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

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

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

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

HOUSE ENROLLED ACT No. 1259

AN ACT to amend the Indiana Code concerning health and to make an appropriation.

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

SECTION 1. IC 12-7-2-91, AS AMENDED BY P.L.246-2023, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 91. "Fund" means the following:

(1) For purposes of IC 12-12-1-9, the fund described in IC 12-12-1-9.

(2) For purposes of IC 12-15-20, the meaning set forth in IC 12-15-20-1.

(3) For purposes of IC 12-17-12, the meaning set forth in IC 12-17-12-4.

(4) For purposes of IC 12-17.2-7.2, the meaning set forth in IC 12-17.2-7.2-4.7.

(5) For purposes of IC 12-17.6, the meaning set forth in IC 12-17.6-1-3.

(6) For purposes of IC 12-21-9, the meaning set forth in IC 12-21-9-1.

~~(6)~~ **(7)** For purposes of IC 12-23-2, the meaning set forth in IC 12-23-2-1.

~~(7)~~ **(8)** For purposes of IC 12-23-18, the meaning set forth in IC 12-23-18-4.

~~(8)~~ **(9)** For purposes of IC 12-24-6, the meaning set forth in IC 12-24-6-1.

~~(9)~~ **(10)** For purposes of IC 12-24-14, the meaning set forth in IC 12-24-14-1.

~~(10)~~ **(11)** For purposes of IC 12-30-7, the meaning set forth in IC 12-30-7-3.

SECTION 2. IC 12-7-2-139.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 139.5. "Psilocybin", for purposes of IC 12-21-9, has the meaning set forth in IC 12-21-9-2.**

SECTION 3. IC 12-7-2-163.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 163.8. "Research institution", for purposes of IC 12-21-9, has the meaning set forth in IC 12-21-9-3.**

SECTION 4. IC 12-21-9 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 9. Therapeutic Psilocybin Research

Sec. 1. As used in this chapter, "fund" refers to the therapeutic psilocybin research fund established by section 4 of this chapter.

Sec. 2. (a) As used in this chapter, "psilocybin" means a naturally occurring psychedelic prodrug compound that is produced by fungi, including members of the genus psilocybe.

(b) The term includes psilocin.

Sec. 3. As used in this chapter, "research institution" refers to an organization that meets all of the following:

(1) Has an academic institution that operates an institutional review board (IRB) that oversees research.

(2) Publishes the results of previous clinical trials in peer reviewed publications.

(3) Has access to a clinical research center and the center's resources, including research dedicated medical staff.

Sec. 4. The therapeutic psilocybin research fund is established for the purpose of providing financial assistance to research institutions in Indiana to study, in accordance with the requirements established in section 7 of this chapter, the use of psilocybin to treat mental health and other medical conditions.

Sec. 5. (a) The fund shall be administered by the division.

(b) The expenses of administering the fund shall be paid from money in the fund.

Sec. 6. (a) The fund consists of:

(1) money received from state or federal grants or programs; and

(2) gifts, money, and donations received from any other source, including transfers from other funds or accounts.

(b) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested. Interest that accrues from these investments shall be deposited in the fund.

(c) Money in the fund at the end of a state fiscal year does not revert to the state general fund.

(d) Money in the fund is continuously appropriated for purposes of this chapter.

Sec. 7. (a) A research institution in Indiana may apply to the division to receive financial assistance from the fund to conduct one (1) or more clinical studies to evaluate the efficacy of psilocybin as an alternative treatment for mental health and other medical conditions, including the following:

(1) Posttraumatic stress disorder, with a focus on treating the disorder in combat veterans and first responders.

(2) Anxiety.

(3) Depression.

(4) Bipolar disorder.

(5) Chronic pain.

(6) Migraines.

(7) Alcohol use disorder.

(8) Tobacco use disorder.

(b) In conducting a clinical study under this section, a research institution that receives a grant under this chapter shall do the following:

(1) Include veterans and first responders in the study sample.

(2) Evaluate and determine whether psilocybin is an effective treatment for mental health and other medical conditions described in subsection (a).

(3) Compare the efficacy of psilocybin as a treatment for mental health and other medical conditions described in subsection (a) with the efficacy of other current treatment options for mental health and other medical conditions described in subsection (a).

(4) Before entering the study, require each participant to undergo a mental health evaluation.

