SENATE BILL No. 400

DIGEST OF INTRODUCED BILL

Citations Affected: IC 10-14-3-12; IC 12-7-2-128.2; IC 12-15; IC 16-18-2; IC 16-19-18; IC 16-21; IC 16-35-2-11; IC 25-0.5-10-1; IC 25-1; IC 25-13-1-8; IC 25-14-1; IC 27-1; IC 27-2-28; IC 27-8; IC 27-13.

Synopsis: Health care matters. Specifies requirements for credentialing a provider for the Medicaid program, an accident and sickness insurance policy, and a health maintenance organization contract. Establishes a provisional credential for Medicaid reimbursement purposes until a decision is made on a provider's credentialing application and allows for retroactive reimbursement. Requires the office of the secretary to reimburse any Medicaid provider that meets specified requirements for the provision of Medicaid rehabilitation option services to an eligible Medicaid recipient. Provides that a hospital's quality assessment and improvement program must include a process for determining and reporting the occurrence of serious reportable events. Provides that the medical staff of a hospital may make recommendations on the appointment or reappointment of an applicant to the governing board for a period not to exceed 36 months. Requires a hospital with an emergency department to have at least one physician on site and on duty who is responsible for the emergency department. Provides an exception from this requirement for a critical access hospital. Provides that a child who is blind is eligible for the Indiana Children's Special Health Care Services. Establishes the public health fund (fund) for the purpose of providing public health grants. Requires the Indiana professional licensing agency to transfer to the fund certain proceeds from collected licensing

(Continued next page)

Effective: Upon passage; July 1, 2023.

Brown L

January 19, 2023, read first time and referred to Committee on Health and Provider Services.

fees. Requires the legislative services agency to conduct an analysis of licensing fees and provide a report to the budget committee. Requires certain licensing boards to issue an occupational license or government certification to an applicant under certain conditions. Allows the governor to take certain actions concerning occupational licenses during a state of disaster emergency. Removes the dental compliance fee. Allows the commissioner of the department of insurance to issue an order to discontinue a violation of a law (current law specifies orders or rules). Requires a domestic stock insurer to file specified information with the department of insurance. Establishes and amends certain requirements relating to prior authorization. Adds a third party administrator of an employee benefit plan that is subject to the federal Employee Retirement Income Security Act of 1974 to the definition of "health payer" for the purposes of the all payer claims data base. Requires a health plan to post certain information on the health plan's website. Establishes a procedure for an insurer filing a planned premium rate increase for a health insurance policy with the department of insurance. Prohibits an insurer and a health maintenance organization from altering a CPT code for a claim unless the medical record of the claim has been reviewed by an employee who is a licensed physician. Requires an insurer and a health maintenance organization to provide a contracted provider with a current reimbursement rate schedule at specified times. Urges the study by an interim committee of prior authorization exemptions for certain health care providers. Makes an appropriation for donated dental services.

Introduced

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

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 2022 Regular Session of the General Assembly.

SENATE BILL No. 400

A BILL FOR 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:

1 SECTION 1. IC 10-14-3-12, AS AMENDED BY P.L.99-2021,
2 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2023]: Sec. 12. (a) The governor shall declare a disaster
4 emergency by executive order or proclamation if the governor
5 determines that a disaster has occurred or that the occurrence or the
6 threat of a disaster is imminent. The state of disaster emergency
7 continues until the governor:
8 (1) determines that the threat or danger has passed or the disaster
9 has been dealt with to the extent that emergency conditions no
10 longer exist; and
11 (2) terminates the state of disaster emergency by executive order
12 or proclamation.
13 A state of disaster emergency may not continue for longer than thirty
14 (30) days unless the state of disaster emergency is renewed by the
15 governor. The general assembly, by concurrent resolution, may

1 terminate a state of disaster emergency at any time. If the general
2 assembly terminates a state of disaster emergency under this
3 subsection, the governor shall issue an executive order or proclamation
4 ending the state of disaster emergency. All executive orders or
5 proclamations issued under this subsection must indicate the nature of
6 the disaster, the area or areas threatened, and the conditions which have
7 brought the disaster about or that make possible termination of the state
8 of disaster emergency. An executive order or proclamation under this
9 subsection shall be disseminated promptly by means calculated to bring
10 the order's or proclamation's contents to the attention of the general
11 public. Unless the circumstances attendant upon the disaster prevent or
12 impede, an executive order or proclamation shall be promptly filed
13 with the secretary of state and with the clerk of the city or town affected
14 or with the clerk of the circuit court.
15 (b) An executive order or proclamation of a state of disaster
16 emergency:
17 (1) activates the disaster response and recovery aspects of the
18 state, local, and interjurisdictional disaster emergency plans
19 applicable to the affected political subdivision or area; and
20 (2) is authority for:
21 (A) deployment and use of any forces to which the plan or
22 plans apply; and
23 (B) use or distribution of any supplies, equipment, materials,
24 and facilities assembled, stockpiled, or arranged to be made
25 available under this chapter or under any other law relating to
26 disaster emergencies.
27 (c) During the continuance of any state of disaster emergency, the
28 governor is commander-in-chief of the organized and unorganized
29 militia and of all other forces available for emergency duty. To the
30 greatest extent practicable, the governor shall delegate or assign
31 command authority by prior arrangement embodied in appropriate
32 executive orders or regulations. This section does not restrict the
33 governor's authority to delegate or assign command authority by orders
34 issued at the time of the disaster emergency.
35 (d) In addition to the governor's other powers, and subject to
36 sections 12.5 and 12.7 of this chapter, the governor may do the
37 following while the state of emergency exists:
38 (1) Suspend the provisions of any regulatory statute prescribing
39 the procedures for conduct of state business, or the orders, rules,
40 or regulations of any state agency if strict compliance with any of
41 these provisions would in any way prevent, hinder, or delay
42 necessary action in coping with the emergency.

(2) Use all available resources of the state government and of each political subdivision of the state reasonably necessary to cope with the disaster emergency.

(3) Transfer the direction, personnel, or functions of state departments and agencies or units for performing or facilitating emergency services.

(4) Subject to any applicable requirements for compensation under section 31 of this chapter, commandeer or use any private property if the governor finds this action necessary to cope with the disaster emergency.

(5) Assist in the evacuation of all or part of the population from any stricken or threatened area in Indiana if the governor considers this action necessary for the preservation of life or other disaster mitigation, response, or recovery.

(6) Prescribe routes, modes of transportation, and destinations in connection with evacuation.

(7) Control ingress to and egress from a disaster area, the movement of persons within the area, and the occupancy of premises in the area.

(8) Suspend or limit the sale, dispensing, or transportation of alcoholic beverages, explosives, and combustibles.

(9) Make provision for the availability and use of temporary emergency housing.

(10) Allow persons who:

(A) are registered as volunteer health practitioners by an approved registration system under IC 10-14-3.5; or

(B) hold a license to practice:

(i) medicine;

(ii) dentistry;

(iii) pharmacy;

(iv) nursing;

(v) engineering;

(vi) veterinary medicine;

(vii) mortuary service; and

(viii) similar other professions as may be specified by the governor;

to practice their respective profession in Indiana during the period of the state of emergency if the state in which a person's license or registration was issued has a mutual aid compact for emergency management with Indiana.

