2023 Indiana Legislative Health Summary

May 18, 2023

The 2023 Legislative Session wrapped during the early morning hours of Friday, April 28, at 2:46 am, just 2 days earlier than the statutory deadline for a long session.

The budget session began on Monday, January 9th and had a pace unlike many others. A total of 673 bills were introduced in the House and 138 will become law – a passing percentage of 21%. A total of 489 bills were introduced in the Senate and 114 will become law – a passing percentage of 23.3%. All bills have now been signed by the leaders in each chamber and the Governor.

This final legislative report will summarize EFI's priority pieces of legislation.

2023 Accomplishments of the Employers' Forum of Indiana

1. EFI advocated successfully for many provisions that ultimately ended up in HEA 1004. This includes the following:
    A. A statutory benchmark for DOI's third party contractor to compare hospital prices by certain health plans and years to 285% of Medicare and report back DOI, the health care cost oversight task force and the budget committee for review.
    B. Prohibiting unwarranted facility fees – Requires Indiana's five largest hospital systems that bill for health care services provided at an off-campus hospital outpatient office setting must be submitted on an individual provider form. Submission on an institutional (facility) form is not permitted. (originally in SB6)
    C. Establishing the Health Care Cost Oversight Task Force, made of legislators, that will study a long list of items including noncompete agreements PBM reporting, competition in the insurance market, etc.
    D. Incentives for independent physicians, such as tax credits for primary care physicians.
    E. The payer affordability fund, the purpose of which is to receive fines for violations of hospital reporting and claims data provisions.
    F. Increased price and financial reporting for hospitals.
2. EFI successfully advocated for language banning physician noncompete agreements in SEA 7. Though the final language that passed is more limited than we had hoped, banning physician noncompete agreements for primary care physicians moving forward from July 1, 2023 is a great start. There are also additional provisions dictating when other physician noncompete agreements are not enforceable, and language detailing a mediation process for determining a reasonable buy-out price for physicians.
3. One of EFI's top priorities for the session was PBM and prescription drug price transparency. EFI successfully advocated spread pricing language in SEA 8 which will require PBMs to report every 6

months overall aggregate amounts charged to a health plan for pharmaceutical claims and paid to pharmacies for the claims they process. Additionally, SEA includes provisions requiring certain percentages of rebates be passed on to covered individuals and plan sponsors and increases transparency in the process.

4. EFI wrote a letter of support for HEA 1568, which will allow pharmacists to prescribe hormonal contraceptives.
5. The Employers' Forum of Indiana (EFI) supported efforts to increase public health funding. Provisions in SEA 4 (Public health commission) and HEA 1001 (State budget) amend funding streams and increase the overall state commitment to public health funding.
    A. Additionally, the health care cost oversight task force will be studying whether noncompete clauses in practitioner contracts contributes to a restraint of trade and prohibiting noncompete clauses would create greater competition in the health workforce.

Table of Contents

Senate Enrolled Acts

1. **SEA 4 Public Health Commission (Senator Ed Charbonneau)**
    A. Effective Date: July 1, 2023 unless noted otherwise.
    B. Defines "core public health services" for purposes of public health laws.
        i. "Core public health services" means basic services provided by local health departments or though local health department contracts or grants with an entity, including the following:
            a. Food protection under IC 16-20-8 and IC 16-42-5.
            b. Communicable disease prevention and control under IC 16-20-1 and IC 16-41.
            c. Screening and case management for childhood lead exposure and poisoning under IC 16-41-39.4.
            d. Pest and vector control and abatement under IC 16-41-33 and IC 16-41-34.
            e. Inspection and testing of public and semipublic pools under rules adopted by the state department in accordance with IC 16-19-3-4.
            f. Residential onsite sewage system permitting and inspections under IC 13-26-5 and IC 16-41-25.
            g. Orders for the decontamination of property used to illegally manufacture a controlled substance under IC 16-19-3.1 and IC 16-41-20.
            h. Sanitary inspections and surveys of public buildings under IC 16-20-1-22.
            i. Sanitary operation of tattoo parlors and body piercing facilities under rules adopted by the state department under IC 16-19-3-4(c).
            j. Sanitary operations of facilities where eyelash extensions are applied under rules adopted by the state department under IC 16-19-3-4.5.
            k. Vital statistics under IC 16-20-1-17.
            l. Access to childhood and adult immunizations, including immunizations required under IC 16-41-19.
            m. Tobacco prevention and cessation, including education on vaping and smoking cessation for youth and pregnant women.
            n. Partnering with schools and school nurses to support student health, including the following: Evidence based education on nutrition and physical activity; and hearing screenings under IC 20-34-3-14, vision screenings under IC 20-34-3-12, and oral health screenings.
            o. Child fatality review under IC 16-49-2.
            p. Suicide and overdose fatality review under IC 16-49.5-2.
            q. Maternal and child health.
            r. Testing and counseling for HIV, hepatitis C, and other sexually transmitted infections, in accordance with IC 20-30-5-13.
            s. Health promotion and education for preventing trauma and injury, including safe sleep, child safety car seats, and bicycle helmets for children.
            t. Tuberculosis control and case management.
            u. Emergency preparedness.
            v. Referrals to clinical care, including health screenings, prenatal care and substance use disorder treatment.

w. The prevention and reduction of chronic illnesses, including; obesity, diabetes, cardiovascular diseases (including hypertension and hyperlipidemia), hepatitis C and cancer.

