**	**243**	**20%**

Table of Contents

PRIORITY LEGISLATION

HEA 1003, HEA 1004, HEA 1427, HEA 1666, SEA 3, SEA 475

A Quick Note:

Effective dates are noted on the introductory slide for each bill and/or after individual provisions.

HEA 1003: Health Matters

Author: Rep. Brad Barrett (R-Richmond) | **Co-Authors:** Rep. Matt Lehman (R-Berne), Rep. Tony Isa (R-Angola) | **Sponsors:** Sen. Ed Charbonneau (R-Valparaiso), Sen. Tyler Johnson (R-Leo), Sen. Lonnie Randolph (D-East Chicago)

Final Vote: House: 67-25 | Senate: 30-20

Effective Date: Varies | [Link to Bill]

Summary: HEA 1003 is a comprehensive health care bill that includes provisions on site of service, price transparency, contracting, prior authorization and more.

HEA 1003

“Site of Service”: How the location (site) of where a service is provided affects the total cost.

A service provided in a hospital outpatient department costs more than it would if it was provided in a physician’s office.

Site of Service

- Operationalizes “site of service” language passed in 2023 that **prohibits** a “Big Five” nonprofit hospital system (Ascension St. Vincent, Community Health Network, Franciscan Health, Indiana University Health and Parkview Health) from billing facility fees for an outpatient service performed at an off-campus location beginning Jan. 1, 2026.
- Requires a Big Five system to submit a complete list of facilities to the state department of health (DOH) that may bill a facility fee by July 1, 2025, and every two years thereafter with licensure renewal. (Upon Passage)
- Requires a Big Five system to notify DOH of a new facility that may bill a facility fee, or the closure or change of a location of a facility that may bill a facility fee not later than 30 days after such an event occurs. (Upon Passage)

HEA 1003

Price Transparency

- Requires the state department of insurance (DOI) to determine 50 laboratory services and 50 diagnostic imaging services to be disclosed by clinical laboratories and diagnostic imaging facilities respectively as shoppable. (July 1, 2025)
- Requires clinical laboratories and diagnostic imaging facilities to post various information and pricing on their website for 50 shoppable services not later than July 31, 2026.
- Requires practitioners to provide good faith estimates within **two business days** after a health care service is ordered. Previously, practitioners had five business days to provide a good faith estimate. (July 1, 2025)

HEA 1003

Contracting

- Prohibits pharmacy benefit managers (PBMs) and third-party administrators (TPAs) from redacting claims data due to a "**trade secret**." (July 1, 2025)
- Declares that a health provider contract that requires parties to commence negotiations to amend the terms of the contract if there is a change in law or that guarantees that the health carrier or provider will be **made whole** for the financial effects of a law or regulation are void and unenforceable. (July 1, 2025)
- Prohibits health provider contracts from including certain provisions, including provisions that:
  - Limit the ability of the health carrier to introduce or modify a select network plan or tiered network plan by granting the provider a guaranteed right of participation;
  - Require the health carrier to place all facilities **in the same tier** of a tiered network plan;
  - Require the health carrier to include all facilities in a select network plan on an **all-or-nothing basis**; and
  - Require a provider to participate in a new select network or tiered network plan that the health carrier introduces without granting the provider the right to opt out of the new plan at least sixty (60) days before the new plan is submitted to the commissioner for approval. (July 1, 2025)

HEA 1003

Prior Authorization

- Allows DOH to enter into partnerships and joint ventures to encourage best practices in the appropriate and effective use of prior authorization in health care. (July 1, 2025)
- Allows a health care provider or health plan to submit information concerning a dispute between a health care provider and a health plan regarding prior authorization to DOH. (July 1, 2025)
  - Prohibits DOH from adjudicating or otherwise mediating any dispute; and
  - Requires DOH to submit a report to the general assembly by December 1, 2026, with any findings and recommendations related to the information reported.

HEA 1004: Health Care Matters

Author: Rep. Martin Carbaugh (R-Fort Wayne) | **Co-Authors:** Rep. Julie McGuire (R-Indianapolis), Rep. Ben Smaltz (R-Auburn), Rep. Mitch Gore (D-Indianapolis) | **Sponsors:** Sen. Chris Garten (R-Charlestown), Sen. Justin Busch (R-Fort Wayne), Sen. Ed Charbonneau (R-Valparaiso), Sen. Lonnie Randolph (D-East Chicago)

Final Vote: House: 67-23 | Senate: 37-13

Effective Date: Varies | [Link to Bill]

Summary: HEA 1004 is a hospital pricing bill that seeks to lower prices at the “Big Five” nonprofit hospital systems to the statewide average by June 30, 2029, and revokes a system’s state tax-exempt status for failure to do so. It also includes provisions on nonprofit hospital financial transparency, contracting, prescription drugs, disclosures, the hospital assessment fee (HAF), managed care assessment fee (MCAF) and more.

