COMMITTEE REPORT

MADAM PRESIDENT:

The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1414, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-7-2-25.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 25.1. "Case rate", for purposes of IC 12-15, means a fixed rate per encounter used to reimburse for emergency services, regardless of the patient's level of acuity.**".

Page 1, line 4, delete "may" and insert "**has the meaning set forth in IC 27-1-37.6-15.**".

Page 1, delete lines 5 through 17.

Page 2, delete lines 1 through 7.

Page 2, delete lines 24 through 42, begin a new paragraph and insert:

"SECTION 4. IC 12-15-12-12.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 12.2. (a) This section does not apply to a risk based managed care program described in section 12.5(a) of this chapter.**

(b) A managed care organization and a provider may enter into

a value based health care reimbursement agreement in writing that provides for reimbursement, a reimbursement rate, or payment methodology for a Medicaid service that is greater than a minimum rate set by the office of the secretary for the service. However, a managed care organization may not do any of the following:

(1) Impose, either directly or indirectly, a reimbursement or payment methodology through:

(A) a notice of contract change;

(B) a policy; or

(C) a provider manual change;

to a provider.

(2) Condition a provider's participation, reimbursement, or any other term contained in any other contractual agreement between the parties based on the provider's acceptance of a different reimbursement or payment methodology under this section.

(3) Impact a supplemental payment that is applicable to an original reimbursement rate, reimbursement, or payment methodology.

(c) If a managed care organization and a provider enter into a value based health care reimbursement agreement under this section, the managed care organization shall notify the office of the secretary.

SECTION 5. IC 12-15-12-12.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 12.3. A managed care organization and a provider may mutually enter into an agreement in writing that provides for reimbursement to be made to the provider using a case rate. However:**

(1) a managed care organization may not impose a case rate through a notice of contract change, a policy, or a provider manual change to a provider; and

(2) a case rate may not impact a supplemental payment applicable to the original payment rate or methodology.".

Page 3, delete lines 1 through 8.

Page 3, line 20, delete "may" and insert "**shall contract with any willing provider that:**

(1) meets licensure and certification requirements and enrollment criteria established by the office of the secretary; and

(2) agrees to accept the terms and conditions of a managed care organization to provide covered services under the risk based managed care program.

(c) A managed care organization shall reimburse a provider that contracts to provide services under the risk based managed care program in accordance with federal and state law.

(d) The office of the secretary shall establish a minimum reimbursement rate for a covered service provided by a provider for a Medicaid recipient participating in the Medicaid risk based managed care program described in subsection (a). A managed care organization shall reimburse a provider at least at the reimbursement rate established by the office of the secretary.".

Page 3, delete lines 21 through 23.

Page 4, line 35, delete "in writing providing" and insert "**in accordance with section 12.2 of this chapter.**".

Page 4, delete lines 36 through 38.

Page 5, line 34, delete "in writing providing for a different rate or payment" and insert "**in accordance with section 12.2 of this chapter.**".

Page 5, delete lines 35 through 37.

Page 6, line 36, delete "in writing providing for a different rate" and insert "**in accordance with section 12.2 of this chapter.**".

Page 6, delete lines 37 through 38.

Page 6, line 39, delete "a notice of contract change to a provider.".

Page 6, delete line 42.

Page 7, delete lines 1 through 3.

Page 7, line 12, after "secretary" insert ";".

Page 7, line 12, delete "unless the managed care".

Page 7, delete lines 13 through 14.

Page 7, line 15, delete "different rate or payment methodology;".

Page 7, line 18, delete "A" and insert "**However, a**".

Page 7, line 18, delete "may not impose a different rate or" and insert "**and a provider may enter into a value based health care reimbursement agreement in accordance with IC 12-15-12-12.2.**".

Page 7, delete lines 19 through 20.

Page 7, delete lines 26 through 29, begin a new paragraph and insert:

"SECTION 9. 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) A health plan shall make any current prior authorization requirements and restrictions, including written clinical criteria, readily accessible on the health plan'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 health plan may not implement a new prior authorization requirement or restriction or amend an existing requirement or restriction unless:

(1) the health plan's website has been updated to reflect the new or amended requirement or restriction; and

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

(c) A health plan shall make statistics available regarding prior authorization approvals and denials on the health plan'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 health plan shall:

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

(2) submit the report to the department.

SECTION 10. IC 27-1-37.6-15, AS ADDED BY P.L.203-2023, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 15. (a) As used in this chapter, "value based health care reimbursement agreement" may include the following:

(1) An accountable care organization that has a contract with a health plan in which the health plan:

(A) does not assume risk for prior authorization to a provider organization; or

(B) delegates risk to a provider organization to manage prior authorization.

(2) Bundled payments.

(3) A capitated rate reimbursement arrangement.

(4) A pay for performance arrangement.

(5) Any other health care reimbursement arrangement in which the health care provider accepts at most ten percent (10%) of the downside risk.

(b) The term does not include any of the following:

(1) Narrow networks.

(2) Fixed fee schedules.

(3) A supplemental payment for the original rate or payment methodology.