C. Adds one public health professional (including an epidemiologist) and one citizen representative to the executive board of the Indiana Department of Health (IDOH).
D. Amends requirements related to the makeup of local boards of health, based on county population. Includes provisions for appointments for multiple county boards of health.
E. Provides that IDOH may provide technical support to local health departments who provide core public health services, including the following:
    i. Epidemiology;
    ii. Data analytics;
    iii. Legal services;
    iv. Communications;
    v. Grants;
    vi. Training;
    vii. Accreditation; and
    viii. Assistance with reporting requirements, metric developments, and metric tracking.
F. Includes various requirements and metrics for local boards of health to be eligible to receive and continue to receive state funding, including ensuring core public health services are provided, maintenance efforts and funding requirements, reporting, and establishing a local public health services fund to receive the funding, etc.
G. Specifies a method of allocation and percentage of how additional state funding may be expended on core public health services for certain local health departments:
    i. At least 60% on communicable disease prevention and control, vital statistics, tobacco prevention and cessation, supporting student health, child fatality review, suicide and overdose fatality review, maternal and child health, testing and counseling for HIV, hepatitis C and other STIs, tuberculosis control and case management, emergency preparedness, referrals to clinical care, prevention and reduction of chronic illnesses, screening and case management for childhood lead exposure and poisoning, health promotion and education for preventing trauma and injury, and access to childhood and adult immunizations.
    ii. No more than 40% on food protection, pest and vector control and abatement, inspection and testing of public and semipublic pools, residential onsite sewage system permitting and inspections, orders for the decontamination of property used to illegally manufacture a controlled substance, sanitary inspections and surveys of public buildings, sanitary operation of tattoo parlors, body piercing facilities, and facilities where eyelash extensions are applied.
    iii. Includes provisions for a waiver as to the percentage requirements.
    iv. Effective upon passage.
H. Allows the local health department to enter into contracts or approve grants for core public health services.

I. Requires IDOH to make annual local health department reports available to the public. Must also submit certain metrics and reports to the legislative council, and present to the state budget committee.
J. Changes the qualification requirements for a local health officer to include being a physician licensed under IC 25-22.5 or have at least a master's degree in public health and 5 years of experience in public health. Requires approval in accordance with IC 16-20-2-16 and certain training.
    i. Includes provisions allowing a non-physician to fill this role if certain other conditions are met.
K. Requires IDOH to identify state level metrics and county level metrics and requires local health departments that vote to receive additional state funding for core public health services to report to the state department activities and metrics on the delivery of those services.
    i. Effective upon passage – state level metrics must be identified by July 1, 2023 and county level metrics must be identified in consultation with the local departments before December 31, 2024.
L. Requires local health departments post a position or contract for the provision or administration of core public health services for at least 30 days. (Effective upon passage.)
M. Requires a local health department to provide the following educational information before administering a vaccine:
    i. The immunization data registry under IC 16-38-5, including information concerning exclusion from the registry;
    ii. The Vaccine Adverse Event Reporting System maintained by the CDC and FDA;
    iii. The Countermeasures Injury Compensation Program; and
    iv. The National Vaccine Injury Compensation Program.
N. Requires a multiple county health department to maintain at least one physical office in each represented county.
O. Provides that a new city health department cannot be created after December 31, 2022, but allows current city health departments to continue to operate.
P. Creates the Indiana Trauma Care Commission and the makeup of its membership. Duties include:
    i. Develop and promote, in cooperation with state, regional, and local public and private organizations, a statewide program for the provision of trauma care and a comprehensive state trauma plan.
    ii. Use trauma data to promote and support state and regional quality improvement initiatives and evaluations.
    iii. Develop and implement a trauma system performance improvement plan.
    iv. Support state level multi-disciplined disaster planning.
    v. Identify opportunities for, and promote the training of, trauma personnel and programs for the education of the general public in injury prevention and trauma care.
    vi. Develop, in coordination with the state department, criteria for the awarding of trauma grant funds in the areas of:
        a. trauma system development;
        b. quality improvement;

c. trauma and non-trauma center engagement; and
d. injury prevention programming.

vii. Advise the state department on state trauma center designation.
viii. Not later than November 30 of each year, develop and make written recommendations to the Governor and, in an electronic format under IC 5-14-6, to the legislative council concerning the results of the commission's work. The commission shall make the report available to the public.

Q. Allows a school corporation that cannot obtain an ophthalmologist or optometrist to perform the modified clinical technique vision test to conduct certain specified vision screenings. Requires the school to send to the parent of a student any recommendation for further testing by the vision screener.
R. Allows for standing orders to be used for emergency stock medication in schools. Allows the state health commissioner or designee to issue a statewide standing order, prescription, or protocol for emergency stock medication for schools.
S. Removes the distance requirement for an access practice dentist to provide communication with a dental hygienist.