HEA 1004

‘Big Five’ Nonprofit Hospital System Pricing

- Requires a “Big Five” nonprofit hospital system (Ascension St. Vincent, Community Health Network, Franciscan Health, Indiana University Health and Parkview Health) to lower prices to **at least** the state average by June 30, 2029.
- Requires the state office of management and budget (OMB) to develop a methodology to determine the statewide average inpatient and outpatient hospital prices **as a percent of Medicare** using 2023 and 2024 commercial claims data and present it to the state budget committee (SBC) for approval. The study, using the approved methodology, must be conducted by OMB before June 30, 2026.
- Requires OMB to adjust the determined statewide averages before June 30, 2027, and every year thereafter, using a methodology approved by the SBC.
- **Revokes** the state tax-exempt status of a Big Five system if its average inpatient and outpatient hospital prices are not **equal to or less than** the statewide average by June 30, 2029.
  - A Big Five system that forfeits its tax-exempt status can reestablish it if OMB determines their prices are equal to or less than the statewide average.

HEA 1004

Hospital Financial Transparency

- Requires the "Big Five" nonprofit hospital systems to **annually** submit audited financial statements for the immediately preceding two years to DOH. (Upon Passage)
  - Failure to submit by June 1 will result in a $10,000 **per day** penalty.
- Requires each nonprofit hospital to **annually** submit **the entirety** of its federal Schedule H of their Form 990 — the form that details community benefit spending — to DOH. (Upon Passage)
  - Failure to submit will result in a $10,000 **per day** penalty.
- Requires DOH to provide the Schedule Hs to the health care cost oversight taskforce (HCCOTF) for publication on the general assembly's website. (Upon Passage)

Contracting

- Prohibits a hospital from entering into a contract that includes a provision that links to **or** negotiates reimbursement or terms under a separate contract or product. (July 1, 2025)
- Requires a Big Five system to offer a direct-to-employer health care arrangement that is **at or below 260%** of full Medicare by September 1, 2025, and all other nonprofit hospitals to offer the same arrangement by September 1, 2026.

HEA 1004

Disclosures

- Requires insurers, health maintenance organizations (HMOs) and TPAs to submit information on commissions, service fees and brokerage fees to the state's all-payer claims database (APCD). (Upon Passage)
- Requires insurance producers to disclose direct and indirect compensation for the sale of a group policy to plan sponsors and receive **a signed acknowledgement** of the compensation from the plan sponsor. (Upon Passage)
- Requires insurance producers to disclose **any other** additional fees to the plan sponsor. (July 1, 2025)
- Requires insurers and HMOs to annually file a report detailing the change in hospital reimbursement rates for inpatient and outpatient services and **the impact of the change** on policy premiums. (Upon Passage)

HEA 1004

Prescription Drugs

- Requires PBMs to provide a notice to the policyholder that states an explanation of what a rebate is, an explanation of how rebates accrue to a health plan from a manufacturer and the aggregate amount of rebates for all drugs dispensed or administrated to covered individuals on the policyholder's health plan that accrued to the health plan during the previous policy year **if less than 85% of the estimated rebates** will be deducted from the cost of prescription drugs before a covered individual's cost sharing requirement is determined. (July 1, 2025)
- Requires a health plan to provide the amount of national average drug acquisition cost for a generic drug on written material provided to the plan sponsor. (July 1, 2025)

Other Provisions

- Requires PBMs and TPAs to **provide** claims data within **15 business days** of a request. Previously, PBM and TPAs only had to acknowledge receipt of the request within 15 business days. (Upon Passage)
- Requires OMB to study the effect of establishing a primary care physician reimbursement floor. (July 1, 2025)

HEA 1004

Other Provisions

- Distributes Hospital Assessment Fee (HAF) money under a weighted distribution model. (Upon Passage)
- **Prohibits** billing Medicaid for facility fees for outpatient services performed at an off-campus location. (Upon Passage)