(11) Give specific authority to allocate drugs, foodstuffs, and other essential materials and services.

(12) Exercise the powers described in IC 25-1-22-17.

SECTION 2. IC 12-7-2-128.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 128.2. "Medicaid rehabilitation option services", for purposes of IC 12-15-47, has the meaning set forth in IC 12-15-47-1.**

SECTION 3. 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 4. IC 12-15-11-9, AS AMENDED BY P.L.32-2021, SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: 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) The office or a managed care organization shall:

(1) issue a credentialing determination not later than thirty (30) calendar days after the provider submits a completed credentialing application; and

(2) except as provided in subsection (d), provide retroactive reimbursement under subsection (c).

(b) If the office or a managed care organization fails to issue a credentialing determination within thirty (30) calendar days as required by subsection (a)(1), the office or the managed care organization shall issue a provisional credentialing license to a provider upon the submission by the provider of a complete credentialing application and verification by the office or the managed care organization that the provider holds a valid license in Indiana for the profession for which the provider is seeking to be credentialed. The provisional credentialing license is valid until

a determination is made on the credentialing application of the provider.

(c) If the office or a managed care organization fully credentials a provider that holds provisional credentialing, reimbursement payments shall be retroactive to the date of the provisional credentialing.

(d) If the office or a managed care organization does not fully credential a provider that holds provisional credentialing, the office or a managed care organization is not required to reimburse for services rendered while the provider was provisionally credentialed.

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

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

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

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

SECTION 5. IC 12-15-35-28, AS AMENDED BY P.L.130-2018, SECTION 48, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 28. (a) The board has the following duties:

(1) The implementation of a Medicaid retrospective and prospective DUR program as outlined in this chapter, including the approval of software programs to be used by the pharmacist for prospective DUR and recommendations concerning the provisions of the contractual agreement between the state and any other entity that will be processing and reviewing Medicaid drug claims and profiles for the DUR program under this chapter.

(2) The development and application of the predetermined criteria and standards for appropriate prescribing to be used in retrospective and prospective DUR to ensure that such criteria

1 and standards for appropriate prescribing are based on the
2 compendia and developed with professional input with provisions
3 for timely revisions and assessments as necessary.
4 (3) The development, selection, application, and assessment of
5 interventions for physicians, pharmacists, and patients that are
6 educational and not punitive in nature.
7 (4) The publication of an annual report that must be subject to
8 public comment before issuance to the federal Department of
9 Health and Human Services and to the Indiana legislative council
10 by December 1 of each year. The report issued to the legislative
11 council must be in an electronic format under IC 5-14-6.
12 (5) The development of a working agreement for the board to
13 clarify the areas of responsibility with related boards or agencies,
14 including the following:
15 (A) The Indiana board of pharmacy.
16 (B) The medical licensing board of Indiana.
17 (C) The SURS staff.
18 (6) The establishment of a grievance and appeals process for
19 physicians or pharmacists under this chapter.
20 (7) The publication and dissemination of educational information
21 to physicians and pharmacists regarding the board and the DUR
22 program, including information on the following:
23 (A) Identifying and reducing the frequency of patterns of
24 fraud, abuse, gross overuse, or inappropriate or medically
25 unnecessary care among physicians, pharmacists, and
26 recipients.
27 (B) Potential or actual severe or adverse reactions to drugs.
28 (C) Therapeutic appropriateness.
29 (D) Overutilization or underutilization.
30 (E) Appropriate use of generic drugs.
31 (F) Therapeutic duplication.
32 (G) Drug-disease contraindications.
33 (H) Drug-drug interactions.
34 (I) Incorrect drug dosage and duration of drug treatment.
35 (J) Drug allergy interactions.
36 (K) Clinical abuse and misuse.
37 (8) The adoption and implementation of procedures designed to
38 ensure the confidentiality of any information collected, stored,
39 retrieved, assessed, or analyzed by the board, staff to the board, or
40 contractors to the DUR program that identifies individual
41 physicians, pharmacists, or recipients.
42 (9) The implementation of additional drug utilization review with

1 respect to drugs dispensed to residents of nursing facilities shall
2 not be required if the nursing facility is in compliance with the
3 drug regimen procedures under 410 IAC 16.2-3.1 and 42 CFR
4 483.60.
5 (10) The research, development, and approval of a preferred drug
6 list for:
7 (A) Medicaid's fee for service program;
8 (B) a risk based managed care program, if the office provides
9 a prescription drug benefit and subject to IC 12-15-5; and
10 (C) the children's health insurance program under IC 12-17.6;
11 in consultation with the therapeutics committee.
12 (11) The approval of the review and maintenance of the preferred
13 drug list at least two (2) times per year.
14 (12) The preparation and submission of a report concerning the
15 preferred drug list at least one (1) time per year to the interim
16 study committee on public health, behavioral health, and human
17 services established by IC 2-5-1.3-4 in an electronic format under
18 IC 5-14-6.
19 (13) The collection of data reflecting prescribing patterns related
20 to treatment of children diagnosed with attention deficit disorder
21 or attention deficit hyperactivity disorder.
22 (14) Advising the Indiana comprehensive health insurance
23 association established by IC 27-8-10-2.1 concerning
24 implementation of chronic disease management and
25 pharmaceutical management programs under IC 27-8-10-3.5.
26 (b) The board shall use the clinical expertise of the therapeutics
27 committee in developing a preferred drug list. The board shall also
28 consider expert testimony in the development of a preferred drug list.
29 (c) In researching and developing a preferred drug list under
30 subsection (a)(10), the board shall do the following:
31 (1) Use literature abstracting technology.
32 (2) Use commonly accepted guidance principles of disease
33 management.
34 (3) Develop therapeutic classifications for the preferred drug list.
35 (4) Give primary consideration to the clinical efficacy or
36 appropriateness of a particular drug in treating a specific medical
37 condition.
38 (5) Include in any cost effectiveness considerations the cost
39 implications of other components of the state's Medicaid program
40 and other state funded programs.
41 (d) Prior authorization is required for coverage under a program
42 described in subsection (a)(10) of a drug that is not included on the

preferred drug list.

(e) The board shall determine whether to include a single source covered outpatient drug that is newly approved by the federal Food and Drug Administration on the preferred drug list not later than sixty (60) days after the date on which the manufacturer notifies the board in writing of the drug's approval. However, if the board determines that there is inadequate information about the drug available to the board to make a determination, the board may have an additional sixty (60) days to make a determination from the date that the board receives adequate information to perform the board's review. Prior authorization may not be automatically required for a single source drug that is newly approved by the federal Food and Drug Administration, and that is:

(1) in a therapeutic classification:

(A) that has not been reviewed by the board; and

(B) for which prior authorization is not required; or

(2) the sole drug in a new therapeutic classification that has not been reviewed by the board.

(f) The board may not exclude a drug from the preferred drug list based solely on price.