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2. SEA 7 Physician Noncompete Agreements (Senator Justin Busch)

A. Effective Date: July 1, 2023.
B. Provides that beginning July 1, 2023, a primary care physician and an employer may not enter into a noncompete agreement.
   i. Primary care physician refers to a physician practicing in one or more of the following areas:
      a. Family medicine;
      b. General pediatric medicine; or
      c. Internal medicine.
C. Provides that beginning July 1, 2023, a physician noncompete agreement is not enforceable if any of the following circumstances occur:
   i. The employer terminates the physician's employment without cause.
   ii. The physician terminates the physician's employment for cause.
   iii. The physician's employment contract has expired and the physician and employer have fulfilled the obligations of the contract.
D. Specifies a process by which a physician or employer may pursue mediation to determine a reasonable price to purchase a release from a noncompete agreement.
   i. Requires good faith negotiation to determine a reasonable purchase price on part of the employer if a physician elects option to purchase a release from the noncompete agreement.
   ii. If a reasonable purchase price cannot be agreed upon, the physician or the employer may serve a notice of intent to pursue mediation (must be served no later than 35 days of notification that the physician would like to purchase release).
   iii. Parties shall mutually select the mediator.

iv. Unless both parties otherwise agree, the mediation must occur within the city in Indiana closest to the physician's primary place of employment during the term of the contract (with a population of more than 50,000).
v. The mediation must conclude no later than 45 days after the notice of intent to pursue mediation.
vi. Unless the parties agree otherwise, the cost of the mediator and any other direct costs of the mediation must be equally divided between the parties engaged in the mediation. All other costs must be paid by the party incurring them.

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3. SEA 8 Prescription Drug Rebates and Pricing (Senator Ed Charbonneau)

A. Effective Date: July 1, 2023.
B. Requires a PBM to provide a report to DOI at least every 6 months. The following information must be included:
   i. Overall aggregate amount charged to a health plan for all pharmaceutical claims processed by the PBM; and
   ii. Overall aggregate amount paid to pharmacies for claims processed by the PBM.
C. Requires, before July 1, 2024 and before July 1 of each year thereafter, the insurance commissioner to submit a copy of reports received from PBMs to the legislative council.
D. For individual health insurance coverage, requires a covered individual's defined cost sharing (co-insurance or deductible) for a prescription drug to be calculated at the point of sale and based on a price that is reduced by an amount equal to at least 85% of all rebates in connection with the dispensing or administration of the prescription drug.
E. For group health insurance coverage, an insurer shall:
   i. Pass through to a plan sponsor 100% of all rebates concerning the dispensing or administration of prescription drugs to the covered individuals of the plan sponsor;
   ii. At the time of contracting, provide a plan sponsor the option of calculating defined cost sharing for covered individuals of the plan sponsor at the point of sale based on a price that is reduced by some or all of the rebates received concerning the dispensing or administration of the prescription drug; and
   iii. Disclose the following information to the plan sponsor annually:
      a. The approximate amount of rebates expected to be received by the insurer concerning the dispensing or administration of prescription drugs to the covered individuals
      b. An explanation that the plan sponsor may choose to apply the rebates to reduce premiums for all covered individuals or calculate defined cost sharing for a covered individual at the point of sale based on a price that is reduced by rebates received or estimated to be received by the insurer concerning the dispensing or administration of the covered individual's prescription drugs.
      c. An explanation that, in the individual market, IC 27-1-49 requires that covered individual defined cost sharing be calculated at the point of sale based on a price that is reduced by at least eighty-five percent (85%) of the rebates concerning the dispensing or administration of the covered individual's prescription drugs.

F. Applies to health insurance policies that are issued, delivered, amended, or renewed after December 31, 2024.
G. Allows DOI to enforce the provisions and allows the DOI commissioner to impose civil penalties (penalty may not exceed $10,000 per violation).
H. Does not apply to ERISA plans.
I. "Price protection rebate" means a negotiated price concession that accrues directly or indirectly to an insurer, or another party on behalf of an insurer, if there is an increase in the wholesale acquisition cost of a prescription drug above a specified threshold.
J. "Rebate" means:
    i. a discount or other negotiated price concession, including base price concessions (whether described as a rebate or otherwise) and reasonable estimates of price protection rebates, and performance based price concessions, that may accrue directly or indirectly or are anticipated to be passed through to an insurer during the coverage year from a manufacturer, dispensing pharmacy, or other party concerning the dispensing or administration of a prescription drug; and
    ii. a reasonable estimate of any negotiated price concession, fee, or other administrative cost that is passed through, or is reasonably anticipated to be passed through, to the insurer and serves to reduce the insurer's liability for a prescription drug.
K. Nothing in this chapter prohibits an insurer from decreasing a covered individual's defined cost sharing by an amount greater than the required amount.
L. Insurer or insurer's agent may not reveal actual amount of rebates on a product, manufacturer, or pharmacy specific basis (trade secret protection).

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4. SEA 11 Marriage and Family Therapists (Senator Stacey Donato)

A. Effective Date: July 1, 2023.
B. Decreases the number of experiential practice hours required to obtain a license as a marriage and family therapist or a therapist associate.
    i. Hours that must be completed during at least 12 month are reduced to at least 300 face to face client contact hours, of which at least 100 must be relational, under the supervision of a licensed marriage and family therapist who has at least 5 years of experience or a qualified supervisor of the board.

