January 19, 2024

SENATE BILL No. 3

DIGEST OF SB 3 (Updated January 17, 2024 11:56 am - DI 140)

Citations Affected: IC 5-10; IC 27-1.

Synopsis: Prior authorization. Provides that a utilization review entity may only impose prior authorization requirements on less than 1% of any given specialty or health care service and 1% of health care providers overall in a calendar year. Prohibits a utilization review entity from requiring prior authorization for: (1) a health care service that is

(Continued next page)

Effective: July 1, 2024.

Johnson T, Charbonneau, Garten, Brown L, Rogers, Baldwin, Messmer, Becker, Bohacek, Busch, Koch, Crider, Leising, Walker K, Alexander, Alting, Doriot, Donato, Ford J.D., Yoder

January 16, 2024, read first time and referred to Committee on Health and Provider Services.

January 18, 2024, reported favorably — Do Pass. Reassigned to Committee on Appropriations pursuant to Rule 68(b).

Digest Continued

part of the usual and customary standard of care; (2) a prescription drug that is approved by the federal Food and Drug Administration; (3) medication for opioid use disorder; (4) pre-hospital transportation; or (5) the provision of an emergency health care service. Sets forth requirements for a utilization review entity that requires prior authorization of a health care service. Provides that all adverse determinations and appeals must be reviewed by a physician who meets certain conditions. Requires a utilization review entity to provide an exemption from prior authorization requirements if in the most recent 12 month period the utilization review entity has approved or would have approved at least 80% of the prior authorization requests submitted by the health care provider for a particular health care service. Repeals superseded provisions regarding prior authorization. Makes corresponding changes.

January 19, 2024

Second Regular Session of the 123rd General Assembly (2024)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2023 Regular Session of the General Assembly.

SENATE BILL No. 3

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 5-10-8-19, AS ADDED BY P.L.77-2018, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 19. A self-insurance program established under section 7(b) of this chapter to provide health care coverage shall comply with the prior authorization requirements that apply to a ~~health plan~~ **utilization review entity** under IC 27-1-37.5.

SECTION 2. IC 27-1-37.5-1, AS AMENDED BY P.L.190-2023, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 1. ~~(a) Except as provided in sections 10, 11, 12, 13, and 13.5 of this chapter, this chapter applies beginning September 1, 2018.~~

~~(b)~~ **(a)** This chapter does not apply to a step therapy protocol exception procedure under IC 27-8-5-30 or IC 27-13-7-23.

~~(c)~~ **(b)** This chapter does not apply to a health plan that is offered by a local unit public employer under a program of group health insurance provided under IC 5-10-8-2.6.

SECTION 3. IC 27-1-37.5-1.5, AS ADDED BY P.L.190-2023,

SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 1.5. As used in this chapter, "adverse determination" means a ~~denial of a request for benefits~~ **decision by a utilization review entity to deny, reduce, or terminate benefit coverage of a health care service furnished or proposed to be furnished to a covered individual** on the grounds that the health **care** service: ~~or item:~~

(1) is not medically necessary; ~~appropriate, effective, or efficient;~~ **or**

~~(2) is not being provided in or at an appropriate health care setting or level of care; or~~

~~(3)~~ **(2)** is experimental or investigational.

The term does not include a decision to deny, reduce, or terminate benefit coverage of a health care service for a reason other than those described in subdivisions (1) and (2).

SECTION 4. IC 27-1-37.5-1.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 1.6. As used in this chapter, "authorization" means a determination by a utilization review entity that:**

(1) a health care service:

(A) has been reviewed; and

(B) based on the information provided, satisfies the utilization review entity's requirements for medical necessity and appropriateness; and

(2) payment will be made for the health care service.

SECTION 5. IC 27-1-37.5-1.7 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 1.7. As used in this chapter, "clinical peer" means a practitioner or other health care provider who either:~~

~~(1) holds a current and valid license in any United States jurisdiction;~~

~~(2) has been granted reciprocity in the state, if reciprocity exists; or~~

~~(3) holds a license that is part of a compact in which the state has entered.~~

SECTION 6. IC 27-1-37.5-1.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 1.8. As used in this chapter, "clinical criteria" means:**

(1) written policies;

(2) written screen procedures;

(3) drug formularies or lists of covered drugs;

(4) determination rules;
(5) determination abstracts;
(6) clinical protocols;
(7) practice guidelines;
(8) medical protocols; and
(9) any other criteria or rationale;

used by the utilization review entity to determine the necessity and appropriateness of a health care service.

