First Regular Session of the 123rd General Assembly (2023)

SENATE ENROLLED ACT No. 400

AN ACT to amend the Indiana Code concerning health.

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

SECTION 1. IC 5-10-8-26 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 26. (a) As used in this section, "state employee health plan" means a:**

(1) self-insurance program established under section 7(b) of this chapter; or

(2) contract with a prepaid health care delivery plan entered into under section 7(c) of this chapter;

to provide group health coverage for state employees.

(b) As used in this section, "wearable cardioverter defibrillator" means a device that:

(1) is worn externally on an individual's body;

(2) continually monitors and analyzes the individual's heart rhythm; and

(3) delivers a shock to the heart when an abnormal heart rhythm is detected.

(c) A state employee health plan must provide coverage for wearable cardioverter defibrillators, including the cost of the wearable cardioverter defibrillator, any necessary accessory, and ongoing monitoring services.

(d) The coverage required under subsection (c) must be in

accordance with a:

(1) local coverage determination; or

(2) national coverage determination;

as defined in 42 U.S.C. 1395ff(f) for Medicare purposes.

(e) The coverage required under this section may not be subject to an annual or lifetime limitation.

SECTION 2. IC 12-15-11-5, AS AMENDED BY P.L.195-2018, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 5. ~~(a)~~ A provider who participates in the Medicaid program must comply with the enrollment requirements that are established under rules adopted under IC 4-22-2 by the secretary.

~~(b) A provider who participates in the Medicaid program may be required to use the centralized credentials verification organization established in section 9 of this chapter.~~

SECTION 3. IC 12-15-11-9, AS AMENDED BY P.L.32-2021, SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2024]: Sec. 9. ~~(a) The office shall implement a centralized credentials verification organization and credentialing process that:~~

~~(1) uses a common application, as determined by provider type;~~

~~(2) issues a single credentialing decision applicable to all Medicaid programs, except as determined by the office;~~

~~(3) recredentials and revalidates provider information not less than once every three (3) years;~~

~~(4) requires attestation of enrollment and credentialing information every six (6) months; and~~

~~(5) is certificated or accredited by the National Committee for Quality Assurance or its successor organization.~~

(a) As used in this section, "clean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) does not contain an error; and

(3) may be processed by the managed care organization or contractor of the office without returning the application to the provider for a revision or clarification.

(b) As used in this section, "credentialing" means a process by which a managed care organization or contractor of the office makes a determination that:

(1) is based on criteria established by the managed care organization or contractor of the office; and

(2) concerns whether a provider is eligible to:

(A) provide health services to an individual eligible for

Medicaid services; and

(B) receive reimbursement for the health services;

under an agreement that is entered into between the provider and managed care organization or contractor of the office.

(c) As used in this section, "unclean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) contains at least one (1) error; and

(3) must be returned to the provider to correct the error.

(d) This section applies to a managed care organization or contractor of the office.

(e) If the office or managed care organization issues a provisional credential to a provider under subsection (j), the office or managed care organization shall:

(1) issue a final credentialing determination not later than sixty (60) calendar days after the date in which the provider was provisionally credentialed; and

(2) except as provided in subsection (l), provide retroactive reimbursement under subsection (k).

(f) The office shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare in electronic or paper format, which must be used by:

(1) a provider who applies for credentialing by a managed care organization or contractor of the office; and

(2) a managed care organization or contractor of the office that performs credentialing activities.

(g) A managed care organization or contractor of the office shall notify a provider concerning a deficiency on a completed unclean credentialing application form submitted by the provider not later than five (5) business days after the entity receives the completed unclean credentialing application form. A notice described in this subsection must:

(1) provide a description of the deficiency; and

(2) state the reason why the application was determined to be an unclean credentialing application.

(h) A provider shall respond to the notification required under subsection (g) not later than five (5) business days after receipt of the notice.

(i) A managed care organization or contractor of the office shall notify a provider concerning the status of the provider's completed clean credentialing application when:

(1) the provider is provisionally credentialed; and

(2) the entity makes a final credentialing determination concerning the provider.

(j) If the managed care organization or contractor of the office fails to issue a credentialing determination within fifteen (15) days after receiving a completed clean credentialing application form from a provider, the managed care organization or contractor of the office shall provisionally credential the provider in accordance with the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization. The provisional credentialing license is valid until a determination is made on the credentialing application of the provider.

(k) Once a managed care organization or contractor of the office fully credentials a provider that holds provisional credentialing and a network provider agreement has been executed, then reimbursement payments under the contract shall be paid retroactive to the date the provider was provisionally credentialed. The managed care organization or contractor of the office shall reimburse the provider at the rates determined by the contract between the provider and the:

(1) managed care organization; or

(2) contractor of the office.

(l) If a managed care organization or contractor of the office does not fully credential a provider that is provisionally credentialed under subsection (j), the provisional credentialing is terminated on the date the managed care organization or contractor of the office notifies the provider of the adverse credentialing determination. The managed care organization or contractor of the office is not required to reimburse for services rendered while the provider was provisionally credentialed.

~~(b)~~ **(m)** A managed care organization or contractor of the office may not require additional credentialing requirements in order to participate in a managed care organization's network. However, a contractor may collect additional information from the provider in order to complete a contract or provider agreement.

~~(c)~~ **(n)** A managed care organization or contractor of the office is not required to contract with a provider.

~~(d)~~ **(o)** A managed care organization or contractor of the office shall:

(1) send representatives to meetings and participate in the credentialing process as determined by the office; and

(2) not require additional credentialing information from a provider if a non-network credentialed provider is used.

~~(e)~~ **(p)** Except when a provider is no longer enrolled with the office, a credential acquired under this chapter is valid until recredentialing is required.

~~(f)~~ **(q)** An adverse action under this section is subject to IC 4-21.5.

~~(g)~~ **(r)** The office may adopt rules under IC 4-22-2 to implement this section.

SECTION 4. IC 16-21-1-7.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 7.1. (a) A hospital's quality assessment and improvement program under 410 IAC 15-1.4-2 must include a process for determining and reporting the occurrence of serious reportable events, as identified by the National Quality Forum.**

(b) The executive board may not require a hospital's quality assessment and improvement program to determine and report any other types of events that are not described in subsection (a).

(c) The executive board may adopt rules under IC 4-22-2 to implement this section.

SECTION 5. IC 16-21-1-7.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 7.2. (a) The medical staff (as described in IC 16-21-2-7) may make recommendations on the granting of clinical privileges or the appointment or reappointment of an applicant to the governing board of the hospital for a period not to exceed thirty-six (36) months.**

(b) The executive board may adopt rules under IC 4-22-2 to implement this section.