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5. SEA 400 Health Care Matters (Senator Liz Brown)

A. Effective Date: July 1, 2023, unless otherwise noted.
B. Requires the state employee health plan, policies of accident and sickness insurance, and health maintenance organization contracts to provide coverage for wearable cardioverter defibrillators.
C. Specifies requirements for credentialing a provider for the Medicaid program, an accident and sickness insurance policy, and a health maintenance organization contract.

i. Establishes a provisional credential until a decision is made on a provider's credentialing application and allows for retroactive reimbursement.
ii. Effective January 1, 2024.

D. Provides that a hospital's quality assessment and improvement program must include a process for determining and reporting the occurrence of serious reportable events.
E. Provides that the medical staff of a hospital may make recommendations on the granting of clinical privileges and the appointment or reappointment of an applicant to the governing board for a period not to exceed 36 months.
F. Requires a hospital with an emergency department to have at least one physician on site and on duty who is responsible for the emergency department.
G. Requires LSA to conduct an analysis of licensing fees and provide a report to the budget committee.
H. Requires the DOI commissioner to consider the following information before approving or disapproving a premium rate increase:
    i. The products affected, by line of business.
    ii. The number of covered lives affected.
    iii. Whether the product is open or closed to new members in the product block.
    iv. Applicable median cost sharing for the product, as allowed by state or federal law.
    v. The benefits provided and the underlying costs of the health services rendered.
    vi. The implementation date of the increase or decrease.
    vii. The overall percent premium rate increase or decrease that is requested.
    viii. The actual percent premium rate increase or decrease to be approved.
    ix. Incurred claims paid each year for the past three (3) years, if applicable.
    x. Earned premiums for each of the past three (3) years, if applicable.
    xi. Projected medical cost trends in the geographic service region, if the product for which a rate increase or decrease is requested is not a product offered statewide.
    xii. If applicable, historical rebates paid to the policyholder from the most recent health plan year under the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).
    xiii. The median cost sharing amount for an individual covered by the product, or the actuarial value information as required under the Patient Protection and Affordable Care Act, if applicable.
    xiv. When considering whether to approve a premium rate increase, the commissioner shall consider whether the current rate is appropriate for achieving the insurer's target loss ratio.
    xv. To the extent authorized by the Patient Protection and Affordable Care Act and other federal law, the commissioner may consider network adequacy; conduct form review to ensure minimum essential health benefits and nondiscriminatory benefit design; perform accreditation confirmation; and confirm quality measures.
I. Requires a domestic stock insurer to file specified information with DOI.

i. "Domestic stock insurer" means a person that provides coverage under a health plan (as defined in IC 27-1-48-4), is organized under the insurance laws of this state; and is a publicly traded stock corporation.
ii. Domestic stock insurer shall file with DOI:
    a. By March 1 of each calendar year, the domestic stock insurer's annual financial statement from the previous calendar year.
    b. By May 15 of each calendar year, the domestic stock insurer's first quarter financial statement from the current calendar year.
    c. By August 15 of each calendar year, the domestic stock insurer's second quarter financial statement from the current calendar year.
    d. By November 15 of each calendar year, the domestic stock insurer's third quarter financial statement from the current calendar year.
iii. DOI must post the information on the department's website on a single and easily accessible web page not later than 10 business days after receiving it.

J. Prohibits the state employee health plan from requiring prior authorization and from issuing a retroactive denial for medical necessity for certain specified services (by CPT code). Requires interim study committee to review impact of this language before November 1, 2025.
K. Shortens certain health plan's allowable response time for prior authorization requests for urgent care situations and nonurgent care situations. Includes language requiring the reasoning for the denial to be in clear and easy to understand language.
L. Adds an employee benefit plan that is subject to the federal Employee Retirement Income Security Act of 1974 and a state employee health plan to the definition of "health payer" for the purposes of APCD.
    i. Health payers shall begin submitting certain required data to the APCD no later than 3 months from the first day DOI declares the APCD to be fully operational.
    ii. The "opt-in" language for employers to share claims data was eliminated.
    iii. Allows DOI to adopt rules on certain matters concerning APCD.
M. Requires a health plan to offer an alternative method for submission of a claim for when the health plan has technical difficulties with the claims submission system.
    i. The health plan must also post notice of the alternative method for claims submission on the health plan's website.
N. No later than February 1 of each calendar year, requires a health plan to post on the health plan's website:
    i. the 30 most frequently submitted CPT codes that were submitted by participating providers for prior authorization during the previous calendar year; and
    ii. the percentage of the 30 most frequently submitted CPT codes that were approved in the previous calendar year, disaggregated by CPT code.
    iii. A health plan must maintain this information on the website, organized by year and on a single and easily accessible web page.
O. Prohibits an insurer and a health maintenance organization from altering a CPT code for a claim or paying for a CPT code of lesser monetary value unless:

i. the CPT code submitted is not in accordance with certain guidelines and rules, or the terms and conditions of a participating provider's agreement or contract with the insurer or health maintenance organization; or
ii. the medical record of the claim has been reviewed by an employee or contractor of the insurer or health maintenance organization.

P. Requires an insurer and a health maintenance organization to provide a contracted provider with a current reimbursement rate schedule every 2 years and when 3 or more CPT code rates under the agreement are changed in a 12 month period.
Q. Urges the study by an interim committee of:
i. Prior authorization exemptions for certain health care providers; and
ii. whether Indiana should adopt an interstate mobility of occupational licensing.
iii. Requires a health plan to offer a health care provider the option to request a peer to peer review by a clinical peer concerning an adverse determination on a prior authorization request.
iv. Requires a collaborating physician or physician designee to review certain patient encounters performed by a physician assistant within 14 business days.