SECTION 7. IC 27-1-37.5-2, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 2. As used in this chapter, "covered individual" means an individual who is covered under a health plan. **The term includes a covered individual's legally authorized representative.**

SECTION 8. IC 27-1-37.5-3.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 3.3. As used in this chapter, "emergency health care service" means a health care service that is provided in an emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses average knowledge of health and medicine to:**

(1) place an individual's health in serious jeopardy;
(2) result in serious impairment to the individual's bodily function; or
(3) result in serious dysfunction of any bodily organ or part of the individual.

SECTION 9. IC 27-1-37.5-3.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 3.9. (a) As used in this chapter, except as provided in subsection (b), "health care provider" means an individual who holds a license issued by a board described in IC 25-0.5-11.**

(b) The term does not include a veterinarian licensed under IC 25-38.1.

SECTION 10. IC 27-1-37.5-4, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 4. ~~(a)~~ As used in this chapter, "health care service" means a health care ~~related service or product rendered or sold~~ **procedure, treatment, or service provided** by:

(1) a health care facility (as defined in IC 16-18-2-161(a));

(2) an ambulatory outpatient surgical center (as defined in IC 16-18-2-14);

(3) a pharmacy (as defined in IC 27-1-24.5-11); or

(4) a health care provider within the scope of **practice of** the health care provider's license or legal authorization.

The term includes the provision of pharmaceutical products or services or durable medical equipment.

~~including hospital, medical, surgical, mental health, and substance abuse services or products.~~

~~(b) The term does not include the following:~~

~~(1) Dental services.~~

~~(2) Vision services.~~

~~(3) Long term rehabilitation treatment.~~

~~(4) Pharmaceutical services or products.~~

SECTION 11. IC 27-1-37.5-5.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 5.4. As used in this chapter, "medically necessary" means a health care service that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or symptoms in a manner that is:**

(1) in accordance with generally accepted standards of medical practice;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for the:

(A) economic benefit of the health plan or purchaser; or

(B) convenience of the patient, treating physician, or other health care provider.

SECTION 12. IC 27-1-37.5-5.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 5.5. As used in this chapter, "medication for opioid use disorder" means the use of medications, commonly in combination with counseling and behavioral therapies, to provide a comprehensive approach to the treatment of opioid use disorder.**

SECTION 13. IC 27-1-37.5-7, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 7. As used in this chapter, "prior authorization" means ~~a practice implemented by a health plan through which coverage of a health care service is dependent on the covered individual or health care provider obtaining approval from the health plan before the~~

~~health care service is rendered. The term includes prospective or utilization review procedures conducted before a health care service is rendered.~~ **the process by which a utilization review entity determines the medical necessity or medical appropriateness of an otherwise covered health care service before the health care service is rendered. The term includes a utilization review entity's requirement that a covered individual or health care provider notify the utilization review entity prior to providing a health care service.**

SECTION 14. IC 27-1-37.5-8 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 8. As used in this chapter, "urgent care situation" means a situation in which a covered individual's treating physician has determined that the covered individual's condition is likely to result in:~~

~~(1) adverse health consequences or serious jeopardy to the covered individual's life, health, or safety; or~~

~~(2) due to the covered individual's psychological state, serious jeopardy to the life, health, or safety of another individual;~~

~~unless treatment of the covered individual's condition for which prior authorization is sought occurs earlier than the period generally considered by the medical profession to be reasonable to treat routine or non-life threatening conditions.~~

SECTION 15. IC 27-1-37.5-8.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 8.1. As used in this chapter, "urgent health care service" means 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:**

(1) seriously jeopardize:

(A) the life or health of the covered individual; or

(B) the covered individual's ability to regain maximum function; or

(2) 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.