SECTION 6. IC 16-21-2-14.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 14.5. A hospital with an emergency department must have at least one (1) physician on site and on duty who is responsible for the emergency department at all times the emergency department is open.**

SECTION 7. IC 25-1-8-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 9. (a) The legislative services agency shall conduct an analysis of the fees established under section 2 of this chapter.**

(b) Not later than January 31, 2026, the legislative services agency shall submit a report to the budget committee in an electronic format under IC 5-14-6 containing the results of the analysis conducted under subsection (a). The report must include:

(1) the amount of fees collected; and

(2) a description of how the proceeds from the collected fees

were used;

during the two (2) most recent fiscal years.

(c) This section expires July 1, 2026.

SECTION 8. IC 25-1-9-23, AS AMENDED BY P.L.165-2022, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 23. (a) This section does not apply to emergency services.

(b) As used in this section, "covered individual" means an individual who is entitled to be provided health care services at a cost established according to a network plan.

(c) As used in this section, "emergency services" means services that are:

(1) furnished by a provider qualified to furnish emergency services; and

(2) needed to evaluate or stabilize an emergency medical condition.

(d) As used in this section, "in network practitioner" means a practitioner who is required under a network plan to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

(e) As used in this section, "network plan" means a plan under which facilities and practitioners are required by contract to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

(f) As used in this section, "out of network" means that the health care services provided by the practitioner to a covered individual are not subject to the covered individual's health carrier network plan.

(g) As used in this section, "practitioner" means the following:

(1) An individual who holds:

(A) an unlimited license, certificate, or registration;

(B) a limited or probationary license, certificate, or registration;

(C) a temporary license, certificate, registration, or permit;

(D) an intern permit; or

(E) a provisional license;

issued by the board (as defined in IC 25-0.5-11-1) regulating the profession in question.

(2) An entity that:

(A) is owned by, or employs; or

(B) performs billing for professional health care services rendered by;

an individual described in subdivision (1).

The term does not include a dentist licensed under IC 25-14, an optometrist licensed under IC 25-24, or a provider facility (as defined in IC 25-1-9.8-10).

(h) An in network practitioner who provides covered health care services to a covered individual may not charge more for the covered health care services than allowed according to the rate or amount of compensation established by the individual's network plan.

(i) An out of network practitioner who provides health care services at an in network facility to a covered individual may not be reimbursed more for the health care services than allowed according to the rate or amount of compensation established by the covered individual's network plan unless all of the following conditions are met:

(1) At least five (5) business days before the health care services are scheduled to be provided to the covered individual, the practitioner provides to the covered individual, on a form separate from any other form provided to the covered individual by the practitioner, a statement in conspicuous type that meets the following requirements:

(A) Includes a notice reading substantially as follows: "[Name of practitioner] is an out of network practitioner providing [type of care] with [name of in network facility], which is an in network provider facility within your health carrier's plan. [Name of practitioner] will not be allowed to bill you the difference between the price charged by the practitioner and the rate your health carrier will reimburse for the services during your care at [name of in network facility] unless you give your written consent to the charge.".

(B) Sets forth the practitioner's good faith estimate of the amount that the practitioner intends to charge for the health care services provided to the covered individual.

(C) Includes a notice reading substantially as follows concerning the good faith estimate set forth under clause (B): "The estimate of our intended charge for [name or description of health care services] set forth in this statement is provided in good faith and is our best estimate of the amount we will charge. If our actual charge for [name or description of health care services] exceeds our estimate by the greater of:

(i) one hundred dollars ($100); or

(ii) five percent (5%);

we will explain to you why the charge exceeds the estimate.".

(2) The covered individual signs the statement provided under subdivision (1), signifying the covered individual's consent to the

charge for the health care services being greater than allowed according to the rate or amount of compensation established by the network plan.

(j) If an out of network practitioner does not meet the requirements of subsection (i), the out of network practitioner shall include on any bill remitted to a covered individual a written statement in conspicuous type stating that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan plus any required copayment, deductible, or coinsurance.

(k) If a covered individual's network plan remits reimbursement to the covered individual for health care services subject to the reimbursement limitation of subsection (i), the network plan shall provide with the reimbursement a written statement in conspicuous type that states that the covered individual is not responsible for more than the rate or amount of compensation established by the covered individual's network plan and that is included in the reimbursement plus any required copayment, deductible, or coinsurance.

(l) If the charge of a practitioner for health care services provided to a covered individual exceeds the estimate provided to the covered individual under subsection (i)(1)(B) by the greater of:

(1) one hundred dollars ($100); or

(2) five percent (5%);

the facility or practitioner shall explain in a writing provided to the covered individual why the charge exceeds the estimate.

(m) An in network practitioner is not required to provide a covered individual with the good faith estimate if the nonemergency health care service is scheduled to be performed by the practitioner within five (5) business days after the health care service is ordered.

(n) The department of insurance shall adopt emergency rules under IC 4-22-2-37.1 to specify the requirements of the notifications set forth in subsections (j) and (k).

(o) ~~A practitioner may satisfy~~ The requirements of this section ~~by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.~~ **do not apply to a practitioner who:**

(1) is required to comply with; and

(2) is in compliance with;

45 CFR Part 149, Subparts E and G, as may be enforced and amended by the federal Department of Health and Human Services.

SECTION 9. IC 25-1-9.8-20, AS ADDED BY P.L.165-2022,

SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 20. ~~A practitioner may satisfy~~ The requirements of this chapter ~~by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.~~ **do not apply to a practitioner who:**

(1) is required to comply with; and

(2) is in compliance with;

45 CFR Part 149, Subparts E and G, as may be enforced and amended by the federal Department of Health and Human Services.

SECTION 10. IC 25-27.5-6-1, AS AMENDED BY P.L.247-2019, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 1. (a) Collaboration by the collaborating physician or the physician designee must be continuous but does not require the physical presence of the collaborating physician at the time and the place that the services are rendered.

(b) A collaborating physician or physician designee shall review patient encounters not later than ten (10) business days, and within a reasonable time, as established in the collaborative agreement, after the physician assistant has seen the patient, that is appropriate for the maintenance of quality medical care.

(c) The collaborating physician or physician designee shall review within a reasonable time that is not later than ten (10) business days after a patient encounter, that is appropriate for the maintenance of quality medical care, at least the following percentages of the patient charts:

(1) For the first year in which a physician assistant obtains authority to prescribe, at least ten percent (10%) of the patient's records for any prescription prescribed or administered by the physician assistant.