HEA 1427: Department of Local Government Finance

Author: Rep. Craig Snow (R-Warsaw) | **Co-Author:** Rep. Hal Slager (R-Schererville), Rep. Dave Heine (R-Fort Wayne), Rep. Cherrish Pryor (D-Indianapolis) | **Sponsors:** Sen. Eric Bassler (R-Washington), Sen. David Niezgodski (D-South Bend), Sen. J.D. Ford (D-Indianapolis), Sen. Linda Rogers (R-Granger), Sen. Lonnie Randolph (D-East Chicago)

Final Vote: House: 69-23 | Senate: 37-13

Effective Date: January 1, 2025 (retroactive) | [Link to Bill]

- **Expands** the physician practice ownership tax credit to **all physicians engaged in the practice of medicine** that have an ownership interest in a corporation, limited liability company, partnership or other legal entity organization organized to provide health care services as a physician owned entity that is not employed by a health system and has a state income tax liability. Previously, the tax credit was limited to primary care physicians.
- Requires the physician to have provided health care services in the physician owned medical practice for at least six months of a calendar year.

HEA 1666: Ownership of Health Care Providers

Author: Rep. Julie McGuire (R-Indianapolis) | **Co-Authors:** Rep. Ben Smaltz (R-Auburn), Rep. Robin Shackleford (D-Indianapolis), Rep. Lori Goss-Reaves (R-Marion) | **Sponsors:** Sen. Tyler Johnson (R-Leo), Sen. Chris Garten (R-Charlestown), Sen. Ed Charbonneau (R-Valparaiso)

Final Vote: House: 78-13 | Senate: 46-0

Effective Date: July 1, 2025, Jan. 1, 2026 | [Link to Bill]

Summary: HEA 1666 requires the reporting of certain health care provider ownership information to the state.

HEA 1666

- **Requires** reporting of certain information (e.g., name of person or entity with an ownership interest, business address, ownership stake of each person or entity) by a hospital to DOH, by an insurer, TPA and PBM to DOI, and all other health care entities to the secretary of state. (July 1, 2025, July 1, 2025, Jan. 1, 2026)
- Requires DOH to annually **publish online** a report concerning the ownership information and make the information available to the state the legislative council, the office of the attorney general (OAG) and the HCCOTF upon request. (July 1, 2025)
  - DOH can omit information from the report it determines is not widely available to the public.
- Permits OAG to **investigate** the market concentration of a health care entity. (July 1, 2025)
- Exempts health care entities that are majority owned or that would be majority owned by practitioners who are licensed in Indiana and routinely provide health care services in the practitioner owned practice from the state's mergers and acquisition statute. (July 1, 2025)

SEA 3: Fiduciary Duty in Health Plan Administration

Authors: Sen. Justin Busch (R-Fort Wayne), Sen. Chris Garten (R-Charlestown), Sen. Ed Charbonneau (R-Valparaiso) | **Co-Authors:** Sen. Tyler Johnson (R-Leo), Sen. Lonnie Randolph (D-East Chicago) | **Sponsors:** Rep. Martin Carbaugh (R-Fort Wayne), Rep. Chris Campbell (D-West Lafayette)
Final Vote: House: 89-0 | Senate: 48-0

Effective Date: July 1, 2025 | [Link to Bill]

Summary: SEA 3 requires PBMs and TPAs acting on behalf of a plan sponsor to act as a fiduciary.

- "Fiduciary duty" includes the duty to:
  - Act with loyalty and care in the best interest of the plan sponsor;
  - Ensure that all fees, costs and commissions are reasonably and fully disclosed;
  - Avoid self-dealing and conflicts of interest; and
  - Maintain transparency in all financial and contractual arrangements related to the plan sponsor's health insurance coverage, including prescription drug benefits.

SEA 119: Certificate of Public Advantage

Authors: Sen. Ed Charbonneau (R-Valparaiso), Sen. Tyler Johnson (R-Leo) | **Co-Author:** Sen. Lonnie Randolph (D-East Chicago) | **Sponsors:** Rep. Brad Barrett (R-Richmond), Rep. Robert Heaton (R-Terre Haute), Rep. Beau Baird (R-Greencastle), Rep. Tonya Pfaff (D-Terre Haute)

Final Vote: House: 95-0 | Senate: 46-1

Effective Date: Upon Passage | [Link to Bill]

COPA: Requires the regulation of a merged hospital system by the state department of health instead of regulation by the Federal Trade Commission through antitrust laws.