SECTION 16. IC 27-1-37.5-8.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 8.3. As used in this chapter, "utilization review entity" means an individual or entity that performs prior authorization for one (1) or more of the following:**

(1) An employer who employs a covered individual.

(2) A health plan.

(3) A preferred provider organization.

(4) Any other individual or entity that:

(A) provides;

(B) offers to provide; or

(C) administers;

hospital, outpatient, medical, prescription drug, or other health benefits to a covered individual.

SECTION 17. IC 27-1-37.5-9 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 9. (a) A health plan shall make available to participating providers on the health plan's Internet web site or portal the applicable CPT code for the specific health care services for which prior authorization is required.~~

~~(b) A health plan shall make available to participating providers, on the health plan's Internet web site or portal, a list of the health plan's prior authorization requirements, including specific information that a provider must submit to establish a complete request for prior authorization. This subsection does not prevent a health plan from requiring specific additional information upon review of the request for prior authorization.~~

~~(c) A health plan shall, not less than forty-five (45) days before the prior authorization requirement becomes effective, disclose to a participating provider any new prior authorization requirement.~~

~~(d) A disclosure made under subsection (c) must:~~

~~(1) be sent via electronic or United States mail and conspicuously labeled "Notice of Changes to Prior Authorization Requirements"; and~~

~~(2) specifically identify the location on the health plan's Internet web site or portal of the new prior authorization requirement.~~

~~However, a health plan is considered to have met the requirements of this subsection if the health plan conspicuously posts the information required by this subsection, including the effective date of the new prior authorization requirement, on the health plan's Internet web site.~~

~~(e) A participating provider shall, not more than seven (7) days after the change is made, notify the health plan of a change in the participating provider's electronic or United States mail address.~~

SECTION 18. IC 27-1-37.5-10, AS ADDED BY P.L.208-2018, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 10. (a) This section ~~applies to a request for prior authorization delivered to a health plan after December 31, 2019.~~ **does not apply to prior authorization for a prescription drug.**

(b) A ~~health plan~~ **utilization review entity** shall accept a request for prior authorization delivered to the ~~health plan~~ **utilization review**

entity by a covered individual's health care provider through a secure electronic transmission. A health care provider shall submit a request for prior authorization through a secure electronic transmission. A ~~health plan~~ **utilization review entity** shall provide for:

(1) a secure electronic transmission; and

(2) acknowledgment of receipt, by use of a transaction number or another reference code;

of a request for prior authorization and any supporting information.

(c) Subsection (b) does not apply and a ~~health plan~~ **utilization review entity** that requires prior authorization shall accept a request for prior authorization that is not submitted through a secure electronic transmission if a covered individual's health care provider and the ~~health plan~~ **utilization review entity** have entered into an agreement under which the ~~health plan~~ **utilization review entity** agrees to process prior authorization requests that are not submitted through a secure electronic transmission because:

(1) secure electronic transmission of prior authorization requests would cause financial hardship for the health care provider;

(2) the area in which the health care provider is located lacks sufficient Internet access; or

(3) the health care provider has an insufficient number of covered individuals as patients or customers, as determined by the commissioner, to warrant the financial expense that compliance with subsection (b) would require.

(d) If a covered individual's health care provider is described in subsection (c), the ~~health plan~~ **utilization review entity** shall accept from the health care provider a request for prior authorization as follows:

(1) The prior authorization request must be made on the standardized prior authorization form established by the department under section 16 of this chapter.

(2) The ~~health plan~~ **utilization review entity** shall provide for secure electronic transmission and ~~acknowledgement~~ **acknowledgment** of receipt of the standardized prior authorization form and any supporting information for the prior authorization by use of a transaction number or another reference code.

SECTION 19. IC 27-1-37.5-11 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 11. (a) This section applies to a prior authorization request delivered to a health plan after December 31, 2019.~~

~~(b) A health plan shall respond to a request delivered under section 10 of this chapter as follows:~~

(1) If the request is delivered under section 10(b) of this chapter, the health plan shall immediately send to the requesting health care provider an electronic receipt for the request.