(2) For each subsequent year of practice of the physician assistant, the percentage of charts that the collaborating physician or physician designee determines to be reasonable for the particular practice setting and level of experience of the physician assistant, as stated in the collaborative agreement, that is appropriate for the maintenance of quality medical care.

(d) Subject to subsection (c), but notwithstanding any other provision of this section, when a physician assistant performs an annual wellness visit, gathers patient information, or performs a health evaluation, including diagnostic screening, during an in-home evaluation that does not involve providing direct treatment or the prescribing of medication, the collaborating

physician or physician designee shall review the patient encounter within fourteen (14) business days after the action.

SECTION 11. IC 27-1-3-19 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 19. (a) Whenever the commissioner determines that any insurance company to which this article is applicable:

(1) is conducting its business contrary to law or in an unsafe or unauthorized manner;

(2) has had its capital or surplus fund impaired or reduced below the amount required by law; or

(3) has failed, neglected, or refused to observe and comply with any **law,** order, or rule of the department or commissioner;

then the commissioner may, by an order in writing addressed to the board of directors, board of trustees, attorney in fact, partners, or owners of or in any such insurance company, to direct the discontinuance of any such illegal, unauthorized, or unsafe practice, the restoration of an impairment to the capital or the surplus fund, or the compliance with any such law, order, or rule of the department or commissioner. The order shall be mailed to the last known principal office of the insurance company by certified or registered mail or delivered to an officer of the company and shall be considered to be received by the insurance company three (3) days after mailing or on the date of delivery.

(b) If the insurance company fails, neglects, or refuses to comply with the terms of that order within thirty (30) days after its receipt by the insurance company, or within a shorter period set out in the order if the commissioner determines that an emergency exists, the commissioner may, in addition to any other remedy conferred upon the department or the commissioner by law, bring an action against any such insurance company, its officers, and agents to compel that compliance.

(c) The action shall be brought by the commissioner in the Marion County circuit court. The action shall be commenced and prosecuted in accordance with the Indiana Rules of Trial Procedure, and relief for noncompliance of the order includes any remedy appropriate under the facts, including injunction, preliminary injunction, and temporary restraining order. In that action, a change of venue from the judge, but no change of venue from the county, is permitted.

SECTION 12. IC 27-1-3.5-6.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 6.2. (a) As used in this section, "domestic stock insurer" means a person that:**

(1) provides coverage under a health plan (as defined in IC 27-1-48-4);

(2) is organized under the insurance laws of this state; and

(3) is a publicly traded stock corporation.

(b) A domestic stock insurer shall file the following with the department:

(1) Not later than March 1 of each calendar year, the domestic stock insurer's annual financial statement from the previous calendar year.

(2) Not later than May 15 of each calendar year, the domestic stock insurer's first quarter financial statement from the current calendar year.

(3) Not later than August 15 of each calendar year, the domestic stock insurer's second quarter financial statement from the current calendar year.

(4) Not later than November 15 of each calendar year, the domestic stock insurer's third quarter financial statement from the current calendar year.

(c) The department must post the information filed under subsection (b) on the department's website on a single and easily accessible web page not later than ten (10) business days after receiving the information.

SECTION 13. IC 27-1-37.5-1, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 1. (a) Except as provided in sections 10, 11, 12, ~~and~~ 13, **and 13.5** of this chapter, this chapter applies beginning September 1, 2018.

(b) 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) 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 14. IC 27-1-37.5-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 1.5. As used in this chapter, "adverse determination" means a denial of a request for benefits on the grounds that the health service or item:**

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

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

(3) is experimental or investigational.

SECTION 15. IC 27-1-37.5-1.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **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 16. IC 27-1-37.5-11, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: 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 ~~seventy-two (72)~~ **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 ~~seven (7)~~ **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 ~~seventy-two (72)~~ **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 17. IC 27-1-37.5-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 13.5. (a) This section applies only to the state employee health plan (as defined in IC 5-10-8-6.7(a)).**

(b) The state employee health plan may not require a participating provider to obtain prior authorization for the following CPT codes:

(1) 11200.
(2) 11201.
(3) 17311.
(4) 17312.
(5) 17313.
(6) 17314.
(7) 44140.
(8) 44160.
(9) 44970.
(10) 49505.
(11) 70450.
(12) 70551.
(13) 70552.
(14) 70553.
(15) 71250.
(16) 71260.
(17) 71275.
(18) 72141.
(19) 72148.
(20) 72158.
(21) 73221.
(22) 73721.
(23) 74150.
(24) 74160.
(25) 74176.
(26) 74177.
(27) 74178.
(28) 74179.
(29) 74181.
(30) 74183.
(31) 78452.
(32) 92507.

(33) 92526.
(34) 92609.
(35) 93303.
(36) 93306.
(37) 95044.
(38) 95806.
(39) 95810.
(40) 97110.
(41) 97112.
(42) 97116.
(43) 97129.
(44) 97130.
(45) 97140.
(46) 97530.
(47) V5010.
(48) V5256.
(49) V5261.
(50) V5275.

(c) The state employee health plan may not issue a retroactive denial for medical necessity for a CPT code listed in subsection (b).

(d) Before November 1, 2025, the:

(1) interim study committee on public health, behavioral health, and human services; and

(2) interim study committee on financial institutions and insurance;

shall jointly review the impact of this section, including any relief on the administrative burdens to participating providers and any differences in utilization of the CPT codes listed in subsection (b).

(e) This section expires June 30, 2026.

SECTION 18. IC 27-1-37.5-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **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 19. IC 27-1-44.5-2, AS AMENDED BY P.L.165-2022, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 2. As used in this chapter, "health payer" includes the following:

(1) Medicare.

(2) Medicaid or a managed care organization (as defined in IC 12-7-2-126.9) that has contracted with Medicaid to provide services to a Medicaid recipient.

(3) An insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1), except for the following types of coverage:

(A) Accident only, credit, dental, vision, long term care, or disability income insurance.

(B) Coverage issued as a supplement to liability insurance.

(C) Automobile medical payment insurance.

(D) A specified disease policy.

(E) A policy that provides indemnity benefits not based on any expense incurred requirements, including a plan that provides coverage for:

(i) hospital confinement, critical illness, or intensive care; or

(ii) gaps for deductibles or copayments.

(F) Worker's compensation or similar insurance.

(G) A student health plan.

(H) A supplemental plan that always pays in addition to other coverage.

(4) A health maintenance organization (as defined in IC 27-13-1-19).

(5) A pharmacy benefit manager (as defined in IC 27-1-24.5-12).

(6) An administrator (as defined in IC 27-1-25-1).