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House Enrolled Acts

1. HEA 1004 Health Care Matters (Representative Donna Schaibley)

A. Effective Date: Upon Passage, July 1, 2023, or July 1, 2024 (as noted).
B. Establishes the Health Care Cost Oversight Task Force. Membership includes the following:
i. 2 members of the House, appointed by the Speaker of the House.
ii. 1 member of the House appointed by the Minority Leader.
iii. 2 members of the Senate, appointed by the President Pro Tempore.
iv. 1 member of the Senate, appointed by the Minority Leader.
v. Chairs of the taskforce will alternate between the President Pro Tempore's appointment and the Speaker of the House's appointment.
C. Duties of the task force include:
i. Review and make recommendations concerning the cost of health care in the state and in comparison to other states.
ii. Review and make recommendations concerning reductions in health care costs with the goal of ensuring that any reduction in health care prices ultimately reaches the health care payer.
iii. Review and make recommendations concerning reports submitted to the task force.
iv. Study and make recommendations concerning the availability of value-based care and other health care models that emphasize prevention and cost avoidance.
v. Study and make recommendations concerning the market concentration of health care providers and contributing factors, including.
a. Whether noncompete clauses in practitioner contracts contributes to a restraint of trade and prohibiting noncompete clauses would create greater competition in the health workforce;
b. contract tiering with health carriers;

c. all-or-nothing network plans; and
d. disclosure of cost and price information to plan sponsors.

vi. Study and make recommendations concerning whether medical consumers would benefit from prohibiting anti-competitive practices or otherwise encouraging increased competition among providers.

vii. Study and make recommendations concerning whether medical consumers overall would benefit from reestablishing the former Indiana comprehensive health insurance association policies.

viii. Review and make recommendations concerning required reporting for PBMs to DOI.

ix. Study and make recommendations concerning whether there is sufficient competition in the commercial insurance market and whether health care consumers would benefit from policies designed to increase competition among commercial carriers, including the promotion of direct contracting, narrow networks and insurance brokers.

x. Study and make recommendations concerning whether there is sufficient innovation in the design of health insurance plans, including whether health care consumers would benefit from policies that better distinguish wellness and prevention from catastrophic coverage; promote price discounts based on individual underwriting and empower the health care consumer with a focus on prevention and shoppable services.

xi. Any other topic the task force deems relevant to the oversight of health care costs in Indiana.

D. FSSA, IDOH, and DOI will provide whatever data, documents, and other information that the task force deems necessary to perform its duties.

E. Effective date of task force provisions is upon passage.

F. Provides a credit against state tax liability to primary care physicians who have an ownership interest in a physician practice and meet other eligibility criteria.

i. Primary care physician refers to a physician practicing in 1 or more of the following areas:
a. Family medicine;
b. General pediatric medicine;
c. General internal medicine; or
d. The general practice of medicine.

ii. Physician cannot be employed by a health system or have any state income tax liability.

iii. Entity must be established and open and providing primary care services after December 31, 2023 and have billed for health care services for at least 6 months in that taxable year.

iv. Amount of credit is $20,000 for that taxable year, may also be claimed for the 2 years immediately following that year and can be carried over no more than 10 years.

v. If it is determined the physician has sold, transferred, granted or otherwise relinquished his or her ownership interest to a health system or non-physician owned

medical practice within 5 years of the receipt of the tax credit, an assessment shall be imposed equal to the amount of the tax credits provided.

G. After December 31, 2023, allows a credit against the state tax liability of an employer with fewer than 50 employees if the employer has adopted a health reimbursement arrangement in lieu of a traditional employer provided health insurance plan and if the employer's contribution toward the health reimbursement arrangement meets a certain standard.
    i. Taxpayer may claim a credit against his or her tax liability for up to $400 in the first year per covered individual if the amount provided toward the health reimbursement arrangement is equal to or greater than either the level of benefits provided in the previous benefit year, or if the amount the employer contributes toward the health reimbursement arrangement equals the same amount contributed per covered individual toward the employer provided health insurance plan during the previous benefit year.
    ii. The credit decreases to two hundred dollars ($200) per covered employee in the second year.
    iii. Taxpayer must report to DOI every 3 years if the credit is claimed.
    iv. Amount of credit may not exceed $10 million in any taxable year and may not exceed the state tax liability of the taxpayer.
    v. Credit cannot carry over more than 10 years.
H. Requires FSSA to research and compile data concerning Medicaid reimbursement rates for Indiana and all other states and the national reimbursement rate average for inpatient hospital services, outpatient hospital and clinical services and professional hospital services.
    i. Must distinguish base rates, supplemental payment rates and any other payment that contributes to total Medicaid reimbursement for IN and all other U.S. states.
    ii. Effective July 1, 2023, must be submitted by December 1, 2023 to the health care cost oversight task force and the General Assembly.
I. Establishes the payer affordability penalty fund, the purpose of which is to receive fines collected for violations of hospital reporting and claims data provisions.
    i. Fund is to be used for the state's share of the Medicaid program and the study of hospitals that are impacted by changes made in the disproportionate share hospital methodology payments (DSH).
    ii. Effective July 1, 2023.
J. Specifies additional information that a hospital must report to IDOH in the hospital's annual report and establishes a $1,000 per day fine for a hospital that fails to timely file the report.
    i. Effective July 1, 2023.
K. In addition to the information already required to be reported yearly, a hospital must report the following:
    i. Net patient revenue and total number of paid claims, including providing the information as follows:
        a. The net patient revenue and total number of paid claims for inpatient services for Medicare; Medicaid; commercial insurance, including inpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan; self-pay; and any other category of payer.