Summary: SEA 119 repeals the state's certificate of public advantage (COPA) statute and requires DOH to make a determination on the pending Terre Haute Regional Hospital and Union Health COPA application by November 9, 2025.

SEA 475: Physician Noncompete Agreements

Authors: Sen. Justin Busch (R-Fort Wayne), Sen. Ed Charbonneau (R-Valparaiso), Sen. Tyler Johnson (R-Leo) | **Co-Authors:** Sen. JD Ford (D-Indianapolis), Sen. La Keisha Jackson (D-Indianapolis), Sen. Fady Qaddoura (D-Indianapolis) | **Sponsors:** Rep. Ethan Manning (R-Logansport), Rep. Chris Judy (R-Fort Wayne), Rep. Becky Cash (R-Zionsville), Rep. Brad Barrett (R-Richmond)

Final Vote: House: 89-0 | Senate: 48-0

Effective Date: July 1, 2025 | [Link to Bill]

Summary: SEA 475 prohibits a physician and a hospital, a parent company of a hospital, an affiliated manager of a hospital or a hospital system from entering into a noncompete agreement on or after July 1, 2025. It does not apply to noncompete agreements **originally entered into** before this date.

OTHER HEALTH CARE LEGISLATION

HEA 1604, SEA 118, SEA 119, SEA 140, SEA 480

HEA 1604: Cost Sharing; Out-of-Pocket Expense Credit

Author: Rep. Julie McGuire (R-Indianapolis) | **Co-Authors:** Rep. Joanna King (R-Middlebury), Rep. Robert Morris (R-Fort Wayne), Rep. Robin Shackleford (D-Indianapolis) | **Sponsors:** Sen. Cyndi Carrasco (R-Indianapolis), Sen. Kyle Walker (R-Lawrence), Sen. Aaron Freeman (R-Indianapolis), Sen. Lonnie Randolph (D-East Chicago), Sen. Andrea Hunley (D-Indianapolis), Sen. J.D. Ford (D-Indianapolis), Sen. Fady Qaddoura (D-Indianapolis), Sen. Mike Bohacek (R-Michiana Shores), Sen. Linda Rogers (R-Granger), Sen. Shelli Yoder (D-Bloomington)

Final Vote: House: 91-0 | Senate: 45-2

Effective Date: July 1, 2025, January 1, 2026 | [Link to Bill]

Summary: HEA 1604 expands eligible contributions for cost sharing purposes and seeks to incentivize patients to shop around for lower priced health care services and items.

HEA 1604

Cost Sharing

- Requires a PBM, insurer and administrator to apply the annual limitation on cost sharing set forth in the federal Patient Protection and Affordable Care Act to prescription drugs that are covered by a health plan administered by the PBM, lifesaving or intended to manage chronic pain and **do not** have an approved generic version.
- Requires a PBM, insurer and administrator to include any cost sharing amounts paid by the covered individual **or on behalf of the covered individual (e.g., copay card)** when calculating a covered individual's contribution to an applicable cost sharing requirement.
- Prohibits a PBM, insurer and administrator from directly or indirectly setting, altering, implementing or conditioning the terms of health plan coverage, including benefit design, based in part of entirely on information about the availability or amount of financial or product assistance available for a prescription drug.
- Exempts self-funded health benefit plans that comply with the federal Employee Retirement Income Security Act (ERISA) of 1974. (Jan. 1, 2026)

HEA 1604

Out-of-Pocket Expense Credit

- Requires a health plan to credit toward a covered individual's deductible and annual maximum out-of-pocket expenses any amount the covered individual pays directly to any health care provider for a **medically necessary covered health care service** if a claim for the health care service is not submitted to the health plan and the amount paid by the covered individual to the health care provider is **less than** the average discounted rate for the health care service paid to a health care provider in the health plan's network.
- Requires a health plan to either publish average discounted rates that the health plan has negotiated to pay health care providers for health care services or refer to average or typical rates on the APCD for the purposes of a covered individual claiming a credit.
- Requires a health plan to publish a link to the APCD on its website.

SEA 118: 340B Drug Program Report

Authors: Sen. Ed Charbonneau (R-Valparaiso), Sen. Michael Crider (R-Greenfield), Sen. Tyler Johnson (R-Leo) | **Co-Authors:** Sen. Spencer Deery (R-West Lafayette), Sen. Vaneta Becker (R-Evansville), Sen. Justin Busch (R-Fort Wayne) | **Sponsors:** Rep. Brad Barrett (R-Richmond), Rep. Julie McGuire (R-Indianapolis), Rep. Tony Isa (R-Angola), Rep. Lori Goss-Reaves (R-Marion)

Final Vote: House: 89-2 | Senate: 48-0

Effective Date: July 1, 2025 | [Link to Bill]

Summary: SEA 118 requires 340B entities to report certain information to the state.