(7) A multiple employer welfare arrangement (as defined in IC 27-1-34-1).

(8) An employee benefit plan that is subject to the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), including a third party administrator of an employee benefit plan.

(9) A state employee health plan (as defined in IC 5-10-8-6.7(a)).

~~(8)~~ **(10)** Any other person identified by the commissioner for participation in the data base described in this chapter.

SECTION 20. IC 27-1-44.5-5, AS AMENDED BY P.L.195-2021, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 5. ~~(a)~~ A health payer shall begin submitting the required data in a format specified by the administrator of the data base not later than three (3) months from the first day the department declares the data base to be fully operational.

~~(b) An employer may opt-in to share claims data with the data base.~~

~~(c) The state, the Indiana Medicaid state plan, and Medicaid managed care entities must submit data for the data base.~~

SECTION 21. IC 27-1-44.5-11, AS ADDED BY P.L.195-2021, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 11. (a) The department shall adopt emergency rules under IC 4-22-2-37.1 to implement this chapter. The rules must include a requirement that health payer data sources submit necessary information to the administrator. Rules enacted under this subsection must cover all health payer data sources as follows:

(1) The department shall adopt rules that apply to health payers regulated under IC 27.

(2) The office of the secretary of family and social services shall adopt rules that apply to health payers regulated under IC 12.

(b) The department shall adopt emergency rules under IC 4-22-2-37.1 establishing a fee formula for data licensing and the collection and release of claims data.

(c) The department may adopt rules under IC 4-22-2 concerning the:

(1) requirement that health payers submit required data under section 5 of this chapter; and

(2) establishment of a fee formula for data licensing, collection, and release of claims described in section 9 of this chapter.

~~(c)~~ **(d)** The department may impose a civil penalty on a health payer that is required to submit information under this chapter and fails to comply. A civil penalty collected under this section must be deposited in the department of insurance fund created by IC 27-1-3-28.

SECTION 22. IC 27-1-45-10, AS ADDED BY P.L.165-2022, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 10. ~~A facility or a practitioner may satisfy~~ The requirements of this chapter ~~by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.~~ **do not apply to a facility or practitioner that:**

(1) is required to comply with; and

(2) is in compliance with;

45 CFR Part 149, Subparts E and G, as may be enforced and amended by the federal Department of Health and Human Services.

SECTION 23. IC 27-1-46-18, AS ADDED BY P.L.165-2022, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 18. ~~A provider facility may satisfy~~ The requirements of this chapter ~~by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.~~ **do not apply to a facility or practitioner that:**

(1) is required to comply with; and

(2) is in compliance with;

45 CFR Part 149, Subparts E and G, as may be enforced and amended by the federal Department of Health and Human Services.

SECTION 24. IC 27-1-48 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 48. Health Plan Notices

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health plan.

Sec. 2. As used in this chapter, "CPT code" refers to the medical billing code that applies to a specific health care service, as published in the Current Procedural Terminology code set maintained by the American Medical Association.

Sec. 3. (a) As used in this chapter, "health care service" means a health care related service or product rendered or sold by a health care provider within the scope of the health care provider's license or legal authorization, 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.

Sec. 4. (a) As used in this chapter, "health plan" means any of the following that provides coverage for health care services:

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(3) The Medicaid risk based managed care program under IC 12-15.

(b) The term includes a person that administers any of the following:

(1) A policy described in subsection (a)(1).

(2) A contract described in subsection (a)(2).

(3) Medicaid risk based managed care.

Sec. 5. As used in this chapter, "participating provider" refers to the following:

(1) A health care provider that has entered into an agreement with an insurer under IC 27-8-11-3.

(2) A participating provider (as defined in IC 27-13-1-24).

Sec. 6. 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.

Sec. 7. A health plan must:

(1) offer an alternative method for submission of a claim for when the health plan has technical difficulties with the health plan's claims submission system; and

(2) post notice of the alternative method for claims submission on the health plan's website.

Sec. 8. (a) Not later than February 1 of each calendar year, a health plan must post on the health plan's website:

(1) the thirty (30) most frequently submitted CPT codes that

were submitted by participating providers for prior authorization during the previous calendar year; and

(2) the percentage of the thirty (30) most frequently submitted CPT codes that were approved in the previous calendar year, disaggregated by CPT code.

(b) A health plan must maintain the information required under subsection (a) on the health plan's website, organized by year and on a single and easily accessible web page.

SECTION 25. IC 27-8-5-1.5, AS AMENDED BY P.L.124-2018, SECTION 76, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 1.5. (a) This section applies to a policy of accident and sickness insurance issued on an individual, a group, a franchise, or a blanket basis, including a policy issued by an assessment company or a fraternal benefit society.

(b) As used in this section, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(c) As used in this section, "grossly inadequate filing" means a policy form filing:

(1) that fails to provide key information, including state specific information, regarding a product, policy, or rate; or

(2) that demonstrates an insufficient understanding of applicable legal requirements.

(d) As used in this section, "policy form" means a policy, a contract, a certificate, a rider, an endorsement, an evidence of coverage, or any amendment that is required by law to be filed with the commissioner for approval before use in Indiana.

(e) As used in this section, "type of insurance" refers to a type of coverage listed on the National Association of Insurance Commissioners Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix under the heading "Continuing Care Retirement Communities", "Health", "Long Term Care", or "Medicare Supplement".

(f) Each person having a role in the filing process described in subsection (i) shall act in good faith and with due diligence in the performance of the person's duties.

(g) A policy form, including a policy form of a policy, contract, certificate, rider, endorsement, evidence of coverage, or amendment that is issued through a health benefit exchange (as defined in IC 27-19-2-8), may not be issued or delivered in Indiana unless the policy form has been filed with and approved by the commissioner.

(h) The commissioner shall do the following:

(1) Create a document containing a list of all product filing

requirements for each type of insurance, with appropriate citations to the law, administrative rule, or bulletin that specifies the requirement, including the citation for the type of insurance to which the requirement applies.

(2) Make the document described in subdivision (1) available on the department of insurance Internet site.

(3) Update the document described in subdivision (1) at least annually and not more than thirty (30) days following any change in a filing requirement.

(i) The filing process is as follows:

(1) A filer shall submit a policy form filing that:

(A) includes a copy of the document described in subsection (h);

(B) indicates the location within the policy form or supplement that relates to each requirement contained in the document described in subsection (h); and

(C) certifies that the policy form meets all requirements of state law.

(2) The commissioner shall review a policy form filing and, not more than thirty (30) days after the commissioner receives the filing under subdivision (1):

(A) approve the filing; or

(B) provide written notice of a determination:

(i) that deficiencies exist in the filing; or

(ii) that the commissioner disapproves the filing.