(g) The following requirements apply to a preferred drug list developed under subsection (a)(10):

(1) Except as provided by IC 12-15-35.5-3(b), ~~and~~ IC 12-15-35.5-3(c), **and IC 12-15-35.5-4.5(b),** the office or the board may require prior authorization for a drug that is included on the preferred drug list under the following circumstances:

(A) To override a prospective drug utilization review alert.

(B) To permit reimbursement for a medically necessary brand name drug that is subject to generic substitution under IC 16-42-22-10.

(C) To prevent fraud, abuse, waste, overutilization, or inappropriate utilization.

(D) To permit implementation of a disease management program.

(E) To implement other initiatives permitted by state or federal law.

(2) All drugs described in IC 12-15-35.5-3(b) must be included on the preferred drug list.

(3) The office may add a drug that has been approved by the federal Food and Drug Administration to the preferred drug list without prior approval from the board.

(4) The board may add a drug that has been approved by the federal Food and Drug Administration to the preferred drug list.

1 (h) At least one (1) time each year, the board shall provide a report
2 to the interim study committee on public health, behavioral health, and
3 human services established by IC 2-5-1.3-4 in an electronic format
4 under IC 5-14-6. The report must contain the following information:
5 (1) The cost of administering the preferred drug list.
6 (2) Any increase in Medicaid physician, laboratory, or hospital
7 costs or in other state funded programs as a result of the preferred
8 drug list.
9 (3) The impact of the preferred drug list on the ability of a
10 Medicaid recipient to obtain prescription drugs.
11 (4) The number of times prior authorization was requested, and
12 the number of times prior authorization was:
13 (A) approved; and
14 (B) disapproved.
15 (5) Any recommendations received from the mental health
16 Medicaid quality advisory committee under section 51(h) of this
17 chapter.
18 (i) The board shall provide the first report required under subsection
19 (h) not later than six (6) months after the board submits an initial
20 preferred drug list to the office.
21 SECTION 6. IC 12-15-35.5-4.5 IS ADDED TO THE INDIANA
22 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
23 [EFFECTIVE JULY 1, 2023]: **Sec. 4.5. (a) As used in this section,**
24 **"office" includes:**
25 **(1) the office of the secretary of family and social services;**
26 **(2) a managed care organization that has contracted with the**
27 **office of Medicaid policy and planning under this article; and**
28 **(3) a person that has contracted with a managed care**
29 **organization described in subdivision (2).**
30 **(b) If the office has not previously required prior authorization**
31 **for a prescription drug during a calendar year, the office may not**
32 **require prior authorization for the prescription drug for the**
33 **remainder of the calendar year.**
34 SECTION 7. IC 12-15-47 IS ADDED TO THE INDIANA CODE
35 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
36 JULY 1, 2023]:
37 **Chapter 47. Medicaid Rehabilitation Option Services**
38 **Reimbursement**
39 **Sec. 1. As used in this chapter, "Medicaid rehabilitation option**
40 **services" means clinical behavioral health services provided to**
41 **recipients and families of recipients living in the community who**
42 **need aid intermittently for emotional disturbances, mental illness,**

and addiction as part of the Medicaid rehabilitation option program.

Sec. 2. (a) Except as provided in subsection (b), the office shall reimburse any Medicaid provider to provide Medicaid rehabilitation option services to an eligible Medicaid recipient if the provider provides the services within the provider's scope of practice and is accredited by any of the following:

(1) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or its successor.

(2) The Commission on Accreditation of Rehabilitation Facilities (CARF), or its successor.

(3) The Council on Accreditation (COA), or its successor.

(b) This section is subject to the provider complying with federal law requirements concerning the Medicaid rehabilitation option program.

Sec. 3. The office shall apply to the United States Department of Health and Human Services and any other necessary federal agency for any state plan amendment or waiver necessary to implement this chapter.

Sec. 4. The office may adopt rules under IC 4-22-2 necessary to implement this chapter.

SECTION 8. IC 16-18-2-37.5, AS AMENDED BY P.L.3-2008, SECTION 103, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 37.5. **(a) "Board", for purposes of IC 16-19-18, has the meaning set forth in IC 16-19-18-1.**

~~(a)~~ **(b)** "Board", for purposes of IC 16-22-8, has the meaning set forth in IC 16-22-8-2.1.

~~(b)~~ **(c)** "Board", for purposes of IC 16-41-42.2, has the meaning set forth in IC 16-41-42.2-1.

SECTION 9. IC 16-18-2-143, AS AMENDED BY P.L.1-2010, SECTION 69, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 143. (a) "Fund", for purposes of IC 16-26-2, has the meaning set forth in IC 16-26-2-2.

(b) "Fund", for purposes of IC 16-31-8.5, has the meaning set forth in IC 16-31-8.5-2.

(c) "Fund", for purposes of IC 16-41-39.4, refers to the childhood lead poisoning prevention fund established by IC 16-41-39.4-3.1.

(d) "Fund", for purposes of IC 16-41-39.8, refers to the lead trust fund established by IC 16-41-39.8-7.

(e) "Fund", for purposes of IC 16-46-5, has the meaning set forth in IC 16-46-5-3.

(f) "Fund", for purposes of IC 16-46-12, has the meaning set forth

1 in IC 16-46-12-1.
2 (g) "Fund", for purposes of IC 16-41-42.2, has the meaning set forth
3 in IC 16-41-42.2-2.
4 (h) "Fund", for purposes of IC 16-35-8, has the meaning set forth in
5 IC 16-35-8-2.
6 **(i) "Fund", for purposes of IC 16-19-18, has the meaning set**
7 **forth in IC 16-19-18-2.**
8 SECTION 10. IC 16-18-2-202.3 IS ADDED TO THE INDIANA
9 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
10 [EFFECTIVE JULY 1, 2023]: **Sec. 202.3. "Licensing agency", for**
11 **purposes of IC 16-19-18, has the meaning set forth in**
12 **IC 16-19-18-3.**
13 SECTION 11. IC 16-19-18 IS ADDED TO THE INDIANA CODE
14 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
15 JULY 1, 2023]:
16 **Chapter 18. Public Health Fund**
17 **Sec. 1. As used in this chapter, "board" has the meaning set**
18 **forth in IC 25-1-8-1.**
19 **Sec. 2. As used in this chapter, "fund" refers to the public health**
20 **fund established by section 4 of this chapter.**
21 **Sec. 3. As used in this chapter, "licensing agency" means the**
22 **Indiana professional licensing agency established by IC 25-1-5-3.**
23 **Sec. 4. (a) The public health fund is established for the purpose**
24 **of providing public health grants.**
25 **(b) The fund shall be administered by the state department.**
26 **(c) The fund consists of the following:**
27 **(1) Money transferred to the fund under section 5 of this**
28 **chapter.**
29 **(2) Appropriations made by the general assembly.**
30 **(3) Grants, gifts, and donations intended for deposit in the**
31 **fund.**
32 **(d) The expenses of administering the fund shall be paid from**
33 **money in the fund.**
34 **(e) The treasurer of state shall invest the money in the fund not**
35 **currently needed to meet the obligations of the fund in the same**
36 **manner as other public money may be invested. Interest that**
37 **accrues from these investments shall be deposited in the fund.**
38 **(f) Money in the fund at the end of a state fiscal year reverts to**
39 **the state general fund.**
40 **Sec. 5. The licensing agency shall transfer to the fund fees**
41 **established under IC 25-1-8-2 that:**
42 **(1) are collected by a board or the licensing agency;**