b. The net patient revenue and total number of paid claims for outpatient services for the same group listed above.
c. The total net patient revenue and total number of paid claims for: (i) Medicare for the same group listed above.

ii. Net patient revenue and total number of paid claims from facility fees, including providing the information as follows:
a. The net patient revenue and total number of paid claims for inpatient services from facility fees for Medicare; Medicaid; commercial insurance, including inpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan; self-pay; and any other category of payer.
b. The net patient revenue and total number of paid claims for outpatient services from facility fees for the same group listed above.
c. The total net patient revenue and total number of paid claims from facility fees for the same group listed above.

iii. Net patient revenue and total number of paid claims from professional fees, including providing the information as follows:
a. The net patient revenue and total number of paid claims for inpatient services from professional fees for Medicare; Medicaid; commercial insurance, including inpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan; self-pay; and any other category of payer.
b. The net patient revenue and total number of paid claims for outpatient services from professional fees for the same group above.
c. The total net patient revenue and total number of paid claims from professional fees for same group listed above.

iv. "Net patient revenue" means gross patient revenue less deductions for contractual adjustments, bad debts, and charity.

L. Provides that a bill for health care services provided by certain qualified providers in an office setting must be submitted on an individual provider form.
i. "Individual provider form" means a medical claim form that:
a. is accepted by the federal Centers for Medicare and Medicaid Services for use by individual providers or groups of providers; and
b. includes a claim field for disclosure of the site at which the health care services to which the form relates were provided.

ii. The term includes the following:
a. The CMS-1500 form or its successor form.
b. The HCFA-1500 form or its successor form.
c. The HIPAA X12 837P electronic claims transaction for professional services, or its successor transaction.

M. Prohibits an insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services from accepting a bill that is submitted on an institutional provider form.

i. "Institutional provider form" means a medical claim form that:
   a. is accepted by the federal Centers for Medicare and Medicaid Services for use by institutional providers; and
   b. does not include a claim field for disclosure of the site at which the health care services to which the form relates were provided.
ii. the term includes the following:
   a. The HIPAA X12 837I institutional form or its successor form.
   b. The CMS-1450 form or its successor form. (3) The UB-04 form or its successor form.

N. "Office setting" for site of service provisions means a location of a qualified provider where health care services are provided and that:
   i. is located more than two hundred fifty (250) yards from the main building of any hospital owned in whole or in part by the Indiana nonprofit hospital system; and
   ii. is where a qualified provider routinely provides health examinations, diagnosis, or non-invasive treatment of illness or injury on an ambulatory basis.

O. Applies only to certain Indiana nonprofit hospital systems, defined as a hospital that:
   i. is organized as a nonprofit corporation or a charitable trust under Indiana law or the laws of any other state or country and that is eligible for tax exempt bond financing or exempt from state or local taxes;
   ii. is licensed under IC 16-21-2;
   iii. filed jointly 1 hospital audited financial statement with IDOH in 2021; and
   iv. has an annual patient service revenue of at least $2,000,000,000 based on the hospital system's 2021 audited financial statement filed with the Indiana department of health. As used in this subdivision, "patient service revenue" includes similar terms, including net patient service revenue and patient care service revenue.

P. Site of service provisions do not apply to the following:
   i. A hospital licensed under IC 16-21-2 that is operated by a county; a city pursuant to IC 16-23; or the health and hospital corporation established under IC 16-22-8.
   ii. A critical access hospital that meets the criteria under 42 CFR 485.601 through 42 CFR 485.647.
   iii. A rural health clinic (as defined in 42 U.S.C. 1396d(l)(1)).
   iv. A federally qualified health center (as defined in 42 U.S.C. 1396d(l)(2)(B)).
   v. An oncology treatment facility, even if owned or operated by a hospital.
   vi. A health facility licensed under IC 16-28.
   vii. A community mental health center certified under IC 12-21-2-3(5)(C).
   viii. A private mental health institution licensed under IC 12-25, including a service facility location for a private mental health institution and reimbursed as a hospital-based outpatient service site.
   ix. Services provided for the treatment of individuals with psychiatric disorders or chronic addiction disorders in any part of a hospital, whether or not a distinct part; or an outpatient off campus site that is within thirty-five (35) miles of a hospital.
   x. Billing under the Medicare program or a Medicare advantage plan.
   xi. Billing under the Medicaid program.