A written notice provided by the commissioner under clause (B) must be based only on the requirements set forth in the document described in subsection (h) and must cite the specific requirements not met by the filing. A written notice provided by the commissioner under clause (B)(i) must state the reasons for the commissioner's determination in sufficient detail to enable the filer to bring the policy form into compliance with the requirements not met by the filing.

(3) A filer may resubmit a policy form that:

(A) was determined deficient under subdivision (2) and has been amended to correct the deficiencies; or

(B) was disapproved under subdivision (2) and has been revised.

A policy form resubmitted under this subdivision must meet the requirements set forth as described in subdivision (1) and must be resubmitted not more than thirty (30) days after the filer receives the commissioner's written notice of deficiency or disapproval. If

a policy form is not resubmitted within thirty (30) days after receipt of the written notice, the commissioner's determination regarding the policy form is final.

(4) The commissioner shall review a policy form filing resubmitted under subdivision (3) and, not more than thirty (30) days after the commissioner receives the resubmission:

(A) approve the resubmitted policy form; or

(B) provide written notice that the commissioner disapproves the resubmitted policy form.

A written notice of disapproval provided by the commissioner under clause (B) must be based only on the requirements set forth in the document described in subsection (h), must cite the specific requirements not met by the filing, and must state the reasons for the commissioner's determination in detail. The commissioner's approval or disapproval of a resubmitted policy form under this subdivision is final, except that the commissioner may allow the filer to resubmit a further revised policy form if the filer, in the filer's resubmission under subdivision (3), introduced new provisions or materially modified a substantive provision of the policy form. If the commissioner allows a filer to resubmit a further revised policy form under this subdivision, the filer must resubmit the further revised policy form not more than thirty (30) days after the filer receives notice under clause (B), and the commissioner shall issue a final determination on the further revised policy form not more than thirty (30) days after the commissioner receives the further revised policy form.

(5) If the commissioner disapproves a policy form filing under this subsection, the commissioner shall notify the filer, in writing, of the filer's right to a hearing as described in subsection ~~(m).~~ **(r).** A disapproved policy form filing may not be used for a policy of accident and sickness insurance unless the disapproval is overturned in a hearing conducted under this subsection.

(6) If the commissioner does not take any action on a policy form that is filed or resubmitted under this subsection in accordance with any applicable period specified in subdivision (2), (3), or (4), the policy form filing is considered to be approved.

(j) Except as provided in this subsection, the commissioner may not disapprove a policy form resubmitted under subsection (i)(3) or (i)(4) for a reason other than a reason specified in the original notice of determination under subsection (i)(2)(B). The commissioner may disapprove a resubmitted policy form for a reason other than a reason specified in the original notice of determination under subsection (i)(2)

if:

(1) the filer has introduced a new provision in the resubmission;

(2) the filer has materially modified a substantive provision of the policy form in the resubmission;

(3) there has been a change in requirements applying to the policy form; or

(4) there has been reviewer error and the written disapproval fails to state a specific requirement with which the policy form does not comply.

(k) The commissioner may return a grossly inadequate filing to the filer without triggering a deadline set forth in this section.

(l) The commissioner may disapprove a policy form if:

(1) the benefits provided under the policy form are not reasonable in relation to the premium charged; or

(2) the policy form contains provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.

(m) Before approving or disapproving a premium rate increase or decrease, the commissioner shall consider the following:

(1) The products affected, by line of business.

(2) The number of covered lives affected.

(3) Whether the product is open or closed to new members in the product block.

(4) Applicable median cost sharing for the product, as allowed by state or federal law.

(5) The benefits provided and the underlying costs of the health services rendered.

(6) The implementation date of the increase or decrease.

(7) The overall percent premium rate increase or decrease that is requested.

(8) The actual percent premium rate increase or decrease to be approved.

(9) Incurred claims paid each year for the past three (3) years, if applicable.

(10) Earned premiums for each of the past three (3) years, if applicable.

(11) 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.

(12) 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).

(13) 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.

(n) The commissioner shall not approve a new product unless the commissioner has, at a minimum, considered the matters set forth in subsection (m)(1) through (m)(13).

(o) The information compiled, prepared, and considered by the commissioner under subsection (m)(1) through (m)(13) is subject to the requirements of IC 5-14-3. However, the commissioner's approval of a new product or a rate increase or decrease may take effect before the information compiled, prepared, and considered by the commissioner under subsection (m)(1) through (m)(13) is made accessible to the public under IC 5-14-3.

(p) 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.

(q) To the extent authorized by the Patient Protection and Affordable Care Act and other federal law, the commissioner, under this section, may:

(1) consider network adequacy;

(2) conduct form review to ensure:

(A) minimum essential health benefits; and

(B) nondiscriminatory benefit design;

(3) perform accreditation confirmation; and

(4) confirm quality measures.

~~(m)~~ **(r)** Upon disapproval of a filing under this section, the commissioner shall provide written notice to the filer or insurer of the right to a hearing within twenty (20) days of a request for a hearing.

~~(n)~~ **(s)** Unless a policy form approved under this chapter contains a material error or omission, the commissioner may not:

(1) retroactively disapprove the policy form; or

(2) examine the filer of the policy form during a routine or targeted market conduct examination for compliance with a policy form filing requirement that was not in existence at the time the policy form was filed.

SECTION 26. IC 27-8-5.7-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 2.5. As used in this chapter, "CPT code" refers to the medical billing code that applies to a specific**

health care service, as published in the Current Procedural Terminology code set maintained by the American Medical Association.

SECTION 27. IC 27-8-5.7-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 5. (a) An insurer shall pay or deny each clean claim in accordance with ~~section~~ **sections** 6 **and 6.5** of this chapter.

(b) An insurer shall notify a provider of any deficiencies in a submitted claim not more than:

(1) thirty (30) days for a claim that is filed electronically; or

(2) forty-five (45) days for a claim that is filed on paper;

and describe any remedy necessary to establish a clean claim.

(c) Failure of an insurer to notify a provider as required under subsection (b) establishes the submitted claim as a clean claim.

SECTION 28. IC 27-8-5.7-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 6.5. (a) An insurer may not alter the CPT code submitted for a clean claim or pay for a CPT code of lesser monetary value unless:**

(1) the CPT code submitted is not in accordance with correct coding guidelines and rules, clinical care guidelines, or the terms and conditions of the participating provider's agreement or contract with the insurer; or

(2) the medical record of the clean claim has been reviewed by an employee or contractor of the insurer.

