# 2025 Indiana Legislative Healthcare Summary

**May 20, 2025**

The 2025 Indiana legislative session was a significant year for health care policy. The agendas of the House and Senate Republican caucuses included three health care priorities: HEA 1003 (health matters), HEA 1004 (health care matters) and SEA 3 (fiduciary duty in health plan administration).

Of the 1,229 bills introduced during the session (708 in the House and 521 in the Senate) 243 were passed (140 House bills and 103 Senate bills), representing roughly 20% of all proposed legislation.

Governor Mike Braun signed all pieces of legislation that reached his desk into law.

**2025 Accomplishments of the Employers' Forum of Indiana**

The Employers' Forum of Indiana (EFI) successfully advocated for several bills to increase health care transparency, affordability and accountability during the 2025 legislative session, including:

1. HEA 1003, which operationalizes site of service language championed by EFI and passed in 2023, and includes provisions aimed at increasing price transparency and reforming health care provider contracting. These provisions include a ban on anticompetitive contract clauses, a declaration that provisions requiring health carriers be made whole for the financial effects of a law or regulation are void, and a prohibition against pharmacy benefit managers and third-party administrators redacting claims data under the guise of trade secrets.
2. HEA 1004, which requires the state office of management and budget to conduct a study to determine the statewide average inpatient and outpatient hospital prices as a percent of Medicare and revokes the state tax-exempt status of a Big Five nonprofit hospital system (Indiana University Health, Ascension St. Vincent, Community Health Network, Franciscan Health and Parkview Health) if its hospital prices are not equal to or less than the statewide average by June 30, 2029. The Senate-passed version of HEA 1004 included a provision that would have adjusted the statewide average prices each year by the medical Consumer Price Index (CPI), which over time could have allowed a Big Five nonprofit hospital system to meet the average without lowering its prices. EFI successfully advocated to remove this provision.
3. HEA 1666, which requires health care entities to report ownership information to the state. The Senate-passed version of HEA 1666 included a provision that specified the information was confidential and could not be disclosed under the state's laws governing public records and public meetings, which would have made the bill largely moot. EFI successfully advocated to remove this provision.
4. SEA 3, which requires third-party administrators and pharmacy benefit managers acting on behalf of a plan sponsor to act as a fiduciary to the plan sponsor. A drafted amendment would have significantly weakened protections for plan sponsors and employees. EFI successfully

advocated to prevent this amendment from being introduced and instead offered language to strengthen the definition of "fiduciary duty," which was included in the final version of the bill.

5. SEA 118, which requires entities participating in the federal 340B Drug Pricing Program under Section 340B of the federal Public Health Service Act (42 U.S.C. 256b(a)(4)) to annually report information to the state.
6. SEA 475, which prohibits noncompete agreements between physicians and hospitals, parent companies of hospitals, affiliated managers of hospitals and hospital systems.

**Note:** This report was prepared by Hallowell Consulting, the Indiana lobbying and government affairs team for EFI.

**Hallowell Consulting**
www.hallowellconsulting.com
WBE certified with the city of Indianapolis.

The Hallowell Consulting-EFI Team:
Jennifer Hallowell, President
Sabra Stevens, Vice President
Luke Thomas, MPP, Director of Government Relations & Communications

## Table of Contents

## EFI PRIORITY LEGISLATION

### House Enrolled Acts

**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 Dates:** Upon passage, July 1, 2025

**Link**

Site of Service Provisions

1. Operationalizes site of service language established under IC 16-51 by:
    a. Prohibiting a qualified provider from billing health care services with a place of service code 21 (inpatient hospital) or 22 (on campus – outpatient hospital), as published in the place of service code set maintained by the federal Centers for Medicare and Medicaid Services; and
    b. Requiring a payor to pay claims incurred by an in-network qualified provider based on the physician fee schedule.
2. Requires an "Indiana nonprofit hospital 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.
3. Defines "Indiana nonprofit hospital system" as a hospital that is licensed in Indiana and organized as a nonprofit corporation or as a charitable trust under Indiana law or the laws of any other state or country and is eligible for tax exempt bond financing or exempt from state or local taxes, filed jointly one hospital audited financial statement with the state department of health in 2021, and has an annual patient service revenue derived in Indiana of at least $2 billion based on the hospital system's most recently submitted audited financial statements (i.e., Indiana University Health, Ascension St. Vincent, Community Health Network, Franciscan Health and Parkview Health, collectively the "Big Five" nonprofit hospital systems).
4. Requires a Big Five nonprofit hospital 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.