Q. All site of service provisions are effective January 1, 2025.
R. Repeals language requiring a hospital to hold a public forum.
S. Requires DOI to contract with a third party to calculate an Indiana nonprofit hospital system's prices from certain health plans for specified calendar years.
    i. The calculation for the Indiana nonprofit hospital system's prices from the commercially insured market, shall be categorized by:
        a. self-funded plan prices;
        b. fully-funded plan prices;
        c. the individual market prices; and
        d. the total combined prices of clauses above.
        e. Expressed as a percentage of how much Medicare would have paid for the same services for the 2021 calendar year, the 2022 calendar year, and the 2023 calendar year.
    ii. No later than December 1, 2024, a report with these findings must be prepared and submitted to DOI, the health care cost oversight task force, and the budget committee for review.
    iii. Before March 1, 2024, and before March 1 of each subsequent year, an Indiana nonprofit hospital system shall submit the following:
        a. Information IDOH or the IDOH's third party contractor determines is necessary to make the assessments required above.
        b. Standard charge information required to be made public by the federal Centers for Medicare and Medicaid Services for price transparency for each hospital facility within the Indiana nonprofit hospital system.
    iv. Does not apply to:
        a. A nonprofit hospital that is owned by a county;
        b. A critical access hospital that meets the criteria under 42 CFR 485.601 et seq.;
        c. An independent hospital; or
        d. A governmental hospital.
T. Before November 1, 2024, and before November 1 each subsequent year, requires DOI's third party contractor to compare Indiana nonprofit hospital system facility pricing information (outlined above) with 285% of Medicare.
    i. Before December 1, 2024, and before December 1 of each subsequent year, DOI shall submit a report of the third party contractor's findings outlined above to the health care cost oversight task force.
U. Provides that a health care provider that enters into:
    i. a value-based health care reimbursement agreement; and
    ii. an electronic medical records access agreement; with a health plan may qualify to participate in the health plan's program to reduce or eliminate prior authorization requirements.
    iii. Effective July 1, 2023.
V. Requires a health plan that establishes a program to reduce or eliminate prior authorization requirements to provide certain information to health care providers concerning their eligibility for the program.

i. Effective July 1, 2023.

W. Requires a third party administrator, insurer, or health maintenance organization that has contracted with a person to administer a self-funded insurance plan or a fully insured group plan to provide claims data to the person not later than 15 days from a request for the data.
   i. Limit to no more than twice annually for a contract holder.
   ii. Specifies certain claims data to be provided and establishes a fine ($1,000 per day after 15 day deadline from the request) for a failure to timely provide the claims data.
   iii. The claims data must include the following:
      a. The effective date of coverage.
      b. The total number of covered individuals.
      c. The total monthly earned premium.
      d. The total monthly dollar value of paid claims, regardless of the period in which the claims were incurred.
      e. The beginning and ending date of the period for which claims were paid; and percentage of claims that were paid in:
         1. less than 30 days;
         2. 30 days to 60 days;
         3. 61 days to 90 days; and
         4. over 90 days.
      f. For groups insuring at least 100 employees:
         1. the reserve value as of the beginning of the period; and
         2. the reserve value as of the date through which the paid claims data was obtained.
      g. A description of each large or catastrophic claim exceeding $50,000, including:
         1. the diagnosis;
         2. the dollar amount of the claim;
         3. whether the claim is opened or closed; and
         4. the length of time the claim was open.
      h. Any other claims data requested by the contract holder.

X. Requires the APCD advisory board to discuss specified issues concerning reimbursement rates, including:
   i. Indiana's health insurance premium rates, Medicaid reimbursement rates, and Medicare reimbursement rates with all other states; and
   ii. Discuss auditing and comparing Indiana's health insurance reimbursement claim denials with all other states.

Y. Allows for the provisional credentialing of physicians who establish or join an independent primary care practice.

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2. HEA 1212 Privacy Protections for Nonprofit Organizations (Representative Mike Karickhoff)

A. Effective Date: July 1, 2023

B. Provides that the personal information of a member, supporter, volunteer, or donor of a nonprofit organization is subject to certain protections.

i. Does not apply to a national securities association or information it provides to the secretary of state under IC 23-19.

C. Defines "personal information" as data that directly or indirectly identifies a "person" (including an individual, a corporation, a limited liability company, a government entity, a partnership, a trust, an estate, or other entity) as a member or supporter of, volunteer for or donor to a nonprofit organization.

D. With certain exceptions, prohibits a state agency (including an executive, judicial, or legislative branch agency, state educational institution, or body corporate and politic) or political subdivision from doing the following:
   i. Require or otherwise compel any person or nonprofit organization to provide the public agency with personal information.
   ii. Release, publicize, or otherwise publicly disclose personal information in the possession of the public agency.
   iii. Request or require a current or prospective contractor for or grantee of the public agency to provide a list of nonprofit organizations to which the current or prospective contractor or grantee has provided financial or nonfinancial support.

E. Defines "nonprofit organization" as:
   i. A domestic corporation (as defined in IC 23-17-2-11).
   ii. A foreign corporation (as defined in IC 23-17-2-13).
   iii. An entity that is exempt from federal income tax under Section 501(c) of the Internal Revenue Code.
   iv. An entity that has submitted an application with the Internal Revenue Service for recognition of an exemption under Section 501(c) of the Internal Revenue Code.

F. Defines "nonprofit hospital" as a hospital licensed under IC 16-21 that is organized as a nonprofit organization or charitable trust and is eligible for tax exempt bond financing or from state or local taxes.
   i. Does not include a county hospital or municipal hospital licensed under IC 16-21-2 that is governed by IC 16-22-2, IC 16-22-8, or 16-23.