1 **(2) have not been used by a board or the licensing agency at**
2 **the end of a state fiscal year; and**
3 **(3) do not revert to the state general fund.**
4 SECTION 12. IC 16-21-1-7.1 IS ADDED TO THE INDIANA
5 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
6 [EFFECTIVE JULY 1, 2023]: **Sec. 7.1. (a) A hospital's quality**
7 **assessment and improvement program under 410 IAC 15-1.4-2**
8 **must include a process for determining and reporting the**
9 **occurrence of serious reportable events, as identified by the**
10 **National Quality Forum.**
11 **(b) The executive board may not require a hospital's quality**
12 **assessment and improvement program to determine and report**
13 **any other types of events that are not described in subsection (a).**
14 **(c) The executive board may adopt rules under IC 4-22-2 to**
15 **implement this section.**
16 SECTION 13. IC 16-21-1-7.2 IS ADDED TO THE INDIANA
17 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
18 [EFFECTIVE JULY 1, 2023]: **Sec. 7.2. (a) The medical staff (as**
19 **described in IC 16-21-2-7) may make recommendations on the**
20 **appointment or reappointment of an applicant to the governing**
21 **board for a period not to exceed thirty-six (36) months.**
22 **(b) The executive board may adopt rules under IC 4-22-2 to**
23 **implement this section.**
24 SECTION 14. IC 16-21-2-14.5 IS ADDED TO THE INDIANA
25 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
26 [EFFECTIVE JULY 1, 2023]: **Sec. 14.5. (a) This section does not**
27 **apply to a critical access hospital that meets the criteria under 42**
28 **CFR 485.601 through 42 CFR 485.647.**
29 **(b) A hospital with an emergency department must have at least**
30 **one (1) physician on site and on duty who is responsible for the**
31 **emergency department at all times the emergency department is**
32 **open.**
33 SECTION 15. IC 16-35-2-11 IS ADDED TO THE INDIANA
34 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
35 [EFFECTIVE JULY 1, 2023]: **Sec. 11. (a) An individual who is:**
36 **(1) blind; and**
37 **(2) less than twenty-one (21) years of age;**
38 **has an eligible medical condition under this chapter.**
39 **(b) The state department shall extend all care, services, and**
40 **materials provided under this chapter to an individual described**
41 **in subsection (a) who meets any additional eligibility criteria**
42 **established by the state department under this chapter.**

1 SECTION 16. IC 25-0.5-10-1, AS AMENDED BY P.L.177-2015,
2 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2023]: Sec. 1. As used in IC 25-1-1.1, ~~and~~ IC 25-1-8-6, **and**
4 **IC 25-1-22,** "board" means any of the entities described in this chapter.
5 SECTION 17. IC 25-1-8-9 IS ADDED TO THE INDIANA CODE
6 AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
7 1, 2023]: **Sec. 9. (a) The legislative services agency shall conduct an**
8 **analysis of the fees established under section 2 of this chapter.**
9 **(b) Not later than January 31, 2026, the legislative services**
10 **agency shall submit a report to the budget committee in an**
11 **electronic format under IC 5-14-6 containing the results of the**
12 **analysis conducted under subsection (a). The report must include:**
13 **(1) the amount of fees collected; and**
14 **(2) a description of how the proceeds from the collected fees**
15 **were used;**
16 **during the two (2) most recent fiscal years.**
17 **(c) This section expires July 1, 2026.**
18 SECTION 18. IC 25-1-22 IS ADDED TO THE INDIANA CODE
19 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
20 JULY 1, 2023]:
21 **Chapter 22. Interstate Mobility of Occupational Licensing**
22 **Sec. 1. As used in this chapter, "board" has the meaning set**
23 **forth in IC 25-0.5-10-1.**
24 **Sec. 2. As used in this chapter, "government certification"**
25 **means a voluntary, government granted, and nontransferable**
26 **recognition to an individual who meets personal qualifications**
27 **related to a lawful occupation. The term includes a government's**
28 **initial and continuing approval to use the titles "government**
29 **certified" or "state certified". The term does not include**
30 **credentials that are prerequisites to working lawfully in an**
31 **occupation, including credentials:**
32 **(1) used for medical board certification; or**
33 **(2) held by a certified public accountant.**
34 **Sec. 3. As used in this chapter, "lawful occupation" means a**
35 **course of conduct, pursuit, or profession that includes the sale of**
36 **goods or services that are not themselves illegal to sell, irrespective**
37 **of whether the individual selling the goods or services is subject to**
38 **an occupational license. The term does not include an occupation**
39 **regulated by the supreme court.**
40 **Sec. 4. As used in this chapter, "military" means the armed**
41 **forces of the United States, including the Air Force, Army, Coast**
42 **Guard, Marine Corps, Navy, Space Force, National Guard, and all**

1 **reserve components and auxiliaries. The term also includes the**
2 **military reserves and militia of any United States territory or state.**
3 **Sec. 5. As used in this chapter, "occupational license" is a**
4 **nontransferable authorization in law for an individual to perform**
5 **exclusively a lawful occupation based on meeting personal**
6 **qualifications. The term includes a military occupational specialty.**
7 **Sec. 6. As used in this chapter, "other state" or "another state"**
8 **means a:**
9 **(1) state in the United States; or**
10 **(2) territory of the United States;**
11 **other than Indiana. The term also means a branch or unit of the**
12 **military.**
13 **Sec. 7. As used in this chapter, "scope of practice" means the**
14 **procedures, actions, processes, and work that an individual may**
15 **perform under an occupational license or government certification**
16 **issued in Indiana.**
17 **Sec. 8. (a) Notwithstanding any other law, after June 30, 2023,**
18 **a board shall issue an occupational license or government**
19 **certification to an individual upon application, if the following**
20 **conditions are met:**
21 **(1) The applicant holds a current and valid occupational**
22 **license or government certification in another state in a lawful**
23 **occupation with a similar scope of practice, as determined by**
24 **the board.**
25 **(2) The applicant has held the occupational license or**
26 **government certification in the other state for at least one (1)**
27 **year.**
28 **(3) The regulating entity in the other state required the**
29 **applicant to:**
30 **(A) pass an examination; or**
31 **(B) meet education, training, or experience standards.**
32 **(4) The regulating entity in the other state holds the applicant**
33 **in good standing.**
34 **(5) The applicant does not have a disqualifying criminal**
35 **record as determined by the board.**
36 **(6) A regulating entity in another state has not revoked the**
37 **applicant's occupational license or government certification**
38 **because of negligence or intentional misconduct related to the**
39 **applicant's work in the occupation.**
40 **(7) The applicant did not surrender an occupational license or**
41 **government certification because of negligence or intentional**
42 **misconduct related to the applicant's work in the occupation**