Pricing Transparency Provisions

1. Requires the state department of insurance (DOI) to determine 50 laboratory services to be disclosed by clinical laboratories as shoppable.
2. Requires clinical laboratories to post various information and pricing on their website for 50 shoppable services, including:
    a. A description of the service in plain language;
    b. The discounted cash price;
    c. The de-identified minimum negotiated charge; and
    d. The de-identified maximum negotiated charge.
5. Defines "clinical laboratories" as a laboratory that provides clinical services, holds a federal Clinical Laboratory Improvement Act (CLIA) certificate of accreditation and is not owned or operated by a licensed hospital.
6. Requires DOI to determine 50 diagnostic imaging services to be disclosed by diagnostic imaging facilities as shoppable.
7. Requires diagnostic imaging facilities to post various information and pricing on their website for 50 shoppable services, including:
    a. A description of the service in plain language;
    b. The discounted cash price;
    c. The de-identified minimum negotiated charge; and
    d. The de-identified maximum negotiated charge.
8. Defines "diagnostic imaging facility" as an entity that provides diagnostic imaging to an individual for the purpose of health care and is not owned or operated by a licensed hospital. The term excludes dental offices, optometrist offices and practitioner offices.
9. 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.)

Contracting Provisions

1. Prohibits health provider contracts from including certain provisions, including:
    a. A provision that limits 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;
    b. A provision that requires the health carrier to place all facilities in the same tier of a tier network plan;
    c. A provision that requires the health carrier to include all facilities in a select network plan on an all-or-nothing basis; and

   d. A provision that requires a provider to participate in a new select network or tiered network plan without allowing the provider to opt out of the new plan at least 60 days before the new plan is submitted to DOI for approval.
2. Prohibits pharmacy benefit managers (PBMs) and third-party administrators (TPAs) from redacting claims data provided on a CMS-1500, HCFA-1500, HIPAA X12 837P, HIPAA X12 837I, CMS-1450, UB-04 form or any successor form due to a trade secret.
3. 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 against public policy and void and unenforceable.

Prior Authorization

1. 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.
2. 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.
   a. Prohibits DOH from adjudicating or otherwise mediating any dispute; and
   b. Requires DOH to submit a report to the general assembly by December 1, 2026, with any findings and recommendations related to the information reported.

Waste, Fraud and Abuse

1. Allows the state's Medicaid Fraud unit to investigate provider fraud, insurer fraud, duplicative billing and other instances of fraud.

**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 Dates:** Upon passage, July 1, 2025

**Link**

Hospital Pricing

1. 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.
2. Requires OMB to adjust the determined statewide averages before June 30, 2027, and every year thereafter using a methodology approved by the SBC.
3. Revokes the state tax-exempt status of a Big Five nonprofit hospital system if its average inpatient and outpatient hospital prices are not equal to or less than the statewide average by June 30, 2029.
    a. A Big Five nonprofit hospital system that forfeits its tax-exempt status can reestablish it if OMB determines their prices are equal to or less than the statewide average.

Hospital Financial Transparency

1. Requires the Big Five nonprofit hospital systems to annually submit audited financial statements for the immediately preceding two years to DOH.
    a. Failure to by a Big Five nonprofit hospital system to submit audited financial statements by June 1 will result in a $10,000 per day penalty.
2. Requires each nonprofit hospital to annually submit the entirety of its federal Schedule H of their Form 990 to DOH.
    a. Failure by a nonprofit hospital to submit the entirety of its Schedule H by October 1 will result in a $10,000 per day penalty.
3. Requires DOH to provide the Schedule Hs to the health care cost oversight taskforce (HCCOTF) for publication on the general assembly's website.

Contracting Provisions

1. 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.
2. Requires a Big Five nonprofit hospital system to offer a direct to employer health care arrangement that is at or below 260% of full Medicare by September 1, 2025.
3. Requires all other nonprofit hospitals to offer a direct to employer health care arrangement that is at or below 260% of full Medicare by September 1, 2026.

Third-Party Disclosures

1. 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).
2. 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.
3. Requires insurance producers to disclose any other additional fees to the plan sponsor.
4. 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.

Prescription Drugs

1. 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.
2. 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.

Other Provisions

1. Requires PBMs and TPAs to provide claims data within 15 business days of a request.
2. Requires OMB to study the effect of establishing a primary care physician reimbursement floor.
3. Distributes Hospital Assessment Fee (HAF) money under a weighted distribution model.
4. Removes the exemption of billing under the Medicaid program under IC 16-51.