Sec. 8. After a research institution that receives a grant under this chapter completes and finalizes a study under this chapter, a research institution shall prepare and submit a report summarizing the results of the study and any recommendations for

legislation to the following:

(1) The interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6.

(2) The Indiana department of health.

(3) The division.

Sec. 9. Not later than July 1, 2024, the division shall establish a process to administer the fund and process applications under this chapter.

SECTION 5. IC 16-21-6-3, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2024 GENERAL ASSEMBLY AND SEA 132-2024, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 3. (a) Each hospital shall file with the state department a report for the preceding fiscal year within one hundred twenty (120) days after the end of the hospital's fiscal year. For the filing of a report, the state department ~~shall~~ **may** grant an extension of the time to file the report if the hospital shows good cause for the extension. The report must contain the following:

(1) A copy of the hospital's balance sheet, including a statement describing the hospital's total assets and total liabilities.

(2) A copy of the hospital's income statement.

(3) A statement of changes in financial position.

(4) A statement of changes in fund balance.

(5) Accountant notes pertaining to the report.

(6) A copy of the hospital's report required to be filed annually under 42 U.S.C. 1395g, and other appropriate utilization and financial reports required to be filed under federal statutory law.

(7) Net patient revenue and total number of paid claims, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue for services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(8) Net patient revenue and total number of paid claims from facility fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient

revenue from facility fees provided ~~from facility fees~~ to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(9) Net patient revenue and total number of paid claims from professional fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(10) A statement including:

(A) Medicare gross revenue;

(B) Medicaid gross revenue;

(C) other revenue from state programs;

(D) revenue from local government programs;

(E) local tax support;
(F) charitable contributions;
(G) other third party payments;
(H) gross inpatient revenue;
(I) gross outpatient revenue;
(J) contractual allowance;
(K) any other deductions from revenue;
(L) charity care provided;
(M) itemization of bad debt expense; and
(N) an estimation of the unreimbursed cost of subsidized health services.

(11) A statement itemizing donations.

(12) A statement describing the total cost of reimbursed and unreimbursed research.

(13) A statement describing the total cost of reimbursed and unreimbursed education separated into the following categories:

(A) Education of physicians, nurses, technicians, and other medical professionals and health care providers.
(B) Scholarships and funding to medical schools, and other postsecondary educational institutions for health professions education.
(C) Education of patients concerning diseases and home care in response to community needs.
(D) Community health education through informational programs, publications, and outreach activities in response to community needs.
(E) Other educational services resulting in education related costs.

(b) The information in the report filed under subsection (a) must be provided from reports or audits certified by an independent certified public accountant or by the state board of accounts.

(c) A hospital that fails to file the report required under subsection (a) by the date required shall pay to the state department a fine of one thousand dollars ($1,000) per day for which the report is past due. A fine under this subsection shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

SECTION 6. IC 25-23-1-20.3, AS ADDED BY P.L.69-2022, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 20.3. (a) As used in this section, "clinical preceptor" means an individual who is:

(1) employed by a cooperating agency; and
(2) responsible for supervising one (1) nursing student at a time

in a clinical facility.

(b) As used in this section, "cooperating agency" means an institution that cooperates with a nursing program to provide clinical facilities for the clinical experiences (as defined in section 20.2 of this chapter) of nursing students.

(c) Each clinical preceptor must

~~(1)~~ be a nurse licensed under this article. ~~and~~

~~(2) have at least eighteen (18) months of experience as a registered nurse.~~

(d) Not later than July 1, ~~2023,~~ **2025,** the board shall adopt rules under IC 4-22-2 to implement this section.

SECTION 7. IC 25-23-1-20.4, AS ADDED BY P.L.69-2022, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 20.4. (a) As used in this section, "faculty" refers to a group of individuals who are employed to administer and teach in a nursing program.

(b) Beginning July 1, ~~2022,~~ **2024,** the majority of employees on the faculty of a nursing program ~~that:~~

~~(1) is operated by a state educational institution, as defined in IC 21-7-13-32; and~~

~~(2) predominantly issues associate degrees;~~

may be part-time employees of ~~the~~ **an approved postsecondary** educational institution **(as defined in IC 21-7-13-6(a))** or **a** hospital that conducts the nursing program.