1 **in another state.**
2 **(8) Except as provided in subsection (b), the applicant does**
3 **not have a complaint, allegation, or investigation pending**
4 **before a regulating entity in another state that relates to**
5 **unprofessional conduct or an alleged crime.**
6 **(9) The applicant pays all applicable fees in Indiana.**
7 **(b) If the applicant has a complaint, allegation, or investigation**
8 **pending under subsection (a)(8), the board shall not issue or deny**
9 **an occupational license or government certification to the applicant**
10 **until the:**
11 **(1) complaint, allegation, or investigation is resolved; or**
12 **(2) applicant otherwise meets the criteria for an occupational**
13 **license or government certification in Indiana to the**
14 **satisfaction of the board.**
15 **(c) If another state issued to the applicant a government**
16 **certification but Indiana requires an occupational license to work,**
17 **the board shall issue an occupational license to the applicant if the**
18 **applicant otherwise satisfies the conditions of subsection (a).**
19 **Sec. 9. Notwithstanding any other law, after June 30, 2023, a**
20 **board shall issue an occupational license or government**
21 **certification to an individual upon application based on the**
22 **individual's work experience in another state, if the following**
23 **conditions are met:**
24 **(1) The applicant worked in a state that does not use an**
25 **occupational license or government certification to regulate**
26 **the lawful occupation, but Indiana uses an occupational**
27 **license or government certification to regulate a lawful**
28 **occupation with a similar scope of practice, as determined by**
29 **the board.**
30 **(2) The applicant has worked for at least three (3) years in the**
31 **lawful occupation.**
32 **(3) The applicant satisfies the requirements described in**
33 **section 8(a)(5) through 8(a)(9) of this chapter.**
34 **Sec. 10. A board may require an individual to pass a**
35 **jurisprudential examination specific to relevant state laws that**
36 **regulate the occupation, if an occupational license or government**
37 **certification in Indiana requires an individual to pass a**
38 **jurisprudential examination specific to:**
39 **(1) relevant state statutes; and**
40 **(2) administrative rules;**
41 **that regulate the occupation.**
42 **Sec. 11. The board shall provide an applicant with a written**

1 **decision concerning an application submitted under this chapter**
2 **not later than thirty (30) days after the board receives a completed**
3 **application.**
4 **Sec. 12. (a) Subject to subsection (b), an applicant may appeal**
5 **under IC 4-21.5-5 the board's decision under section 11 of this**
6 **chapter to a court of competent jurisdiction.**
7 **(b) An applicant may appeal the board's:**
8 **(1) denial of an occupational license or government**
9 **certification;**
10 **(2) determination of the appropriate occupation;**
11 **(3) determination of the similarity of the scope of practice of**
12 **the occupational license or government certification issued; or**
13 **(4) other determinations under this chapter.**
14 **Sec. 13. An individual who obtains an occupational license or**
15 **government certification under this chapter is subject to the:**
16 **(1) laws regulating the occupation in Indiana; and**
17 **(2) jurisdiction of the applicable board.**
18 **Sec. 14. (a) An occupational license or government certification**
19 **issued under this chapter is valid only in Indiana. Unless otherwise**
20 **provided by law, the occupational license or government**
21 **certification does not make the individual eligible to work in**
22 **another state under an interstate compact or reciprocity**
23 **agreement.**
24 **(b) This chapter may not be construed to:**
25 **(1) prohibit an individual from applying for an occupational**
26 **license or government certification under another statute or**
27 **rule in state law;**
28 **(2) prevent Indiana from entering into a licensing compact or**
29 **reciprocity agreement with another state, a foreign province,**
30 **or a foreign country;**
31 **(3) prevent Indiana from recognizing occupational credentials**
32 **issued by a private certification organization, foreign**
33 **province, foreign country, international organization, or other**
34 **entity; or**
35 **(4) require a private certification organization to grant or**
36 **deny private certification to any individual.**
37 **Sec. 15. (a) An individual who does not possess a valid**
38 **occupational license may not perform an occupation for which a**
39 **license is required.**
40 **(b) An individual who has not been approved to use the titles**
41 **"government certified" or "state certified" may perform the**
42 **lawful occupation for compensation, but may not use the title**

"government certified" or "state certified". However, this subsection does not authorize a person to practice a lawful occupation:

(1) without a license or certification; and

(2) if a license or certification is required to perform the lawful occupation.

Sec. 16. (a) A board may charge a fee for each application submitted under this chapter.

(b) The fee charged under subsection (a) may not exceed one hundred dollars ($100).

Sec. 17. Notwithstanding any other law, during a state of disaster emergency under IC 10-14-3-12, the governor may:

(1) order the recognition of an occupational license from another state or a foreign country as if the license is issued in Indiana; and

(2) expand the scope of practice of any license and authorize a licensee to provide services in Indiana in person, telephonically, or by other means for the duration of the emergency.

Sec. 18. This chapter preempts the laws of:

(1) a unit (as defined in IC 36-1-2-23); and

(2) other governments in Indiana that regulate occupational licenses and government certification.

SECTION 19. IC 25-13-1-8, AS AMENDED BY P.L.78-2017, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 8. (a) A license to practice dental hygiene in Indiana may be issued to candidates who pass an examination administered by an entity that has been approved by the board. Subject to IC 25-1-2-6(e), the license shall be valid for the remainder of the renewal period in effect on the date the license was issued.

(b) Prior to the issuance of the license, the applicant shall pay a fee set by the board under section 5 of this chapter. Subject to IC 25-1-2-6(e), a license issued by the board expires on a date specified by the Indiana professional licensing agency under IC 25-1-5-4(l) of each even-numbered year.

(c) Subject to IC 25-1-2-6(e), an applicant for license renewal must satisfy the following conditions:

(1) Pay ~~(A)~~ the renewal fee set by the board under section 5 of this chapter on or before the renewal date specified by the Indiana professional licensing agency in each even-numbered year. ~~and~~

~~(B) a compliance fee of twenty dollars ($20) to be deposited in the dental compliance fund established by IC 25-14-1-3.7.~~