G. Provides that personal information is considered confidential and is not subject to disclosure under Indiana's access to public records act (APRA).

H. Provides that a person alleging a violation of the bill's provisions may bring a civil action for injunctive relief, specified damages, or both.

I. Provides that:
   i. a public employee, a public official, or an employee or officer of a contractor or subcontractor for a public agency who violates the bill's provisions is subject to the penalties and discipline that apply with respect to violations of APRA.

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3. HEA 1445 Audit of Medicaid Program Prescription Drug Costs (Representative Ann Vermilion)

A. Effective upon passage.

B. Amends the requirements for a physician to provide office based opioid treatment.

C. Provides that the attorney general may issue a request for proposal to audit the prescription drug programs within the state employee health plan and the Medicaid program. The RFP for the audit may include the following:
    i. Cost sharing.
    ii. Spread pricing.
    iii. Patient steering.
    iv. Proper brand and generic definitions.
    v. Effective rate clawbacks.
    vi. Medical loss ratio inflation.
    vii. Formulary compliance.
    viii. Discriminatory pricing.
    ix. Specialty drug definition and categorization.
    x. Adherence to contracted pricing terms.
    xi. Adherence to plan design, including:
        a. quantity limits; and
        b. prior authorization guidelines.
    xii. Under market reimbursements to pharmacies.
    xiii. Dispensing fees.
    xiv. Lesser of logic pricing.
    xv. Fraud, waste, and abuse.
    xvi. Rebates.
    xvii. Compliance with federal law.
    xviii. Review of practices of any of the following used within the Medicaid program:
        a. Managed care organizations.
        b. Pharmacies.
        c. Pharmacy services administrative organizations.
        d. Wholesalers.
        e. Drug manufacturers.
    xix. Any other metric determined by the attorney general for inclusion in the audit of the Medicaid program.
D. Provides that the audit look back period must be the previous five state fiscal years.
E. Provides that the results of the audits must be provided to the interim study committee on public health, behavioral health, and human services before September 1, 2024.
F. Provides that a practitioner is not required to obtain information about a patient from the INSPECT data base or through the patient's integrated health record before prescribing certain medications if the patient is enrolled in a hospice program.

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4. HEA 1568 Prescription for Hormonal Contraceptives (Representative Elizabeth Rowray)

A. Allows pharmacists who meet certain requirements to prescribe and dispense hormonal contraceptive patches and self-administered hormonal contraceptives to a woman who is at least 18 years of age, regardless of whether the woman has evidence of a previous prescription from a primary care practitioner or women's health care practitioner.

B. Establishes requirements for pharmacists who elect to prescribe and dispense contraceptives, including the following:
    i. Complete a training program approved by the board that is related to prescribing hormonal contraceptive patches and self-administered hormonal contraceptives. The board may adopt a training program developed by another state.
    ii. Provide a self-screening risk assessment tool that the woman must use before the pharmacist's prescribing of the hormonal contraceptive patch or self-administered hormonal contraceptive.
    iii. Refer the woman to a primary care practitioner or the women's health care practitioner upon prescribing and dispensing the hormonal contraceptive patch or self-administered hormonal contraceptive.
    iv. Provide the woman with a written record of the hormonal contraceptive patch or the self-administered hormonal contraceptive prescribed and dispensed and advise the woman to consult with a primary care practitioner or women's health care practitioner.
    v. If the pharmacist works at a site which, in the regular course of business, has a provider who is a physician, advanced practice registered nurse, or physician assistant who is available to deliver patient care and who is capable of prescribing the hormonal contraceptive patch or self-administered hormonal contraceptive, suggest that the woman see the provider.
    vi. Administer the screening protocols before issuing each prescription for a hormonal contraceptive patch or self-administered hormonal contraceptive.
    vii. Provide that a prescription for a contraceptive patch or self-administered hormonal contraceptive may not be for more than a 6 month period and that the pharmacist may not issue a prescription to the woman after 12 months unless the woman has been seen by a physician, advanced practice registered nurse, or physician assistant in the previous 12 month period.
    viii. A pharmacist may not require a woman to schedule an appointment with the pharmacist for the prescribing or dispensing of a hormonal contraceptive patch or self-administered hormonal contraceptive.
C. Provides that a pharmacist is not required to prescribe a contraceptive to a woman if the pharmacist believes the contraceptive is contraindicated or objects on ethical, moral, or religious grounds.
D. Provides that an individual who is a pharmacy technician, pharmacy technician in training, pharmacist student, or pharmacist intern is not required to dispense a contraceptive to a woman if the individual objects on ethical, moral, or religious grounds.
E. Requires the Indiana board of pharmacy to revoke the license of a pharmacist who knowingly or intentionally prescribes a drug that is intended to cause an abortion.
F. Establishes penalties for a pharmacist who prescribes a drug that is intended to cause an abortion.
G. Requires the state health commissioner or the commissioner's designated public health authority to issue a standing order that allows a pharmacist to prescribe and dispense contraceptives until the board adopts rules that adopt the standing order.

i. Establishes requirements for the standing order.

H. Requires FSSA to reimburse a pharmacist for services and prescriptions for contraceptives provided to an eligible Medicaid recipient.

i. FSSA must apply for the appropriate waiver by July 1, 2023 (effective upon passage.)

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