SEA 118

340B Drug Program: A federal program that allows qualifying hospitals and clinics that treat low-income and uninsured patients to buy outpatient prescription drugs at a discount of 25 percent to 50 percent.

- **Requires** 340B covered entities to annually report specified data (e.g., the aggregate acquisition cost for all prescription drugs obtained under the 340B program and dispensed or administered to patients, how the 340B covered entity uses any savings from participating in the 340B program, including the amount of savings used for the provision of charity care, community benefits or a similar program of providing unreimbursed or subsidized health care, etc.) to DOH.
- Institutes a $1,000 **per day** penalty for failure to submit the report by April 1 of each year.

SEA 140: Pharmacy Benefits

Authors: Sen. Ed Charbonneau (R-Valparaiso), Sen. Tyler Johnson (R-Leo), Sen. Andy Zay (R-Huntington) | **Co-Authors:** Sen. Lonnie Randolph (D-East Chicago), Sen. Gary Byrne (R-Byrneville), Sen. Vaneta Becker (R-Evansville) | **Sponsors:** Rep. Julie McGuire (R-Indianapolis), Rep. Chris Campbell (D-West Lafayette), Rep. Robin Shackleford (D-Indianapolis)

Final Vote: House: 84-1 | Senate: 39-10

Effective Date: Jan. 1, 2026 | [Link to Bill]

Summary: SEA 140 is a comprehensive pharmacy bill that includes provisions on network adequacy, minimum prescription drug reimbursement, prohibited actions by PBMs and TPAs, and more.

SEA 140

Network Adequacy

- Requires reasonably adequate and accessible networks for pharmacy benefits to, **at a minimum**, offer an adequate number of accessible pharmacies that are not mail order pharmacies and provide convenient access to pharmacies that are not mail order pharmacies within a reasonable distance of **not more than 30 miles** from each insured's residence to the extent that pharmacy or pharmacist services are available.

Minimum Prescription Drug Reimbursement

- Requires a minimum reimbursement for a prescription drug at a pharmacy **licensed to sell alcohol** at the pharmacy's actual acquisition cost for the drug plus a "fair and reasonable dispensing fee."
- Requires a minimum reimbursement for a prescription drug at a pharmacy **not licensed to sell alcohol** at the national average drug acquisition cost (NADAC) plus a professional dispensing fee equal to the Medicaid fee for service dispensing fee ($10.48).
  - Medicaid, the state employee health plan and managed care organizations are exempt from these provisions.

SEA 140

Prohibited Actions

- Prohibits an insurer, PBM or any other administrator of pharmacy benefits from penalizing a pharmacy for selling **a lower cost alternative** to an insured if a lower cost alternative is available.
- Prohibits an insurer, PBM or any other administrator of pharmacy benefits from requiring an insured to obtain a **specialty drug** from a pharmacy affiliate. (Mail order pharmacies are exempted from this provision.)
- **Prohibits** an insurer, PBM or any other administrator of pharmacy benefits from charging less cost sharing to an insured who uses a pharmacy affiliate than a nonaffiliated pharmacy.
- Prohibits a TPA from **requiring** a plan sponsor (with more than 100 employees or members) to contract with a particular PBM or charging a different fee for services provided by the TPA to a plan sponsor based on the selection of a particular PBM.

SEA 480: Prior Authorization

Authors: Sen. Tyler Johnson (R-Leo), Sen. Ed Charbonneau (R-Valparaiso), Sen. Liz Brown (R-Fort Wayne) | **Co-Authors:** 40 Senators | **Sponsors:** Rep. Brad Barrett (R-Richmond), Rep. Martin Carbaugh (R-Fort Wayne), Rep. Julie McGuire (R-Indianapolis), Rep. Joanna King (R-Middlebury)

Final Vote: House: 84-1 | Senate: 39-10

Effective Date: July 1, 2025 | [Link to Bill]

Summary: SEA 480 is a comprehensive prior authorization reform bill that includes provisions that require clinical peer review, lowers prior authorization response times and more.