1 (2) Subject to IC 25-1-4-3, provide the board with a sworn
2 statement signed by the applicant attesting that the applicant has
3 fulfilled the continuing education requirements under IC 25-13-2.
4 (3) Be currently certified or successfully complete a course in
5 basic life support through a program approved by the board. The
6 board may waive the basic life support requirement for applicants
7 who show reasonable cause.
8 (d) If the holder of a license does not renew the license on or before
9 the renewal date specified by the Indiana professional licensing agency,
10 the license expires and becomes invalid without any action by the
11 board.
12 (e) A license invalidated under subsection (d) may be reinstated by
13 the board in three (3) years or less after such invalidation if the holder
14 of the license meets the requirements under IC 25-1-8-6(c).
15 (f) If a license remains invalid under subsection (d) for more than
16 three (3) years, the holder of the invalid license may obtain a reinstated
17 license by meeting the requirements for reinstatement under
18 IC 25-1-8-6(d). The board may require the licensee to participate in
19 remediation or pass an examination administered by an entity approved
20 by the board.
21 (g) The board may require the holder of an invalid license who files
22 an application under this subsection to appear before the board and
23 explain why the holder failed to renew the license.
24 (h) The board may adopt rules under section 5 of this chapter
25 establishing requirements for the reinstatement of a license that has
26 been invalidated for more than three (3) years.
27 (i) The license to practice must be displayed at all times in plain
28 view of the patients in the office where the holder is engaged in
29 practice. No person may lawfully practice dental hygiene who does not
30 possess a license and its current renewal.
31 (j) Biennial renewals of licenses are subject to the provisions of
32 IC 25-1-2.
33 SECTION 20. IC 25-14-1-3.7, AS AMENDED BY P.L.264-2013,
34 SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
35 JULY 1, 2023]: Sec. 3.7. (a) The dental compliance fund is established
36 to provide funds for administering and enforcing the provisions of this
37 article, including investigating and taking enforcement action against
38 violators of:
39 (1) IC 25-1-9 concerning an individual licensed under IC 25-13
40 or this article;
41 (2) IC 25-13; and
42 (3) this article.

The fund shall be administered by the Indiana professional licensing agency.

(b) The expenses of administering the fund shall be paid from the money in the fund. The fund consists of ~~(1) compliance fees paid under IC 25-13-1-8 and section 10(a) of this chapter; and (2)~~ fines and civil penalties collected through investigations of violations of:

~~(A)~~ **(1)** IC 25-1-9 concerning individuals licensed under IC 25-13 or this article;

~~(B)~~ **(2)** IC 25-13; and

~~(C)~~ **(3)** this article;

conducted by the board or the attorney general.

(c) 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.

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

(e) The attorney general and the Indiana professional licensing agency shall enter into a memorandum of understanding to provide the attorney general with funds to conduct investigations and pursue enforcement action against violators of:

(1) IC 25-1-9 if the individual is licensed under IC 25-13 or this article;

(2) IC 25-13; and

(3) this article.

(f) The attorney general and the Indiana professional licensing agency shall present any memorandum of understanding under subsection (e) annually to the board for review.

SECTION 21. IC 25-14-1-10, AS AMENDED BY P.L.78-2017, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 10. (a) Subject to IC 25-1-2-6(e), unless renewed, a license issued by the board expires on a date specified by the agency under IC 25-1-5-4(l). An applicant for renewal shall pay the renewal fee set by the board under section 13 of this chapter on or before the renewal date specified by the agency. ~~In addition to the renewal fee set by the board, an applicant for renewal shall pay a compliance fee of twenty dollars ($20) to be deposited in the dental compliance fund established by section 3.7 of this chapter.~~

(b) The license shall be properly displayed at all times in the office of the person named as the holder of the license, and a person may not be considered to be in legal practice if the person does not possess the license and renewal card.

(c) If a holder of a dental license does not renew the license on or

before the renewal date specified by the agency, without any action by the board the license together with any related renewal card is invalidated.

(d) Except as provided in section 27.1 of this chapter, a license invalidated under subsection (c) may be reinstated by the board in three (3) years or less after its invalidation if the holder of the license meets the requirements under IC 25-1-8-6(c).

(e) Except as provided in section 27.1 of this chapter, if a license remains invalid under subsection (c) for more than three (3) years, the holder of the invalid license may obtain a reinstated license by satisfying the requirements for reinstatement under IC 25-1-8-6(d).

(f) The board may require the holder of an invalid license who files an application under this subsection to appear before the board and explain why the holder failed to renew the license.

(g) The board may adopt rules under section 13 of this chapter establishing requirements for the reinstatement of a license that has been invalidated for more than three (3) years. The fee for a duplicate license to practice as a dentist is subject to IC 25-1-8-2.

(h) Biennial renewal of licenses is subject to IC 25-1-2.

(i) Subject to IC 25-1-4-3, an application for renewal of a license under this section must contain a sworn statement signed by the applicant attesting that the applicant has fulfilled the continuing education requirements under IC 25-14-3.

SECTION 22. 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

1 received by the insurance company three (3) days after mailing or on
2 the date of delivery.
3 (b) If the insurance company fails, neglects, or refuses to comply
4 with the terms of that order within thirty (30) days after its receipt by
5 the insurance company, or within a shorter period set out in the order
6 if the commissioner determines that an emergency exists, the
7 commissioner may, in addition to any other remedy conferred upon the
8 department or the commissioner by law, bring an action against any
9 such insurance company, its officers, and agents to compel that
10 compliance.
11 (c) The action shall be brought by the commissioner in the Marion
12 County circuit court. The action shall be commenced and prosecuted
13 in accordance with the Indiana Rules of Trial Procedure, and relief for
14 noncompliance of the order includes any remedy appropriate under the
15 facts, including injunction, preliminary injunction, and temporary
16 restraining order. In that action, a change of venue from the judge, but
17 no change of venue from the county, is permitted.
18 SECTION 23. IC 27-1-3.5-6.2 IS ADDED TO THE INDIANA
19 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
20 [EFFECTIVE JULY 1, 2023]: **Sec. 6.2. (a) As used in this section,**
21 **"domestic stock insurer" means a person that:**
22 **(1) provides coverage under a health plan (as defined in**
23 **IC 27-1-48-4);**
24 **(2) is organized under the insurance laws of this state; and**
25 **(3) is a publicly traded stock corporation.**
26 **(b) A domestic stock insurer shall file the following with the**
27 **department:**
28 **(1) Not later than March 1 of each calendar year, the domestic**
29 **stock insurer's annual financial statement from the previous**
30 **calendar year.**
31 **(2) Not later than May 15 of each calendar year, the domestic**
32 **stock insurer's first quarter financial statement from the**
33 **current calendar year.**
34 **(3) Not later than August 15 of each calendar year, the**
35 **domestic stock insurer's second quarter financial statement**
36 **from the current calendar year.**
37 **(4) Not later than November 15 of each calendar year, the**
38 **domestic stock insurer's third quarter financial statement**
39 **from the current calendar year.**
40 **(c) The department must post the information filed under**
41 **subsection (b) on the department's website on a single and easily**
42 **accessible web page not later than ten (10) business days after**