(2) If the request is for an urgent care situation, the health plan shall respond with a prior authorization determination not more than forty-eight (48) hours after receiving the request.

(3) If the request is for a nonurgent care situation, the health plan shall respond with a prior authorization determination not more than five (5) business days after receiving the request.

(c) If a request delivered under section 10 of this chapter is incomplete:

(1) the health plan shall respond within the period required by subsection (b) and indicate the specific additional information required to process the request;

(2) if the request was delivered under section 10(b) of this chapter, upon receiving the response under subdivision (1), the health care provider shall immediately send to the health plan an electronic receipt for the response made under subdivision (1); and

(3) if the request is for an urgent care situation, the health care provider shall respond to the request for additional information not more than forty-eight (48) hours after the health care provider receives the response under subdivision (1).

(d) If a request delivered under section 10 of this chapter is denied, the health plan shall respond within the period required by subsection (b) and indicate the specific reason for the denial in clear and easy to understand language.

SECTION 20. IC 27-1-37.5-12 IS REPEALED [EFFECTIVE JULY 1, 2024]. Sec. 12. (a) This section applies to a claim for a health care service rendered by a participating provider:

(1) for which:

(A) prior authorization is requested after December 31, 2019; and

(B) a health plan gives prior authorization; and

(2) that is rendered in accordance with:

(A) the prior authorization; and

(B) all terms and conditions of the participating provider's agreement or contract with the health plan.

(b) The health plan shall not deny the claim described in subsection (a) unless:

(1) the:

(A) request for prior authorization; or

~~(B) claim;~~
~~contains fraudulent or materially incorrect information; or~~
~~(2) the covered individual is not covered under the health plan on the date on which the health care service is rendered.~~
~~(c) If:~~
~~(1) the claim described in subsection (a) contains an unintentional and inaccurate inconsistency with the request for prior authorization; and~~
~~(2) the inconsistency results in denial of the claim;~~
~~the health care provider may resubmit the claim with accurate, corrected information.~~

SECTION 21. IC 27-1-37.5-13 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 13. (a) This section applies to a claim filed after December 31, 2018, for a medically necessary health care service rendered by a participating provider, the necessity of which:~~
~~(1) is not anticipated at the time prior authorization is obtained for another health care service; and~~
~~(2) is determined at the time the other health care service is rendered.~~
~~(b) The health plan shall not deny a claim described in subsection (a) based solely on lack of prior authorization for the unanticipated health care service.~~
~~(c) The health plan:~~
~~(1) shall not deny payment for a health care service that is rendered in accordance with:~~
~~(A) a prior authorization; and~~
~~(B) all terms and conditions of the participating provider's agreement or contract with the health plan; and~~
~~(2) may:~~
~~(A) require retrospective review of; and~~
~~(B) withhold payment for;~~
~~an unanticipated health care service described in subsection (a).~~

SECTION 22. IC 27-1-37.5-14, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 14. A provision that:
(1) is contained in a policy or contract that is entered into, amended, or renewed after June 30, ~~2018;~~ **2024;** and
(2) contradicts this chapter;
is void.

SECTION 23. IC 27-1-37.5-15, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 15. A violation of this chapter by a ~~health plan~~

utilization review entity is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

SECTION 24. IC 27-1-37.5-16, AS AMENDED BY P.L.265-2019, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 16. (a) Except as provided in subsection (b), the department shall establish, post, and maintain on the department's ~~Internet web site~~ **website** a standardized prior authorization form for use by health care providers and ~~health plans~~ **utilization review entities** for purposes of any notice or authorization required by a ~~health plan~~ **utilization review entity** with respect to payment for a health care service rendered to a covered individual.

(b) After December 31, 2020, a Medicaid managed care organization (as defined in IC 12-7-2-126.9) shall use a standardized prior authorization form prescribed by the office of the secretary of family and social services.