SECTION 11. IC 27-7-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]:

Chapter 18. Third Party Access to Dental Provider Networks

Sec. 1. As used in this chapter, "contracting entity" means a dental carrier, a third party administrator, or another person that enters into a provider network contract with providers for the delivery of dental services in the ordinary course of business.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to:

(1) dental services; or

(2) coverage of dental services;

through a provider network contract.

Sec. 3. As used in this chapter, "dental carrier" means any of the following:

(1) An insurer that issues a policy of accident and sickness insurance that covers dental services.

(2) A health maintenance organization that provides, or provides coverage for, dental services.

(3) An entity that:

(A) provides dental services; or

(B) arranges for dental services to be provided;

but is not itself a provider.

Sec. 4. (a) As used in this chapter, "dental service" means any service provided by a dentist within the scope of the dentist's licensure under IC 25-14.

(b) The term does not include a service delivered by a provider that is billed as a medical expense.

Sec. 5. As used in this chapter, "health insurer" means:

(1) an insurer that issues policies of accident and sickness insurance (as defined in IC 27-8-5-1); or

(2) a health maintenance organization (as defined in IC 27-13-1-19).

Sec. 6. As used in this chapter, "person" means an individual, a corporation, a limited liability company, a partnership, or any other legal entity.

Sec. 7. (a) As used in this chapter, "provider" means:

(1) a dentist licensed under IC 25-14; or

(2) a dental office through which one (1) or more dentists licensed under IC 25-14 provide dental services.

(b) The term does not include a physician organization or physician hospital organization that leases or rents the network of the physician organization or physician hospital organization network to a third party.

Sec. 8. As used in this chapter, "provider network contract" means a contract between a contracting entity and one (1) or more providers:

(1) that establishes a network through which the providers:

(A) provide dental services to covered individuals; and

(B) are compensated for providing the dental services; and

(2) that specifies the rights and responsibilities of the contracting entity and the providers concerning the network.

Sec. 9. (a) As used in this chapter, "third party" means a person that enters into a contract with a contracting entity or another third party to gain access to:

(1) a provider network contract;

(2) dental services provided pursuant to a provider network contract; or

(3) contractual discounts provided pursuant to a provider

network contract.

(b) The term does not include an employer or another group or entity for which the contracting entity provides administrative services.

Sec. 10. (a) This section applies if a contracting entity seeks to grant a third party access to:

(1) a provider network contract;

(2) dental services provided pursuant to a provider network contract; or

(3) contractual discounts provided pursuant to a provider network contract.

(b) Except as provided in subsection (c) and section 16 of this chapter, in order for a contracting entity to grant a third party access as described in subsection (a), the following conditions must be satisfied:

(1) When a provider network contract is entered into or renewed, or when there are material modifications to a provider network contract relevant to granting access to a third party as described in subsection (a):

(A) any provider that is a party to the provider network contract must be allowed to choose not to participate in the third party access as described in subsection (a); or

(B) if third party access is to be provided through the acquisition of the provider network by a health insurer, any provider that is a party to the provider network contract must be allowed to enter into a contract directly with the health insurer that acquired the provider network.

(2) The provider network contract must specifically authorize the contracting entity to enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

(3) If the contracting entity seeking to grant a third party access as described in subsection (a) is a dental carrier, a provider that is a party to the provider network contract must have chosen to participate in third party access at the time the provider network contract was entered into or renewed.

(4) If the contracting entity seeking to grant a third party access as described in subsection (a) is a health insurer, the provider network contract must contain a third party access provision specifically granting third party access to the provider network.

(5) If the contracting entity seeking to grant a third party access as described in subsection (a) is a dental carrier, the provider network contract must state that the provider has a right to choose not to participate in the third party access.

(6) The third party being granted access as described in subsection (a) must agree to comply with all of the terms of the provider network contract.

(7) The contracting entity seeking to grant third party access as described in subsection (a) must identify to each provider that is a party to the provider network contract, in writing or electronic form, all third parties in existence as of the date on which the provider network contract is entered into or renewed.

(8) The contracting entity granting third party access as described in subsection (a) must identify, in a list on its website that is updated at least once every ninety (90) days, all third parties to which third party access has been granted.

(9) If third party access as described in subsection (a) is to be granted through the sale or leasing of the network established by the provider network contract, the contracting entity must notify all providers that are parties to the provider network contract of the leasing or sale of the network at least thirty (30) days before the sale or lease of the network takes effect.

(10) The contracting entity seeking to grant third party access to contractual discounts as described in subsection (a)(3) must require each third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken. However, this subdivision does not apply to electronic transactions mandated by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(c) A contracting entity may grant a third party access as described in subsection (a) even if the conditions set forth in

subsection (b)(1) are not satisfied if the contracting entity is not a health insurer or a dental carrier.

(d) Except as provided in subsection (c) and section 16 of this chapter, a provider that is a party to a provider network contract is not required to provide dental services pursuant to third party access granted as described in subsection (a) unless all of the applicable conditions set forth in subsection (b) are satisfied.

Sec. 11. A contracting entity that is a party to a provider network contract with a provider that chooses under section 10(b)(1)(A) of this chapter not to participate in third party access shall not alter the provider's rights or status under the provider network contract because of the provider's choice not to participate in third party access.