(b) An insurer may not alter a clean claim to only pay for the CPT codes necessary for an individual's final diagnosis, if the CPT codes billed were deemed medically necessary according to generally accepted clinical care guidelines to reach the final diagnosis.

(c) This section does not prohibit a provider from appealing a claim.

SECTION 29. IC 27-8-11-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 3. (a) An insurer may:

(1) enter into agreements with providers relating to terms and conditions of reimbursement for health care services that may be rendered to insureds of the insurer, including agreements relating to the amounts to be charged the insured for services rendered or the terms and conditions for activities intended to reduce inappropriate care;

(2) issue or administer policies in this state that include incentives for the insured to utilize the services of a provider that has entered

into an agreement with the insurer under subdivision (1); and

(3) issue or administer policies in this state that provide for reimbursement for expenses of health care services only if the services have been rendered by a provider that has entered into an agreement with the insurer under subdivision (1).

(b) Before entering into any agreement under subsection (a)(1), an insurer shall establish terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1). These terms and conditions may not discriminate unreasonably against or among providers. For the purposes of this subsection, neither differences in prices among hospitals or other institutional providers produced by a process of individual negotiation nor price differences among other providers in different geographical areas or different specialties constitutes unreasonable discrimination. Upon request by a provider seeking to enter into an agreement with an insurer under subsection (a)(1), the insurer shall make available to the provider a written statement of the terms and conditions that must be met by providers wishing to enter into an agreement with the insurer under subsection (a)(1).

(c) No hospital, physician, pharmacist, or other provider designated in IC 27-8-6-1 willing to meet the terms and conditions of agreements described in this section may be denied the right to enter into an agreement under subsection (a)(1). When an insurer denies a provider the right to enter into an agreement with the insurer under subsection (a)(1) on the grounds that the provider does not satisfy the terms and conditions established by the insurer for providers entering into agreements with the insurer, the insurer shall provide the provider with a written notice that:

(1) explains the basis of the insurer's denial; and

(2) states the specific terms and conditions that the provider, in the opinion of the insurer, does not satisfy.

(d) In no event may an insurer deny or limit reimbursement to an insured under this chapter on the grounds that the insured was not referred to the provider by a person acting on behalf of or under an agreement with the insurer.

(e) No cause of action shall arise against any person or insurer for:

(1) disclosing information as required by this section; or

(2) the subsequent use of the information by unauthorized individuals.

Nor shall such a cause of action arise against any person or provider for furnishing personal or privileged information to an insurer. However, this subsection provides no immunity for disclosing or furnishing false

information with malice or willful intent to injure any person, provider, or insurer.

(f) Nothing in this chapter abrogates the privileges and immunities established in IC 34-30-15 (or IC 34-4-12.6 before its repeal).

(g) This subsection does not apply to a rate schedule maintained by state or federal government payers. An insurer that enters into an agreement with a provider under subsection (a)(1) must provide the provider a current reimbursement rate schedule:

(1) every two (2) years; and

(2) when three (3) or more CPT code (as defined in IC 27-1-37.5-3) rates under the agreement are changed in a twelve (12) month period.

SECTION 30. IC 27-8-11-7, AS AMENDED BY P.L.195-2018, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2024]: Sec. 7. (a) This section applies to an insurer that issues or administers a policy that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) As used in this section, "clean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) does not contain an error; and

(3) may be processed by the insurer without returning the application to the provider for a revision or clarification.

(c) As used in this section, "credentialing" means a process by which an insurer makes a determination that:

(1) is based on criteria established by the insurer; and

(2) concerns whether a provider is eligible to:

(A) provide health services to an individual eligible for coverage; and

(B) receive reimbursement for the health services;

under an agreement that is entered into between the provider and the insurer.

(d) As used in this section, "unclean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) contains at least one (1) error; and

(3) must be returned to the provider to correct the error.

~~(b)~~ **(e)** The department of insurance shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format, which must be used by:

(1) a provider who applies for credentialing by an insurer; and

(2) an insurer that performs credentialing activities.

~~(c) An insurer shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than thirty (30) business days after the insurer receives the completed credentialing application form.~~

~~(d) An insurer shall notify a provider concerning the status of the provider's completed credentialing application not later than:~~

~~(1) sixty (60) days after the insurer receives the completed credentialing application form; and~~

~~(2) every thirty (30) days after the notice is provided under subdivision (1), until the insurer makes a final credentialing determination concerning the provider.~~

~~(e) Notwithstanding subsection (d), if an insurer fails to issue a credentialing determination within thirty (30) days after receiving a completed credentialing application form from a provider, the insurer shall provisionally credential the provider if the provider meets the following criteria:~~

~~(1) The provider has submitted a completed and signed credentialing application form and any required supporting material to the insurer.~~

~~(2) The provider was previously credentialed by the insurer in Indiana and in the same scope of practice for which the provider has applied for provisional credentialing.~~

~~(3) The provider is a member of a provider group that is credentialed and a participating provider with the insurer.~~

~~(4) The provider is a network provider with the insurer.~~

~~(f) The criteria for issuing provisional credentialing under subsection (e) may not be less stringent than the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization.~~

~~(g) Once an insurer fully credentials a provider that holds provisional credentialing, reimbursement payments under the contract shall be retroactive to the date of the provisional credentialing. The insurer shall reimburse the provider at the rates determined by the contract between the provider and the insurer.~~

~~(h) If an insurer does not fully credential a provider that is provisionally credentialed under subsection (e), the provisional credentialing is terminated on the date the insurer notifies the provider of the adverse credentialing determination. The insurer is not required to reimburse for services rendered while the provider was provisionally credentialed.~~

(f) An insurer shall notify a provider concerning a deficiency on a completed unclean credentialing application form submitted by

the provider not later than five (5) business days after the entity receives the completed unclean credentialing application form. A notice described in this subsection must:

(1) provide a description of the deficiency; and

(2) state the reason why the application was determined to be an unclean credentialing application.

(g) A provider shall respond to the notification required under subsection (f) not later than five (5) business days after receipt of the notice.

(h) An insurer shall notify a provider concerning the status of the provider's completed clean credentialing application when:

(1) the provider is provisionally credentialed; and

(2) the insurer makes a final credentialing determination concerning the provider.

(i) If the insurer fails to issue a credentialing determination within fifteen (15) days after receiving a completed clean credentialing application form from a provider, the insurer shall provisionally credential the provider in accordance with the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization. The provisional credentialing license is valid until a determination is made on the credentialing application of the provider.