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

SECTION 8. IC 25-34.5-2-14 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 14. (a) The committee shall issue a student permit to an individual if the individual does the following:

(1) Submits the appropriate application to the committee.

(2) Pays the fee established by the board.

(3) Submits written proof to the committee that the individual is a student in good standing in a respiratory care school or program that has been:

(A) approved by the committee for purposes of section 8(b)(1) of this chapter;

(B) approved by the committee for purposes of section 10.1(a)(3)(B) of this chapter; or

(C) otherwise approved by the committee.

(4) Submits satisfactory evidence that the individual:

(A) does not have a conviction described in section 8(a)(1) of

this chapter; and

(B) has not been the subject of a disciplinary action described in section 8(a)(2) of this chapter.

(b) The committee shall issue a student permit as soon as it is reasonably practicable after an individual fulfills the requirements of subsection (a).

(c) An individual who holds a student permit may only perform respiratory care procedures that have been part of a course:

(1) the individual has successfully completed in the respiratory care program designated under subsection (a)(3); and

(2) for which the successful completion has been documented and that is available upon request to the committee.

(d) The committee may expand the list of respiratory care procedures that an individual may perform under the individual's student permit to include additional respiratory care procedures that have been part of a course:

(1) that the individual has successfully completed in the respiratory care program designated under subsection (a)(3); and

(2) for which the individual's successful completion has been documented.

Upon request by the committee, the individual shall provide documentation of the successful completion of a course described in this subsection.

(e) The procedures permitted under subsections (c) and (d) may be performed only:

(1) on ~~adult~~ patients who are not critical care patients; and

(2) under the proximate supervision of a practitioner.

(f) A holder of a student permit shall meet in person at least one (1) time each working day with the permit holder's supervising practitioner or a designated respiratory care practitioner to review the permit holder's clinical activities. The supervising practitioner or a designated respiratory care practitioner shall review and countersign the entries that the permit holder makes in a patient's medical record not more than seven (7) calendar days after the permit holder makes the entries.

(g) A supervising practitioner may not supervise at one (1) time more than three (3) holders of student permits issued under this section.

(h) A student permit expires on the earliest of the following:

(1) The date the permit holder is issued a license under this article.

(2) The date the committee disapproves the permit holder's application for a license under this article.

(3) The date the permit holder ceases to be a student in good

standing in a respiratory care program approved by the committee. The graduation of a student permit holder from a respiratory care program approved by the committee does not cause the student permit to expire under this subdivision.

(4) Sixty (60) days after the date that the permit holder graduates from a respiratory care program approved by the committee.

(5) The date that the permit holder is notified that the permit holder has failed the licensure examination.

(6) Two (2) years after the date of issuance.

SECTION 9. IC 25-36.1-2-2.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 2.8. As used in this chapter, "surgical assistance" means intraoperative surgical patient care that involves the following:**

(1) Making incisions.

(2) Closing surgical sites.

(3) Manipulating or removing tissue.

(4) Implanting surgical devices or drains.

(5) Placing catheters or clamps.

(6) Cauterizing blood vessels or tissue.

(7) Applying dressing to a surgical site.

(8) Harvesting veins.

(9) Injecting local anesthetic.

(10) Other minor surgical tasks similar to those described in subdivisions (1) through (9).

SECTION 10. IC 25-36.1-2-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 7. (a) An individual who provides evidence to a health care facility that the individual was employed before July 1, 2009:**

(1) to provide surgical assistance;

(2) under the supervision of a surgeon; and

(3) in a health care facility;

may provide surgical assistance in a health care facility.

(b) This chapter does not require a health care facility to permit an individual described in subsection (a) to provide surgical assistance at the health care facility.

SECTION 11. IC 27-1-24.5-0.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 0.7. As used in this chapter, "contract holder" means:**

(1) an individual or entity that offers health insurance

coverage to its employees or members through a self-funded health benefit plan, including a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.);

(2) a health plan; or

(3) Medicaid or a managed care organization (as defined in IC 12-7-2-126.9) that provides services to a Medicaid recipient;

that contracts with a pharmacy benefit manager to provide services.