**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

1. 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.)
2. Requires the physician to have an ownership interest that is at least:
    a. For a physician owned medical practice with not more than 10 owners, 5% of the physician owned medical practice's income; or
    b. For a physician owned medical practice with more than 10 owners, 50% of the physician owned medical practice's income divided by the number of physicians who owned an interest in the physician owned medical practice.
3. 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 Dates:** July 1, 2025, January 1, 2026

Link

1. Requires reporting of ownership information by a hospital to DOH, including:
    a. The name of each person or entity with at least a 5% ownership interest (or if the person is a practitioner of the hospital, any ownership interest), a controlling interest or an interest as a private equity partner;
    b. The business address of each person or entity identified;
    c. The website, if applicable, of each person or entity identified;
    d. The national provider identifier (NPI), taxpayer identification number (TIN), employer identification number (EIN), CMS certification number (CCN), national association of insurance commissioners (NAIC) identification number or a personal identification number associated with a license issued by DOI, as applicable; and
    e. The ownership stake of each person of entity identified.
2. Requires reporting of ownership information by an insurer, TPA and PBM to DOI, including:

   a. The name of each person or entity with at least a 5% ownership interest, a controlling interest or an interest as a private equity partner;
   b. The business address of each person or entity identified;
   c. The website, if applicable, of each person or entity identified;
   d. The national provider identifier (NPI), taxpayer identification number (TIN), employer identification number (EIN), CMS certification number (CCN), national association of insurance commissioners (NAIC) identification number or a personal identification number associated with a license issued by DOI, as applicable; and
   e. The ownership stake of each person of entity identified.
3. Requires reporting of ownership information by all other health care entities to the secretary of state, including:
   a. The name of each person or entity with at least a 5% ownership interest, a controlling interest or an interest as a private equity partner;
   b. The business address of each person or entity identified;
   c. The website, if applicable, of each person or entity identified;
   d. The national provider identifier (NPI), taxpayer identification number (TIN), employer identification number (EIN), CMS certification number (CCN), national association of insurance commissioners (NAIC) identification number or a personal identification number associated with a license issued by DOI, as applicable;
   e. The ownership stake of each person of entity identified; and
   f. Whether the health care entity is a Medicaid provider and, if so, whether the health care entity accepted Medicaid recipients during a majority of the preceding two calendar years.
4. Requires the 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.
   a. DOH can omit information from the report it determines is not widely available to the general public.
5. Permits OAG to investigate the market concentration of a health care entity.
6. 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 Indiana Code's mergers and acquisition provisions.

## Senate Enrolled Acts

**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, Rep. Chris Campbell

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

**Effective Date:** July 1, 2025

**Link**

1. Provides a TPA or PBM acting on behalf of a plan sponsor owes a fiduciary duty to the plan sponsor.
    a. "Fiduciary duty" includes the duty to:
        i. Act with loyalty and care in the best interest of the plan sponsor;
        ii. Ensure that all fees, costs and commissions are reasonably and fully disclosed;
        iii. Avoid self-dealing and conflicts of interest; and
        iv. Maintain transparency in all financial and contractual arrangements related to the plan sponsor's health insurance coverage, including prescription drug benefits.

**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**

1. Defines "340B covered entity" as an entity described in 42 U.S.C. 256b(a)(4)(L) through 42 U.S.C. 256b(a)(4)(O) that is authorized to participate in the federal 340B Drug Pricing Program under Section 340B of the federal Public Health Service Act (42 U.S.C. 256b(a)(4)) and has a service address in Indiana as of January 1 of the reporting year. The term includes any offsite outpatient facility affiliated under the 340B program with such an entity.
2. Requires 340B covered entities to annually report specified data to DOH, including:
    a. The name, service address, 340B program identification number and

b. designation of entity type, as specified in 42 U.S.C. 256b(a)(4) of the 340B covered entity;
c. The aggregate acquisition cost for all prescription drugs obtained under the 340B program and dispensed or administered to patients;
d. The aggregate payment amount received for all drugs obtained under the 340B program and dispensed or administered to patients;
e. The aggregate payment made to pharmacies under contract to dispense drugs obtained under the 340B program;
f. The number of claims for prescription drugs described in subdivision (c);
g. 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;
h. The aggregate payments made to any other entity that is not a 340B covered entity and is not a contract pharmacy as described in subdivision (d) for managing any aspect of the 340B covered entity's 340B program;
i. The aggregate payment made for any other administering expense for the 340B program;
j. The aggregate number of prescription drugs dispensed or administered to patients for which a payment was reported under subdivision (c).
k. The percentage of the 340B covered entity's claims that were for prescription drugs obtained under the 340B program;
l. The number and percentage of low income patients of the 340B covered entity that were served by a sliding fee scale for a prescription drug dispensed or administered under the 340B program;
m. The 340B covered entity's total operating costs;
n. The 340B covered entity's total costs for charity care; and
o. A copy of the 340B covered entity's financial assistance policy for the reporting year.