SECTION 25. IC 27-1-37.5-17 IS REPEALED [EFFECTIVE JULY 1, 2024]. ~~Sec. 17. (a) As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation, second opinion, or other clinical information that is directly applicable to the requested service that may be required.~~

~~(b) If a health plan makes an adverse determination on a prior authorization request by a covered individual's health care provider, the health plan must offer the covered individual's health care provider the option to request a peer to peer review by a clinical peer concerning the adverse determination.~~

~~(c) A covered individual's health care provider may request a peer to peer review by a clinical peer either in writing or electronically.~~

~~(d) If a peer to peer review by a clinical peer is requested under this section:~~

~~(1) the health plan's clinical peer and the covered individual's health care provider or the health care provider's designee shall make every effort to provide the peer to peer review not later than seven (7) business days from the date of receipt by the health plan of the request by the covered individual's health care provider for a peer to peer review if the health plan has received the necessary information for the peer to peer review; and~~

~~(2) the health plan must have the peer to peer review conducted between the clinical peer and the covered individual's health care provider or the provider's designee.~~

SECTION 26. IC 27-1-37.5-18 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 18. (a) Except as provided in**

subsection (b), a utilization review entity may only impose prior authorization requirements on less than:

(1) one percent (1%) of any given specialty or health care service; and

(2) one percent (1%) of health care providers overall;

in a calendar year.

(b) A utilization review entity may not require prior authorization for:

(1) a health care service that is part of the usual and customary standard of care;

(2) a prescription drug that is approved by the federal Food and Drug Administration;

(3) medication for opioid use disorder;

(4) pre-hospital transportation; or

(5) the provision of an emergency health care service.

SECTION 27. IC 27-1-37.5-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 19. (a) A utilization review entity shall 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 general public. The prior authorization requirements and restrictions must be described in detail and easily understandable language.**

(b) A utilization review entity may not implement a new prior authorization requirement or restriction or amend an existing requirement or restriction unless:

(1) the utilization review entity's website has been updated to reflect the new or amended requirement or restriction; and

(2) the utilization review entity provides written notice to covered individuals and health care providers at least sixty (60) days before the requirement or restriction is implemented.

(c) A utilization review entity shall 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:

(1) Physician specialty.

(2) Medication or diagnostic test or procedure.

(3) Indication offered.

(4) Reason for denial.

(5) If a decision was appealed.

(6) If a decision was approved or denied on appeal.

(7) The time between submission and the response.

(d) Not later than December 31 of each year, a utilization review entity shall:

(1) prepare a report of the statistics compiled under subsection (c); and

(2) submit the report to the department.

SECTION 28. IC 27-1-37.5-20 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 20. (a) A utilization review entity must ensure that all adverse determinations are made by a physician.**

(b) A physician who makes an adverse determination under subsection (a) must:

(1) possess a current and valid nonrestricted license to practice medicine under IC 25-22.5;

(2) be of the same specialty as the physician who typically:

(A) manages the medical condition or disease; or

(B) provides the health care service;

involved in the prior authorization request;

(3) have experience treating patients with the medical condition or disease for which the health care service is being requested; and

(4) make the adverse determination under the clinical direction of a medical director of the utilization review entity who is:

(A) responsible for the provision of health care services provided to covered individuals; and

(B) a physician licensed under IC 25-22.5.

SECTION 29. IC 27-1-37.5-21 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 21. (a) If a utilization review entity is questioning the medical necessity of a health care service, the utilization review entity must notify the covered individual's physician that medical necessity of the health care service is being questioned.**

(b) Before issuing an adverse determination, the covered individual's physician must have an opportunity to discuss the medical necessity of the health care service on the telephone with the physician who will be responsible for determining prior authorization of the health care service under review.

SECTION 30. IC 27-1-37.5-22 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 22. (a) A utilization review entity must ensure that all appeals are reviewed by a physician.**

(b) A physician who reviews an appeal must:

(1) possess a current and valid nonrestricted license to practice medicine under IC 25-22.5;

(2) be currently in active practice in the same or similar specialty as a physician who typically manages the medical condition or disease involved in the appeal for at least five (5) consecutive years;

(3) be knowledgeable of and have experience providing the health care services under appeal; and

(4) consider all known clinical aspects of the health care service under review, including:

(A) a review of all pertinent medical records provided to the utilization review entity by the covered individual's health care provider;

(B) any relevant records provided to the utilization review entity by a health care facility; and

(C) any medical literature provided to the utilization review entity by the covered individual's health care provider.