1 **receiving the information.**
2 SECTION 24. IC 27-1-37.4-9.3 IS ADDED TO THE INDIANA
3 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
4 [EFFECTIVE JULY 1, 2023]: **Sec. 9.3. If a health plan has not**
5 **previously required prior authorization for a prescription drug**
6 **under a policy or contract, the health plan may not require prior**
7 **authorization for the prescription drug for the remaining term of**
8 **the policy or contract.**
9 SECTION 25. IC 27-1-37.5-1.5 IS ADDED TO THE INDIANA
10 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
11 [EFFECTIVE JULY 1, 2023]: **Sec. 1.5. As used in this chapter,**
12 **"adverse determination" means a denial of a request for benefits**
13 **on the grounds that the health service or item:**
14 **(1) is not medically necessary, appropriate, effective, or**
15 **efficient;**
16 **(2) is not being provided in or at an appropriate health care**
17 **setting or level of care; or**
18 **(3) is experimental or investigational.**
19 SECTION 26. IC 27-1-37.5-1.7 IS ADDED TO THE INDIANA
20 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
21 [EFFECTIVE JULY 1, 2023]: **Sec. 1.7. As used in this chapter,**
22 **"clinical peer" means a practitioner or other health care provider**
23 **who either:**
24 **(1) holds a nonrestricted license in the health care profession**
25 **under IC 25;**
26 **(2) has been granted reciprocity in the state, if reciprocity**
27 **exists; or**
28 **(3) holds a license that is part of a compact in which the state**
29 **has entered.**
30 SECTION 27. IC 27-1-37.5-10, AS ADDED BY P.L.208-2018,
31 SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
32 JULY 1, 2023]: Sec. 10. (a) This section applies to a request for prior
33 authorization delivered to a health plan after December 31, 2019.
34 (b) A health plan shall accept a request for prior authorization
35 delivered to the health plan by a covered individual's health care
36 provider through a secure electronic transmission. A health care
37 provider shall submit a request for prior authorization through a secure
38 electronic transmission. A health plan shall provide for:
39 (1) a secure electronic transmission; and
40 (2) acknowledgment of receipt, by use of a transaction number or
41 another reference code;
42 of a request for prior authorization and any supporting information.

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

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

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

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

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

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

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

(e) A health plan that utilizes a third party to review requests for prior authorization:

(1) may not require a covered individual's health care provider to submit a request for prior authorization to the third party; and

(2) must transmit a request for prior authorization provided by a covered individual's health care provider through secure electronic transmission to the third party.

SECTION 28. 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) 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) 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 29. 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) 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.**

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

(c) If a peer to peer review by a clinical peer is requested under this section, the health plan must:

(1) provide the peer to peer review by a clinical peer 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; and

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

SECTION 30. 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) A third party administrator of an employee benefit plan that is subject to the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

~~(8)~~ **(9)** Any other person identified by the commissioner for participation in the data base described in this chapter.

SECTION 31. IC 27-1-48 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

1 **Chapter 48. Health Plan Notices**
2 **Sec. 1. As used in this chapter, "covered individual" means an**
3 **individual who is entitled to coverage under a health plan.**
4 **Sec. 2. As used in this chapter, "CPT code" refers to the medical**
5 **billing code that applies to a specific health care service, as**
6 **published in the Current Procedural Terminology code set**
7 **maintained by the American Medical Association.**
8 **Sec. 3. (a) As used in this chapter, "health care service" means**
9 **a health care related service or product rendered or sold by a**
10 **health care provider within the scope of the health care provider's**
11 **license or legal authorization, including hospital, medical, surgical,**
12 **mental health, and substance abuse services or products.**
13 **(b) The term does not include the following:**
14 **(1) Dental services.**
15 **(2) Vision services.**
16 **(3) Long term rehabilitation treatment.**
17 **(4) Pharmaceutical services or products.**
18 **Sec. 4. (a) As used in this chapter, "health plan" means any of**
19 **the following that provides coverage for health care services:**
20 **(1) A policy of accident and sickness insurance (as defined in**
21 **IC 27-8-5-1). However, the term does not include the**
22 **coverages described in IC 27-8-5-2.5(a).**
23 **(2) A contract with a health maintenance organization (as**
24 **defined in IC 27-13-1-19) that provides coverage for basic**
25 **health care services (as defined in IC 27-13-1-4).**
26 **(3) The Medicaid risk based managed care program under**
27 **IC 12-15.**
28 **(b) The term includes a person that administers any of the**
29 **following:**
30 **(1) A policy described in subsection (a)(1).**
31 **(2) A contract described in subsection (a)(2).**
32 **(3) Medicaid risk based managed care.**
33 **Sec. 5. As used in this chapter, "participating provider" refers**
34 **to the following:**
35 **(1) A health care provider that has entered into an agreement**
36 **with an insurer under IC 27-8-11-3.**
37 **(2) A participating provider (as defined in IC 27-13-1-24).**
38 **Sec. 6. As used in this chapter, "prior authorization" means a**
39 **practice implemented by a health plan through which coverage of**
40 **a health care service is dependent on the covered individual or**
41 **health care provider obtaining approval from the health plan**
42 **before the health care service is rendered. The term includes**

1 **prospective or utilization review procedures conducted before a**
2 **health care service is rendered.**
3 **Sec. 7. (a) Within twenty-four (24) hours of the identification of**
4 **a technical issue with a health plan's claims submission system that**
5 **would require a participating provider to submit a second claim**
6 **for the same health care service, the health plan must post notice**
7 **of the technical issue on the health plan's website.**
8 **(b) When a technical issue that was posted under subsection (a)**
9 **is resolved, the health plan must post an update on the resolution**
10 **of the technical issue on the health plan's website for not less than**
11 **seventy-two (72) hours.**
12 **Sec. 8. (a) Not later than February 1 of each calendar year, a**
13 **health plan must post on the health plan's website:**
14 **(1) the thirty (30) most frequently submitted CPT codes that**
15 **were submitted by participating providers for prior**
16 **authorization during the previous calendar year; and**
17 **(2) the percentage of the thirty (30) most frequently submitted**
18 **CPT codes that were approved in the previous calendar year,**
19 **disaggregated by CPT code.**
20 **(b) A health plan must maintain the information required under**
21 **subsection (a) on the health plan's website, organized by year and**
22 **on a single and easily accessible web page.**
23 SECTION 32. IC 27-2-28 IS ADDED TO THE INDIANA CODE
24 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
25 JULY 1, 2023]:
26 **Chapter 28. Premium Rate Increases**
27 **Sec. 1. As used in this chapter, "health insurance policy"**
28 **includes the following:**
29 **(1) A policy of accident and sickness insurance (as defined in**
30 **IC 27-8-5-1).**
31 **(2) An individual contract (as defined in IC 27-13-1-21) or a**
32 **group contract (as defined in IC 27-13-1-16).**
33 **Sec. 2. (a) An insurer shall file a planned premium rate increase**
34 **for a health insurance policy with the commissioner or the**
35 **commissioner's designee for review and approval prior to the**
36 **premium rate increase going into effect. The insurer must submit:**
37 **(1) the planned premium rate increase; and**
38 **(2) written justification for the planned premium rate**
39 **increase.**
40 **(b) The commissioner or the commissioner's designee shall**
41 **review a planned premium rate increase filing and, not later than**
42 **thirty (30) days after the commissioner or the commissioner's**

designee receives a filing under subsection (a), either:
(1) approve the filing; or
(2) provide written notice of a determination that the:
(A) filing is deficient; or
(B) planned premium rate increase is denied.
A written notice of deficiency under this subsection must cite the specific requirements not met by the filing and state the reasons for the determination in sufficient detail to enable the insurer to bring the filing into compliance with the requirements.
(c) If an insurer's planned premium rate increase filing is denied by the commissioner or the commissioner's designee under subsection (b), the insurer may submit:
(1) a lower planned premium rate increase; and
(2) written justification for the lower planned premium rate increase;
to the commissioner or the commissioner's designee for review and approval prior to the lower planned premium rate increase going into effect. A lower planned premium rate increase filing submitted under this subsection must be submitted not later than thirty (30) days after the insurer receives the written notice of denial. If a lower planned premium rate increase filing submitted under this subsection is not submitted within thirty (30) days of the insurer's receipt of the written notice of denial, the commissioner's or the commissioner's designee's determination regarding the filing is final.
(d) The commissioner or the commissioner's designee shall review a lower planned premium rate increase filing submitted under subsection (c) and not later than thirty (30) days after the commissioner or the commissioner's designee receives the submission:
(1) approve the lower planned premium rate increase filing; or
(2) provide written notice of a determination that the:
(A) filing is deficient; or
(B) lower planned premium rate increase is denied.
A written notice of deficiency under this subsection must cite the specific requirements not met by the filing. A written notice of denial under this subsection must state the reasons for the commissioner's or the commissioner's designee's determination in detail. The commissioner's or the commissioner's designee's approval or disapproval of a lower planned premium rate increase filing under this subsection is final.