SEA 480

Prior Authorization Response Timeline

URE: Shall respond with an authorization or adverse determination within **24 hours** for an **urgent** health care service or **48 hours** for a **non-urgent health** care service or prescription drug

HCP: May appeal an adverse determination by notifying the URE not later than **48 hours** after receiving notice of the adverse determination

URE: Shall respond not later than **48 hours** after receiving a notice of appeal

HCP: Shall respond not later than **48 hours** after receiving an adverse determination if a typographical, clerical or spelling error needs corrected or if they accept an alternative suggestion by the URE

URE: Not later than **48 hours** after receiving a HCP's response shall render an authorization or adverse determination based on information provided the HCP's response and notify the HCP of the authorization or adverse determination

HCP: May appeal an adverse determination by notifying the URE not later than **48 hours** after receiving notice of the adverse determination

URE: Shall respond not later than **48 hours** after receiving a notice of appeal

KEY

URE: Utilization Review Entity | **HCP:** Health Care Provider

All timeframes exclude weekends and state and federal legal holidays.

SEA 480

Utilization Review Entity Requirements, Prohibited Actions

- Prohibits a utilization review entity from requiring retrospective review of or denying a claim based solely on lack of prior authorization for an **unanticipated and medically necessary** health care service.
- Prohibits a utilization review entity from requiring prior authorization for the **first 12** physical therapy or chiropractic visits of each new episode of care.
- Requires a utilization review entity **to cover emergency health care services necessary to screen and stabilize** a covered individual. If a health care provider certifies in writing to a utilization review entity not later than 72 hours after a covered individual's emergency admission that the covered individual's condition required emergency health care service, the certification will create a presumption that the emergency health care service was medically necessary.
- Prohibits a utilization review entity from revoking, limiting, conditioning or restricting an authorization if the health care provider begins providing the health care service **not later than** 45 days after the date the health care provider received the authorization.

SEA 480

Utilization Review Entity Requirements, Prohibited Actions

- Requires a utilization review entity to make any current prior authorization requirements and restrictions, including written clinical criteria, **readily accessible** on the utilization review entity's website to covered individuals, health care providers and the public. The prior authorization requirements and restrictions must be described **in detail** and in **easily understandable language**.
- **Prohibits** a utilization review entity from implementing a new prior authorization requirement or restriction or amend an existing requirement or restriction **unless** the utilization review entity's website has been updated to reflect the new or amended requirement or restriction and the utilization review entity **provides written notice** to covered individuals and health care providers at least **60 days before** the requirement or restriction is implemented.
- **Requires** a utilization review entity to make statistics available regarding prior authorization approvals and denials (e.g., health care provider specialty, reason for denial, if a decision was appealed, etc.) on the utilization review entity's website in a readily accessible format.

SEA 480

Clinical Peer Review

- Requires a utilization review entity to ensure that all adverse determinations based on medical necessity are made, and appeals reviewed and decided, **by a clinical peer**.
- Requires a utilization review entity to ensure that a clinical peer is under the clinical direction of a medical director of the utilization review entity who is responsible for the provision of health care services provided to covered individuals and is a licensed physician in Indiana.

Other Provisions

- Allows a covered individual or covered individual's health care provider **at least** 24 hours after an emergency admission or provision of emergency health care services for the covered individual or health care provider to notify the utilization review entity of the emergency admission or provision of emergency health care services.
  - This timeframe excludes weekends and state and federal legal holidays.

OTHER HEALTH CARE PROVISIONS

HEA 1001

HEA 1001: State Budget

Authors: Rep. Jeffrey Thompson (R-Lizton) | **Co-Authors:** Rep. Gregory Porter (D-Indianapolis), Rep. Craig Snow (R-Warsaw), Rep. Jack Jordan (R-Bremen) | **Sponsors:** Sen. Ryan Mishler (R-Mishawaka), Sen. Chris Garten (R-Chesterton), Sen. David Niezgodski (D-South Bend)

Final Vote: House: 66-27 | Senate: 39-11

Effective Date: Varies | [Link to Bill]

- Operationalizes “site of service” language passed in 2023 that **prohibits** a “Big Five” nonprofit hospital system (Ascension St. Vincent, Community Health Network, Franciscan Health, Indiana University Health and Parkview Health) from billing facility fees for an outpatient service performed at an off-campus location beginning Jan. 1, 2026.
- **Prohibits** billing Medicaid for facility fees for outpatient services performed at an off-campus location. (Upon Passage)