(c) An appeal may not be reviewed by a physician who:

(1) is employed by a utilization review entity;

(2) is under contract with a utilization review entity other than to participate in one (1) or more of the utilization review entity's health care provider networks or to perform reviews of appeals;

(3) otherwise has any financial interest in the outcome of the appeal; or

(4) was involved in making the adverse determination.

SECTION 31. IC 27-1-37.5-23 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 23. A physician who:**

(1) makes an adverse determination under section 20 of this chapter; or

(2) reviews an appeal under section 22 of this chapter;

owes a duty to the covered individual to exercise the applicable standard of care.

SECTION 32. IC 27-1-37.5-24 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 24. (a) For the purposes of this**

section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

(b) If a utilization review entity requires prior authorization of a health care service, the utilization review entity must:

(1) make a prior authorization or adverse determination; and

(2) notify the covered individual or covered individual's health care provider of the prior authorization or adverse determination;

not more than forty-eight (48) hours after obtaining all necessary information to make the prior authorization or adverse determination.

(c) A utilization review entity may not:

(1) delay prior authorization; or

(2) issue an adverse determination;

based solely on a typographical, clerical, or spelling error in a request for prior authorization.

SECTION 33. IC 27-1-37.5-25 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 25. If a utilization review entity requires prior authorization of an urgent health care service, the utilization review entity must:**

(1) render prior authorization or an adverse determination concerning the urgent health care service; and

(2) notify the covered individual and the covered individual's health care provider of the prior authorization or adverse determination;

not later than twenty-four (24) hours after receiving all information needed to complete the review of the requested urgent health care service.

SECTION 34. IC 27-1-37.5-26 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 26. (a) A utilization review entity shall allow a covered individual and a covered individual's health care provider a minimum of twenty-four (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 the emergency health care service. If the emergency admission or provision of the emergency health care service occurs on a holiday or weekend, a utilization review entity may not require notification until the next business day after the emergency**

admission or provision of the emergency health care service.

(b) A utilization review entity shall 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 seventy-two (72) hours after a covered individual's emergency admission that the covered individual's condition required the emergency health care service, the certification will create a presumption that the emergency health care service was medically necessary. The presumption may be rebutted only if the utilization review entity can establish, with clear and convincing evidence, that the emergency health care service was not medically necessary.

(c) The medical necessity or appropriateness of an emergency health care service may not be based on whether the service was provided by a participating or nonparticipating provider. Any restriction on the coverage of an emergency health care service provided by a nonparticipating provider may not be greater than the restriction that applies when the service is provided by a participating provider.

(d) If a covered individual receives an emergency health care service that requires immediate postevaluation or poststabilization services, a utilization review entity shall make a prior authorization determination not later than sixty (60) minutes after receiving the prior authorization request. If the prior authorization determination is not made within sixty (60) minutes after receiving the prior authorization request, the health care service shall be deemed approved.

SECTION 35. IC 27-1-37.5-27 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 27. (a) A utilization review entity may not revoke, limit, condition, or restrict an authorization if the health care service is provided not later than forty-five (45) business days after the date the health care provider received the authorization.**

(b) A utilization review entity must pay a health care provider at the contracted payment rate for a health care service provided by the health care provider under an authorization unless:

(1) the health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from the utilization review entity;

(2) the health care service was no longer a covered benefit on the date the health care service was provided;

(3) the health care provider was no longer contracted with the patient's health plan on the date the health care service was provided;

(4) the health care provider failed to meet the utilization review entity's timely filing requirements;

(5) the utilization review entity does not have liability for the claim; or

(6) the patient was no longer covered by a health plan on the date the health care service was provided.

SECTION 36. IC 27-1-37.5-28 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 28. (a) An authorization shall be valid for at least one (1) year after the date the health care provider receives the authorization.**

(b) The authorization period under subsection (a) is effective regardless of any changes in dosage for a prescription drug prescribed by the health care provider.