SECTION 12. IC 27-1-24.5-25, AS AMENDED BY P.L.32-2021, SECTION 81, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 25. (a) A ~~party that has contracted with a pharmacy benefit manager to provide services~~ **contract holder** may, ~~at least~~ one (1) time in a calendar year **and not earlier than six (6) months following a previously requested audit,** request an audit of compliance with the contract. **If requested by the contract holder,** the audit ~~may~~ **shall** include full disclosure of **the following data specific to the contract holder:**

(1) Rebate amounts secured on prescription drugs, whether product specific or general rebates, that were provided by a pharmaceutical manufacturer. **The information provided under this subdivision must identify the prescription drugs by therapeutic category.** ~~and~~

(2) Pharmaceutical and device claims received by the pharmacy benefit manager on any of the following:

(A) The CMS-1500 form or its successor form.

(B) The HCFA-1500 form or its successor form.

(C) The HIPAA X12 837P electronic claims transaction for professional services, or its successor transaction.

(D) The HIPAA X12 837I institutional form or its successor form.

(E) The CMS-1450 form or its successor form.

(F) The UB-04 form or its successor form.

The forms or transaction may be modified as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2).

(3) Pharmaceutical and device claims payments or electronic funds transfer or remittance advice notices provided by the pharmacy benefit manager as ASC X12N 835 files or a successor format. The files may be modified as necessary to

comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2). In the event that paper claims are provided, the pharmacy benefit manager shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

(4) Any other revenue and fees derived by the pharmacy benefit manager from the contract, **including all direct and indirect remuneration from pharmaceutical manufacturers regardless of whether the remuneration is classified as a rebate, fee, or another term.**

(b) A ~~contract~~ **pharmacy benefit manager** may not ~~contain provisions that~~ impose **the following:**

(1) ~~unreasonable~~ Fees **for:**

(A) requesting an audit under this section; or

(B) selecting an auditor other than an auditor designated by the pharmacy benefit manager.

(2) Conditions that would ~~severely~~ restrict a ~~party's~~ **contract holder's** right to conduct an audit under this ~~subsection,~~ **section, including restrictions on the:**

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

(E) selection of an auditor as long as the auditor:

(i) does not have a conflict of interest;

(ii) meets a threshold for liability insurance specified in the contract between the parties;

(iii) does not work on a contingent fee basis; and

(iv) does not have a history of breaching nondisclosure agreements.

~~(b)~~ **(c)** A pharmacy benefit manager shall disclose, upon request from a ~~party that has contracted with a pharmacy benefit manager,~~ **contract holder,** to the ~~party~~ **contract holder** the actual amounts **directly or indirectly** paid by the pharmacy benefit manager to **the pharmacist or** ~~any~~ pharmacy **for the drug and for pharmacist services related to the drug.**

~~(c)~~ **(d)** A pharmacy benefit manager shall provide notice to a ~~party~~ **contract holder** contracting with the pharmacy benefit manager of any consideration, **including direct or indirect remuneration,** that the pharmacy benefit manager receives from a ~~pharmacy~~ **pharmaceutical** manufacturer **or group purchasing organization** for ~~any name brand~~

~~dispensing of a prescription when a generic or biologically similar product is available for the prescription.~~ **formulary placement or any other reason.**

~~(d)~~ **(e)** The commissioner may establish a procedure to release information from an audit performed by the department to a ~~party~~ **contract holder** that has requested an audit under this section in a manner that does not violate confidential or proprietary information laws.

~~(e)~~ **(f)** ~~Any provision of~~ A contract **that is** entered into, issued, **amended,** or renewed after June 30, ~~2020,~~ **2024, may not contain a provision** that violates this section. ~~is unenforceable.~~

(g) A pharmacy benefit manager shall:

(1) obtain any information requested in an audit under this section from a group purchasing organization or other partner entity of the pharmacy benefit manager; and

(2) confirm receipt of a request for an audit under this section to the contract holder not later than ten (10) business days after the information is requested.

(h) Information provided in an audit under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

SECTION 13. IC 27-2-25.5-0.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 0.5. As used in this chapter, "plan sponsor" means an individual or entity that offers health insurance coverage to its employees or members through a self-funded health benefit plan, including:**

(1) a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.); and

(2) a self-insurance program established under IC 5-10-8-7(b).

SECTION 14. IC 27-2-25.5-0.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 0.7. As used in section 3 of this chapter, "third party administrator" means an individual or entity that performs administrative services for a self-funded health benefit plan, including:**

(1) a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.); and

(2) a self-insurance program established under IC 5-10-8-7(b).