Sec. 12. A contracting entity that is a party to a provider network contract shall notify a third party granted third party access as described in section 10(a) of this chapter of the termination of the provider network contract not more than thirty (30) days after the date of the termination.

Sec. 13. The right of a third party to contractual discounts described in section 10(a)(3) of this chapter ceases as of the termination date of the provider network contract.

Sec. 14. A contracting entity that is a party to a provider network contract shall make a copy of the provider network contract relied on in the adjudication of a claim available to a participating provider not more than thirty (30) days after the date of the participating provider's request.

Sec. 15. When entering into a provider network contract with providers, a contracting entity shall not reject a provider as a party to the provider network contract because the provider chooses or has chosen under section 10(b)(1)(A) of this chapter not to participate in third party access.

Sec. 16. (a) Section 10 of this chapter does not apply to access as described in section 10(a) of this chapter if granted by a contracting entity to:

(1) a dental carrier or other entity operating in accordance with the same brand licensee program as the contracting entity; or

(2) an entity that is an affiliate of the contracting entity.

(b) For the purposes of this section, a contracting entity shall make a list of the contracting entity's affiliates available to providers on the contracting entity's website.

(c) Section 10 of this chapter does not apply to a provider network contract established for the purpose of providing dental services to beneficiaries of health programs sponsored by the state, including Medicaid (IC 12-15) and the children's health insurance program (IC 12-17.6).

Sec. 17. The provisions of this chapter cannot be waived by contract. A contract provision that:

(1) conflicts with this chapter; or

(2) purports to waive any requirements of this chapter;

is null and void.

Sec. 18. (a) If a person violates this chapter, the insurance commissioner may enter an order requiring the person to cease and desist from violating this chapter.

(b) If a person violates a cease and desist order issued under subsection (a), the insurance commissioner, after notice and hearing under IC 4-21.5, may:

(1) impose a civil penalty upon the person of not more than ten thousand dollars ($10,000) for each day of violation;

(2) suspend or revoke the person's certificate of authority, if the person holds a certificate of authority under this title; or

(3) both impose a civil penalty upon the person under subdivision (1) and suspend or revoke the person's certificate of authority under subdivision (2).

SECTION 12. IC 27-8-11-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 14. (a) As used in this section, "covered individual" means an individual who is entitled to the coverage of dental services by a dental carrier.**

(b) As used in this section, "dental carrier" means any of the following:

(1) An insurer that issues a policy of accident and sickness insurance that covers dental services.

(2) A health maintenance organization that provides, or provides coverage for, dental services.

(3) A preferred provider plan subject to this chapter under

which dental services are provided.

(c) As used in this section, "dental services" means health care services provided by:

(1) a dentist licensed under IC 25-14;

(2) an individual using a dental residency permit issued under IC 25-14-1-5;

(3) an individual who holds:

(A) a dental faculty license under IC 25-14-1-5.5; or

(B) an instructor's license under IC 25-14-1-27.5;

(4) a dental hygienist licensed under IC 25-13; or

(5) a dental assistant (as defined in IC 25-14-1-1.5(4));

within the scope of the individual's license or work description in IC 25-13 or IC 25-14, as appropriate. However, the term does not include a service delivered by a provider if the service is billed as a medical expense.

(d) As used in this section, "network" means all providers that have entered into a contract with a dental carrier under which the providers agree to charge no more than a certain amount for certain dental services provided to covered individuals who are entitled to the coverage of dental services by the dental carrier.

(e) As used in this section, "provider" means:

(1) a dentist licensed under IC 25-14; or

(2) a dental office through which one (1) or more dentists licensed under IC 25-14 provide dental services.

(f) If a covered individual assigns the rights of the covered individual to benefits for dental services to the provider of the dental services, the covered individual's dental carrier shall pay the benefits assigned by the covered individual to the provider of the dental services.

(g) A dental carrier shall make a payment under this section:

(1) directly to the provider of the dental services; and

(2) according to the same criteria and payment schedule under which the dental carrier would have been required to make the payment to the covered individual if the insured had not assigned the insured's rights to the benefits.

(h) An assignment of benefits under this section does not affect or limit the dental carrier's obligation to pay the benefits.

(i) A dental carrier's payment of benefits in compliance with this

section discharges the dental carrier's obligation to pay the benefits to the insured.

(j) If:

(1) a covered individual is entitled to coverage from a dental carrier;

(2) the covered individual is provided dental services by a provider;

(3) the covered individual assigns the covered individual's rights to benefits from the dental carrier to the provider of the dental services; and

(4) the provider of the dental services is a member of the network of the dental carrier;

the provider shall accept compensation from the dental carrier in the amount specified in the network contract as payment in full for the dental services provided to the covered individual and shall not bill the covered individual for the dental services, except for copayments, coinsurance and any deductible amount that remains after the dental carrier's payment for the dental services.".

Renumber all SECTIONS consecutively.

(Reference is to HB 1414 as reprinted February 2, 2024.)

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

Committee Vote: Yeas 10, Nays 0.

Charbonneau Chairperson