(c) If a utilization review entity requires prior authorization for a health care service for the treatment of a chronic or long term care condition, an authorization shall remain valid for the length of the treatment. The utilization review entity may not require the covered individual to obtain prior authorization again for the health care service.

SECTION 37. IC 27-1-37.5-29 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 29. (a) On receipt of information documenting an authorization from a covered individual or a covered individual's health care provider, a utilization review entity shall honor an authorization granted to a covered individual from a previous utilization review entity for at least the initial ninety (90) days of a covered individual's coverage under a new health plan.**

(b) During the time period described in subsection (a), a utilization review entity may perform its own review of the prior authorization request.

(c) If there is a change in:

(1) coverage of; or

(2) approval criteria for;

a previously authorized health care service, the change in coverage or approval criteria may not affect a covered individual who

received authorization before the effective date of the change for the remainder of the plan year.

(d) A utilization review entity shall continue to honor an authorization that the utilization review entity granted to a covered individual when the covered individual changes products under the same health insurance company.

SECTION 38. IC 27-1-37.5-30 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 30. (a) A utilization review entity may not require a health care provider to complete prior authorization for a health care service in order for a covered individual to receive coverage if in the most recent twelve (12) month period the utilization review entity has approved or would have approved at least eighty percent (80%) of the prior authorization requests submitted by the health care provider for that health care service.**

(b) A utilization review entity may evaluate whether a health care provider continues to qualify for an exemption described in subsection (a) not more than once every twelve (12) months.

(c) A health care provider is not required to request an exemption in order to qualify for an exemption.

(d) A health care provider who does not receive an exemption may request from the utilization review entity, at any time but not more than once per year per health care service, evidence to support the utilization review entity's decision. A health care provider may appeal a utilization review entity's decision to deny an exemption.

(e) A utilization review entity may only revoke an exemption at the end of the twelve (12) month period if the utilization review entity:

(1) makes a determination that the health care provider would not have met the approval criteria under subsection (a) based on a retrospective review of the claims for the particular service for which the exemption applies for:

(A) the previous three (3) months; or

(B) a longer period if needed to reach at least ten (10) claims;

(2) provides the health care provider with the information it relied upon in making the determination to revoke the exemption; and

(3) provides the health care provider a plain language explanation of how to appeal the decision.

(f) An exemption remains in effect until:

(1) thirty (30) days after the date the utilization review entity notifies the health care provider of its determination to revoke the exemption; or

(2) if the health care provider appeals the determination, five (5) days after the revocation is upheld on appeal.

(g) A determination to revoke or deny an exemption must be made by a health care provider who:

(1) is in the same or similar specialty as the health care provider being considered for the exemption; and

(2) has experience in providing the service for which the potential exemption applies.

(h) A utilization review entity must provide a health care provider that receives an exemption with a notice that includes the following:

(1) A statement that the health care provider qualifies for an exemption from prior authorization requirements.

(2) A list of services for which the exemption applies.

(3) A statement of the duration of the exemption.

(i) A utilization review entity may not deny or reduce payment for a health care service exempted from a prior authorization requirement under this section, including a health care service performed or supervised by another health care provider when the health care provider who ordered the service received an exemption, unless the rendering health care provider:

(1) knowingly and materially misrepresented the health care service in a request for payment submitted to the utilization review entity with the specific intent to deceive and obtain an unlawful payment from the utilization review entity; or

(2) failed to substantially perform the health care service.

(j) This section does not:

(1) require a utilization review entity to evaluate an existing exemption; or

(2) preclude a utilization review entity from establishing a longer exemption period.

SECTION 39. IC 27-1-37.5-31 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 31. If a utilization review entity fails to comply with the deadlines or other requirements under this chapter, the health care service subject to prior authorization shall be automatically deemed authorized by the utilization review entity.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 3, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill DO PASS.

(Reference is to SB 03 as introduced.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 10, Nays 0

REPORT OF THE PRESIDENT
PRO TEMPORE

Madam President: Pursuant to Senate Rule 68(b), I hereby report that, subsequent to the adoption of the Committee Report on January 18, 2024, Senate Bill 3 was reassigned to the Committee on Appropriations.

BRAY