SECTION 15. IC 27-2-25.5-3 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 3. (a) This section applies to a contract entered into, issued, amended, or renewed after June 30, 2024.**

(b) A contract:

(1) between a:

(A) third party administrator; and

(B) plan sponsor;

(2) between a:

(A) prepaid health care delivery plan under IC 5-10-8-7(c) to provide group health coverage for state employees; and

(B) plan sponsor; or

(3) between:

(A) a pharmacy benefit manager (as defined in IC 27-1-24.5-12); and

(B) either a:

(i) plan sponsor; or

(ii) third party administrator for the administration of a self-funded health benefit plan on behalf of the plan sponsor;

must provide that the plan sponsor owns the claims data relating to the contract. However, a plan sponsor's ownership of the claims data under this section may not be construed to require the pharmacy benefit manager or third party administrator to disclose a trade secret (as defined in IC 24-2-3-2).

(c) Any claims data provided under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

SECTION 16. IC 27-2-25.5-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 4. (a) A plan sponsor that contracts with a third party administrator, the office of the secretary of family and social services that contracts with a managed care organization (as defined in IC 12-7-2-126.9) to provide services to a Medicaid recipient, or the state personnel department that contracts with a prepaid health care delivery plan under IC 5-10-8-7(c) to provide group health coverage for state employees may, one (1) time in a calendar year and not earlier than six (6) months following a previously requested audit, request an audit of compliance with the contract. If requested by the plan sponsor, office of the secretary of family and social services, or state personnel department, the audit shall include full disclosure**

of the following concerning data specific to the plan sponsor, office of the secretary, or state personnel department:

(1) Claims data described in section 1 of this chapter.

(2) Claims received by the third party administrator, managed care organization, or prepaid health care delivery plan on any of the following:

(A) The CMS-1500 form or its successor form.

(B) The HCFA-1500 form or its successor form.

(C) The HIPAA X12 837P electronic claims transaction for professional services, or its successor transaction.

(D) The HIPAA X12 837I institutional form or its successor form.

(E) The CMS-1450 form or its successor form.

(F) The UB-04 form or its successor form.

The forms or transaction may be modified as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2).

(3) Claims payments, electronic funds transfer, or remittance advice notices provided by the third party administrator, managed care organization, or prepaid health care delivery plan as ASC X12N 835 files or a successor format. The files may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191) or to redact a trade secret (as defined in IC 24-2-3-2). In the event that paper claims are provided, the third party administrator, managed care organization, or prepaid health care delivery plan shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

(4) Any fees charged to the plan sponsor, office of the secretary of family and social services, or state personnel department related to plan administration and claims processing, including renegotiation fees, access fees, repricing fees, or enhanced review fees.

(b) A third party administrator, managed care organization, or prepaid health care delivery plan may not impose:

(1) fees for:

(A) requesting an audit under this section; or

(B) selecting an auditor other than an auditor designated by the third party administrator, managed care organization, or prepaid health care delivery plan; or

(2) conditions that would restrict a party's right to conduct an audit under this section, including restrictions on the:

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

(E) selection of an auditor as long as the auditor:

(i) does not have a conflict of interest;

(ii) meets a threshold for liability insurance specified in the contract between the parties;

(iii) does not work on a contingent fee basis; and

(iv) does not have a history of breaching nondisclosure agreements.

(c) A third party administrator, managed care organization, or prepaid health care delivery plan shall confirm receipt of a request for an audit under this section to the plan sponsor, office of the secretary of family and social services, or state personnel department not later than ten (10) business days after the information is requested.

(d) Information provided in an audit under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(e) A contract that is entered into, issued, amended, or renewed after June 30, 2024, may not contain a provision that violates this section.

(f) A violation of this section is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

(g) The department may also adopt rules under IC 4-22-2 to set forth fines for a violation under this section.

SECTION 17. [EFFECTIVE JULY 1, 2024] **(a) 844 IAC 13-5-4(a) is void. The publisher of the Indiana Administrative Code and the Indiana Register shall remove this subsection from the Indiana Administrative Code.**

(b) This SECTION expires July 1, 2025.

SECTION 18. **An emergency is declared for this act.**

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: _____ Time: _____