3. Requires various information to be reported, to the extent feasible, by payer type, including commercial, Medicaid, Medicare and uninsured.
4. Institutes a $1,000 per day penalty for failure to submit the report by April 1 of each year.

**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: 65-21 | Senate: 46-4

**Effective Date:** July 1, 2025

**Link**

1. 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.
2. Defines "noncompete agreement" as a contract, or any part of a contract, to which a physician is a party that has the purpose or effect of restricting or penalizing a physician's ability to engage in the practice of medicine in any geographic area, for any period of time, after the physician's employment relationship with a hospital, a parent company of a hospital, an affiliated manager of a hospital or a hospital system has ended.
3. Provides "noncompete agreement" includes any provision that does the following:
    a. Prohibits the physician from engaging in the practice of medicine with a new employer;
    b. Imposes financial penalties or repayment obligations, or requires reimbursement of bonuses, training expenses, or similar payments that apply to a physician that has been employed by a hospital, a parent company of a hospital, an affiliated manager of a hospital or a hospital system for at least 3 years and are based solely or primarily on the physician's decision to continue engaging in the practice of medicine with a new employer;
    c. Requires the physician to obtain employer consent or submit to equitable relief; to engage in the practice of medicine with a new employer, regardless of geographic area or specialty; or
    d. Imposes indirect restrictions that have the effect of limiting or deterring the physician's practice of medicine with a new employer.
4. Provides "noncompete agreement" does not include:
    a. A nondisclosure agreement that protects confidential business information or trade secrets;
    b. A nonsolicitation agreement that prohibits solicitation of current employees for a period not exceeding one year after the physician's employment ends. However, the nonsolicitation agreement may not restrict patient interactions, patient referrals, clinical collaboration or the physician's professional relationships; or
    c. An agreement made in connection with the bona fide sale of a business entity when the physician owns more than 50% of the business entity at the time of sale.
5. Provides that prohibition does not apply to noncompete agreements originally entered into before July 1, 2025.
6. Defines "originally entered into" as the date on which an agreement is entered into for the first time. The term does not refer to the date of an amendment to an existing agreement or the renewal of an existing agreement.

## OTHER HEALTH CARE LEGISLATION

**House Enrolled Acts**

**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**

Cost Sharing

1. 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 under 42 U.S.C. 18022(c)(1) 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.
2. Requires a PBM, insurer and administrator to include any cost sharing amounts paid by the covered individual or on behalf of the covered individual when calculating a covered individual's contribution to an applicable cost sharing requirement.
3. 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 or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.
4. Defines "administrator" as a person who, directly or indirectly and on behalf of an insurer, underwrites or collects charges or premiums from or adjusts or settles claims on residents of Indiana or residents of another state from offices in Indiana in connection with health insurance coverage offered or provided by an insurer.
5. Defines "cost sharing" as any copayment, coinsurance, deductible or other similar charge that is required of a covered individual for a health care service covered by a policy of health insurance coverage, including a prescription drug, and is paid by or on behalf of the covered individual.
6. Defines "health care service" as a service or good furnished for the purpose of preventing, alleviating, curing or healing human illness, physical disability or injury.

7. Exempts self-funded health benefit plans that comply with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.).

Out-of-Pocket Expense Credit

1. 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.
2. Defines "health care services" as any services or products rendered by a health care provider within the scope of the provider's license or legal authorization.
3. Defines "health plan" as a self-insurance program established under IC 5-10-8-7(b) to provide group coverage, a prepaid health care delivery plan through which health services are provided under IC 5-10-8-7(c), 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)), 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). The term includes a person that administers these program or plans and includes hospital, medical, surgical and pharmaceutical service or products.
4. 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.
5. Requires a health plan to publish a link to the APCD on its website.

**Senate Enrolled Acts**

**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**

1. Prohibits the submission of an application for a certificate of public advantage after May 13, 2025.

2. Requires DOH to make a determination on an application filed between January 1, 2025, through May 13, 2025, by November 9, 2025.

**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 Dates:** Upon passage, January 1, 2026

Link

1. 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.
2. Requires an insurer, PBM or any other administrator of pharmacy benefits to ensure that a network utilized is reasonably adequate and accessible.
3. Requires a reasonably adequate and accessible network 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.
4. 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.
5. 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.)
6. 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.
7. 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." (Medicaid, the state employee health plan (SEHP) and managed care organizations (MCOs) are exempt from this provision.)
8. 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 SEHP and MCOs are exempt from this provision.)