(j) Once an insurer fully credentials a provider that holds provisional credentialing and a network provider agreement has been executed, then reimbursement payments under the contract shall be paid retroactive to the date the provider was provisionally credentialed. The insurer shall reimburse the provider at the rates determined by the contract between the provider and the insurer.

(k) If an insurer does not fully credential a provider that is provisionally credentialed under subsection (i), the provisional credentialing is terminated on the date the insurer notifies the provider of the adverse credentialing determination. The insurer is not required to reimburse for services rendered while the provider was provisionally credentialed.

SECTION 31. IC 27-8-39 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 39. Coverage for Wearable Cardioverter Defibrillators

Sec. 1. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1. The term does not include a policy, plan, or coverage set forth in IC 27-8-5-2.5(a).

Sec. 2. As used in this chapter, "wearable cardioverter defibrillator" means a device that:

(1) is worn externally on an individual's body;

(2) continually monitors and analyzes the individual's heart rhythm; and

(3) delivers a shock to the heart when an abnormal heart rhythm is detected.

Sec. 3. (a) A policy of accident and sickness insurance must provide coverage for wearable cardioverter defibrillators, including the cost of the wearable cardioverter defibrillator, any necessary accessory, and ongoing monitoring services.

(b) The coverage required under subsection (a) must be in accordance with a:

(1) local coverage determination; or

(2) national coverage determination;

as defined in 42 U.S.C. 1395ff(f) for Medicare purposes.

Sec. 4. The coverage required by this chapter may not be subject to an annual or lifetime limitation.

SECTION 32. IC 27-13-7-28.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 28.5. (a) This section applies to an individual contract or a group contract that is entered into, amended, or renewed after June 30, 2023.**

(b) As used in this section, "wearable cardioverter defibrillator" means a device that:

(1) is worn externally on an individual's body;

(2) continually monitors and analyzes the individual's heart rhythm; and

(3) delivers a shock to the heart when an abnormal heart rhythm is detected.

(c) An individual contract or a group contract must provide coverage for a wearable cardioverter defibrillator, including the cost of the wearable cardioverter defibrillator, any necessary accessory, and ongoing monitoring services.

(d) The coverage required under subsection (c) must be in accordance with a:

(1) local coverage determination; or

(2) national coverage determination;

as defined in 42 U.S.C. 1395ff(f) for Medicare purposes.

(e) The coverage required by this section may not be subject to an annual or lifetime limitation.

SECTION 33. IC 27-13-15-1 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 1. (a) A contract between a health maintenance organization and a participating provider of health care services:

(1) must be in writing;

(2) may not prohibit the participating provider from disclosing:

(A) the terms of the contract as it relates to financial or other incentives to limit medical services by the participating provider; or

(B) all treatment options available to an insured, including those not covered by the insured's policy;

(3) may not provide for a financial or other penalty to a provider for making a disclosure permitted under subdivision (2); and

(4) must provide that in the event the health maintenance organization fails to pay for health care services as specified by the contract, the subscriber or enrollee is not liable to the participating provider for any sums owed by the health maintenance organization.

(b) An enrollee is not entitled to coverage of a health care service under a group or an individual contract unless that health care service is included in the enrollee's contract.

(c) A provider is not entitled to payment under a contract for health care services provided to an enrollee unless the provider has a contract or an agreement with the carrier.

~~(d) This section applies to a contract entered, renewed, or modified after June 30, 1996.~~

(d) This subsection does not apply to a rate schedule maintained by state or federal government payers. A health maintenance organization that enters into a contract with a participating provider must provide the participating provider with a current reimbursement rate schedule:

(1) every two (2) years; and

(2) when three (3) or more CPT code (as defined in IC 27-1-37.5-3) rates under the contract change in a twelve (12) month period.

SECTION 34. IC 27-13-20-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 1.5. (a) Before approving or disapproving an increase or decrease in the rates to be used by a health maintenance organization, the commissioner shall review the following:**

(1) The products affected, by line of business.

(2) The number of covered lives affected.

(3) Whether the product is open or closed to new members in the product block.

(4) Applicable median cost sharing for the product, as allowed by state or federal law.

(5) The benefits provided and the underlying costs of the health services rendered.

(6) The implementation date of the increase or decrease.

(7) The overall percent premium rate increase or decrease that is requested.

(8) The actual percent premium rate increase or decrease to be approved.

(9) Incurred claims paid each year for the past three (3) years, if applicable.

(10) Earned premiums for each of the past three (3) years, if applicable.

(11) 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.

(12) If applicable, historical rebates paid to the enrollee 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).

(13) The median cost sharing amount for a member enrolled in the product, or the actuarial value information as required under the Patient Protection and Affordable Care Act, if applicable.

(b) The commissioner shall not approve a rate increase or decrease for an existing product unless the commissioner has, at a minimum, considered the matters set forth in subsection (a)(1) through (a)(13).

(c) The information compiled, prepared, and considered by the commissioner under subsection (a)(1) through (a)(13) is subject to the requirements of IC 5-14-3. However, the commissioner's approval of a rate increase or decrease may take effect before the information compiled, prepared, and considered by the commissioner under subsection (a)(1) through (a)(13) is made accessible to the public under IC 5-14-3.

(d) When considering whether to approve a premium rate increase, the commissioner shall consider whether the current rate is appropriate for achieving the target loss ratio of the health maintenance organization.

(e) To the extent authorized by the Patient Protection and Affordable Care Act and other federal law, the commissioner, under this section, may:

(1) consider network adequacy;

(2) conduct form review to ensure:

(A) minimum essential health benefits; and

(B) nondiscriminatory benefit design;

(3) perform accreditation confirmation; and

(4) confirm quality measures.

SECTION 35. IC 27-13-36.2-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 4.5. (a) A health maintenance organization may not alter the CPT code (as defined in IC 27-1-37.5-3) submitted for a clean claim or pay for a CPT code (as defined in IC 27-1-37.5-3) of lesser monetary value unless:**

(1) the CPT code submitted is not in accordance with correct coding guidelines and rules, clinical care guidelines, or the terms and conditions of the participating provider's agreement or contract with the health maintenance organization; or

(2) the medical record of the clean claim has been reviewed by an employee or contractor of the health maintenance organization.

(b) A health maintenance organization may not alter a clean claim to only pay for the CPT codes (as defined in IC 27-1-37.5-3) necessary for an individual's final diagnosis, if the CPT codes (as defined in IC 27-1-37.5-3) billed were deemed medically necessary according to generally accepted clinical care guidelines to reach the final diagnosis.

(c) This section does not prohibit a provider from appealing a claim.

SECTION 36. IC 27-13-43-2, AS AMENDED BY P.L.1-2006, SECTION 489, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2024]: Sec. 2. **(a) As used in this section, "clean credentialing application" means an application for network participation that:**

(1) is submitted by a provider under this section;

(2) does not contain an error; and

(3) may be processed by the health maintenance organization without returning the application to the provider for a revision or clarification.

(b) As used in this section, "credentialing" means a process by

which a health maintenance organization makes a determination that:

(1) is based on criteria established by the health maintenance organization; and

(2) concerns whether a provider is eligible to:

(A) provide health services to an individual eligible for coverage; and

(B) receive reimbursement for the health services;

under an agreement that is entered into between the provider and the health maintenance organization.

(c) As used in this section, "unclean credentialing application" means an application for network participation that:

(1) is submitted by a provider under this section;

(2) contains at least one (1) error; and

(3) must be returned to the provider to correct the error.

~~(a)~~ **(d)** The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format. The form must be used by:

(1) a provider who applies for credentialing by a health maintenance organization; and

(2) a health maintenance organization that performs credentialing activities.

~~(b) A health maintenance organization shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than thirty (30) business days after the health maintenance organization receives the completed credentialing application form.~~

~~(c) A health maintenance organization shall notify a provider concerning the status of the provider's completed credentialing application not later than:~~

~~(1) sixty (60) days after the health maintenance organization receives the completed credentialing application form; and~~

~~(2) every thirty (30) days after the notice is provided under subdivision (1), until the health maintenance organization makes a final credentialing determination concerning the provider.~~

(e) A health maintenance organization shall notify a provider concerning a deficiency on a completed unclean credentialing application form submitted by the provider not later than five (5) business days after the entity receives the completed unclean credentialing application form. A notice described in this subsection must:

(1) provide a description of the deficiency; and

(2) state the reason why the application was determined to be an unclean credentialing application.

(f) A provider shall respond to the notification required under subsection (e) not later than five (5) business days after receipt of the notice.

(g) A health maintenance organization shall notify a provider concerning the status of the provider's completed clean credentialing application when:

(1) the provider is provisionally credentialed; and

(2) the health maintenance organization makes a final credentialing determination concerning the provider.

(h) If the health maintenance organization fails to issue a credentialing determination within fifteen (15) days after receiving a completed clean credentialing application form from a provider, the health maintenance organization shall provisionally credential the provider in accordance with the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization. The provisional credentialing license is valid until a determination is made on the credentialing application of the provider.

(i) Once a health maintenance organization fully credentials a provider that holds provisional credentialing and a network provider agreement has been executed, then reimbursement payments under the contract shall be paid retroactive to the date the provider was provisionally credentialed. The health maintenance organization shall reimburse the provider at the rates determined by the contract between the provider and the health maintenance organization.

(j) If a health maintenance organization does not fully credential a provider that is provisionally credentialed under subsection (h), the provisional credentialing is terminated on the date the health maintenance organization notifies the provider of the adverse credentialing determination. The health maintenance organization is not required to reimburse for services rendered while the provider was provisionally credentialed.

SECTION 37. IC 27-13-43-3 IS REPEALED [EFFECTIVE JANUARY 1, 2024]. ~~Sec. 3. (a) Notwithstanding section 2 of this chapter, if a health maintenance organization fails to issue a credentialing determination within thirty (30) days after receiving a completed credentialing application form from a provider, the health maintenance organization shall provisionally credential the provider if the provider meets the following criteria:~~

~~(1) The provider has submitted a completed and signed credentialing application form and any required supporting material to the health maintenance organization.~~

~~(2) The provider was previously credentialed by the health maintenance organization in Indiana and in the same scope of practice for which the provider has applied for provisional credentialing.~~

~~(3) The provider is a member of a provider group that is credentialed and a participating provider with the health maintenance organization.~~

~~(4) The provider is a network provider with the health maintenance organization.~~

~~(b) The criteria for issuing provisional credentialing under subsection (a) may not be less stringent than the standards and guidelines governing provisional credentialing from the National Committee for Quality Assurance or its successor organization.~~

~~(c) Once a health maintenance organization fully credentials a provider that holds provisional credentialing, reimbursement payments under the contract shall be retroactive to the date of the provisional credentialing. The health maintenance organization shall reimburse the provider at the rates determined by the contract between the provider and the health maintenance organization.~~

~~(d) If a health maintenance organization does not fully credential a provider that is provisionally credentialed under subsection (a), the provisional credentialing is terminated on the date the health maintenance organization notifies the provider of the adverse credentialing determination. The health maintenance organization is not required to reimburse for services rendered while the provider was provisionally credentialed.~~

SECTION 38. [EFFECTIVE JULY 1, 2023] **(a) 410 IAC 15-1.4-2.2(a) is void. The publisher of the Indiana Administrative Code and Indiana Register shall remove this subsection from the Indiana Administrative Code.**

(b) The Indiana department of health shall amend 410 IAC 15-1.4-2.2 to conform to this act.

(c) In amending the rule as required by this SECTION, the Indiana department of health may adopt an emergency rule in the manner provided by IC 4-22-2-37.1.

(d) Notwithstanding IC 4-22-2-37.1(g), an emergency rule adopted by the Indiana department of health under this SECTION expires on the date on which a rule that supersedes the emergency rule is adopted by the Indiana department of health under

IC 4-22-2-24 through IC 4-22-2-36.

(e) This SECTION expires July 1, 2024.

SECTION 39. [EFFECTIVE JULY 1, 2023] **(a) 410 IAC 15-1.5-5(a)(3) is void. The publisher of the Indiana Administrative Code and Indiana Register shall remove this subdivision from the Indiana Administrative Code.**

(b) This SECTION expires July 1, 2025.

SECTION 40. [EFFECTIVE UPON PASSAGE] **(a) The legislative council is urged to assign to the appropriate interim study committee the task of studying the issue of whether a health insurer or a health maintenance organization should be required to exempt a participating health care provider from needing to receive prior authorization on a particular health care service if the participating health care provider has continuously received approval for the health care service for a determined number of months.**

(b) This SECTION expires January 1, 2024.

SECTION 41. [EFFECTIVE UPON PASSAGE] **(a) The legislative council is urged to assign to the appropriate interim study committee the task of studying the issue of whether Indiana should adopt an interstate mobility of occupational licensing to allow individuals who hold current and valid occupational licenses or government certifications in another state in a lawful occupation with a similar scope of practice as Indiana to practice in Indiana under certain conditions.**

(b) This SECTION expires January 1, 2024.

SECTION 42. **An emergency is declared for this act.**

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: _____ Time: _____