9. Requires, if a PBM is used with regard to the state employee health plan, the state personnel department (SPD) to either create a pharmacy benefit manager within the SPD or contract with an insurer, PBM or any other administrator of pharmacy benefits.
10. Urges the legislative council to assign an interim study committee on contracts for pharmacy benefits under the Medicaid program and the SEHP.

**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: 94-0 | Senate: 39-2

**Effective Date:** July 1, 2025

**Link**

1. 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.
2. Defines "utilization review entity" as an individual or entity that performs prior authorization for an employer who employs a covered individual, a health plan, a preferred provider organization or any other individual that provides, offers to provide or administers hospital, outpatient, medical, prescription drug or other health benefits to a covered individual.
3. Defines "adverse determination" as a decision by a utilization review entity to deny, reduce or terminate benefit coverage of a health care service furnished or produced to be furnished to a covered individual on the grounds that the health care service is not medically necessary, appropriate, effective or efficient, not being provided in or at an appropriate health care setting or level or care, or is experimental or investigational.
4. Defines "medically necessary" as a health care service that a prudent health care provider would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptoms in a manner that is in accordance with generally accepted standards or medical practice, clinically appropriate in terms of type, frequency, extent, site and duration, and is not primarily for the economic benefit of the health plan or purchaser or the convenience of the health plan, patient, treating physician or other health care provider.
5. Defines "clinical peer" for physicians, advanced practice registered nurses, primary care physicians and all other practitioners and health care providers.
6. 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 under IC 25-22-5.

7. Allows a request for a prior authorization to be submitted through an application programming interface.
8. 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.
9. Prohibits a utilization review entity from requiring prior authorization for the first 12 physical therapy or chiropractic visits of each new episode of care.
10. Defines "episode of care" as the medical care ordered to be provided for a specific medical procedure, condition or illness.
11. Requires a utilization review entity to respond to a request for prior authorization for an urgent health care service not later than 24 hours after receiving the request. (This timeframe excludes weekends and state and federal legal holidays.)
12. Defines "urgent health care service" as a health care service in which the application of the time period for making a nonexpedited prior authorization, in the opinion of a physician with knowledge of the covered individual's medical condition could seriously jeopardize the life or health of the covered individual, or the covered individual's ability to regain maximum function, or subject the covered individual to severe pain that cannot be adequately managed without the health care service. The term includes a mental and behavioral health care service.
13. Requires a utilization review entity to respond to a request for prior authorization for a non-urgent health care service or prescription drug not later than 48 hours after receiving the request. (This timeframe excludes weekends and state and federal legal holidays.)
14. Requires a utilization review entity to include specific reasons for an adverse determination and suggested alternatives to the health care service if an adverse determination is issued.
15. Requires a health care provider to respond within 48 hours after receiving an adverse determination if the health care provider needs to correct a typographical, clerical or spelling error or accepts an alternative suggested by the utilization review entity. (This timeframe excludes weekends and state and federal legal holidays.)
16. Requires a utilization review entity to render a prior authorization or adverse determination based on the information provided in the health care provider's response and notify the health care provider of the authorization or adverse determination not later than 48 hours after receiving a health care provider's response. (This timeframe excludes weekends and state and federal legal holidays.)
17. Allows a health care provider to appeal an adverse determination not later than 48 hours after receiving notice of the adverse determination. (This timeframe excludes weekends and state and federal legal holidays.)

18. 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.)
19. 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. (This timeframe excludes weekends and state and federal legal holidays.)
20. 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.
21. 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.
22. Requires a utilization review entity to make statistics available regarding prior authorization approvals and denials on the utilization review entity's website in a readily accessible format, including statistics for the following categories:
    a. Health care provider specialty.
    b. Medication or diagnostic test or procedure.
    c. Indication offered.
    d. Reasons for denial.
    e. If a decision was appealed.
    f. If a decision was approved or denied on appeal.
    g. The time between submissions and the response.
23. 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. (This timeframe excludes weekends and state and federal legal holidays.)

## OTHER HEALTH CARE PROVISIONS

**House Enrolled Acts**

**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 Dates:** Upon passage, January 1, 2026

**Link**

1. Operationalizes site of service language established under IC 16-51 by:
    a. Prohibiting a qualified provider from billing health care services with a place of service code 21 (inpatient hospital) or 22 (on campus – outpatient hospital), as published in the place of service code set maintained by the federal Centers for Medicare and Medicaid Services; and
    b. Requiring a payor to pay claims incurred by an in-network qualified provider based on the physician fee schedule.
2. Removes the exemption of billing under the Medicaid program under IC 16-51.