(e) If a lower planned premium rate increase is denied under subsection (d), the insurer may not increase the premium rate for the health insurance policy for that calendar year.

(f) The department must post the final written justification for a planned premium rate increase on the department's website after the filing has been approved or denied by the commissioner or the commissioner's designee.

Sec. 3. If an insurer's planned premium rate increase is approved under section 2 of this chapter, the insurer must provide written justification of the premium rate increase to an individual or entity covered by the health insurance policy not less than thirty (30) days prior to the premium rate increase going into effect.

SECTION 33. 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 34. 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 35. 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:**

(1) alter the CPT code submitted for a clean claim; and

(2) pay for a CPT code of lesser monetary value;

unless the medical record of the clean claim has been reviewed by an employee of the insurer who is licensed under IC 25-22.5.

(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 to reach the final diagnosis.

SECTION 36. IC 27-8-11-3 IS AMENDED TO READ AS

1 FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 3. (a) An insurer may:
2 (1) enter into agreements with providers relating to terms and
3 conditions of reimbursement for health care services that may be
4 rendered to insureds of the insurer, including agreements relating
5 to the amounts to be charged the insured for services rendered or
6 the terms and conditions for activities intended to reduce
7 inappropriate care;
8 (2) issue or administer policies in this state that include incentives
9 for the insured to utilize the services of a provider that has entered
10 into an agreement with the insurer under subdivision (1); and
11 (3) issue or administer policies in this state that provide for
12 reimbursement for expenses of health care services only if the
13 services have been rendered by a provider that has entered into an
14 agreement with the insurer under subdivision (1).
15 (b) Before entering into any agreement under subsection (a)(1), an
16 insurer shall establish terms and conditions that must be met by
17 providers wishing to enter into an agreement with the insurer under
18 subsection (a)(1). These terms and conditions may not discriminate
19 unreasonably against or among providers. For the purposes of this
20 subsection, neither differences in prices among hospitals or other
21 institutional providers produced by a process of individual negotiation
22 nor price differences among other providers in different geographical
23 areas or different specialties constitutes unreasonable discrimination.
24 Upon request by a provider seeking to enter into an agreement with an
25 insurer under subsection (a)(1), the insurer shall make available to the
26 provider a written statement of the terms and conditions that must be
27 met by providers wishing to enter into an agreement with the insurer
28 under subsection (a)(1).
29 (c) No hospital, physician, pharmacist, or other provider designated
30 in IC 27-8-6-1 willing to meet the terms and conditions of agreements
31 described in this section may be denied the right to enter into an
32 agreement under subsection (a)(1). When an insurer denies a provider
33 the right to enter into an agreement with the insurer under subsection
34 (a)(1) on the grounds that the provider does not satisfy the terms and
35 conditions established by the insurer for providers entering into
36 agreements with the insurer, the insurer shall provide the provider with
37 a written notice that:
38 (1) explains the basis of the insurer's denial; and
39 (2) states the specific terms and conditions that the provider, in
40 the opinion of the insurer, does not satisfy.
41 (d) In no event may an insurer deny or limit reimbursement to an
42 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) 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 37. IC 27-8-11-7, AS AMENDED BY P.L.195-2018, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: 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) 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) Subject to subsection (d), an insurer shall credential a provider not later than thirty (30) calendar days after the provider submits a completed credentialing application form if the provider meets the insurer's credentialing requirements.

~~(c)~~ **(d) If a completed credentialing application form submitted by a provider contains a deficiency,** an insurer shall:

(1) notify ~~a~~ **the** provider concerning ~~a~~ **the** deficiency on ~~a~~ **the** completed credentialing application form ~~submitted by the provider~~ not later than ~~thirty (30) business~~ **seven (7) calendar** days after the insurer receives the completed credentialing application form; **and**

(2) provide updates to the provider concerning the status of

the provider's completed credentialing application form every seven (7) calendar days after the notice is provided under subdivision (1) until the insurer makes a final credentialing determination concerning the provider.

~~(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) **calendar** 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.

SECTION 38. 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) 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 39. 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:**

(1) alter the CPT code (as defined in IC 27-1-37.5-3) submitted for a clean claim; and

(2) pay for a CPT code (as defined in IC 27-1-37.5-3) of lesser monetary value;

unless the medical record of the clean claim has been reviewed by an employee of the health maintenance organization who is licensed under IC 25-22.5.

(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 to reach the final diagnosis.

SECTION 40. IC 27-13-43-2, AS AMENDED BY P.L.1-2006, SECTION 489, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 2. (a) 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) Subject to subsection (c), a health maintenance organization shall credential a provider not later than thirty (30) calendar days after the provider submits a completed credentialing application form if the provider meets the health maintenance organization's credentialing requirements.

~~(b)~~ **(c) If a completed credentialing application form submitted by a provider contains a deficiency,** a health maintenance organization shall:

(1) notify ~~a~~ **the** provider concerning ~~a~~ **the** deficiency on ~~a~~ **the** completed credentialing application form ~~submitted by the provider~~ not later than ~~thirty (30) business~~ **seven (7) calendar** days after the health maintenance organization receives the completed credentialing application form; **and**
(2) provide updates to the provider concerning the status of the provider's completed credentialing application form every seven (7) calendar days after the notice is provided under subdivision (1) until the health maintenance organization makes a final credentialing determination concerning the provider.

~~(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.~~

SECTION 41. IC 27-13-43-3, AS ADDED BY P.L.195-2018, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 3. (a) Notwithstanding section 2 of this chapter, if a health maintenance organization fails to issue a credentialing determination within thirty (30) **calendar** 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 42. [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

1 **15-1.4-2.2 to conform to this act.**
2 **(c) In amending the rule as required by this SECTION, the**
3 **Indiana department of health may adopt an emergency rule in the**
4 **manner provided by IC 4-22-2-37.1.**
5 **(d) Notwithstanding IC 4-22-2-37.1(g), an emergency rule**
6 **adopted by the Indiana department of health under this SECTION**
7 **expires on the date on which a rule that supersedes the emergency**
8 **rule is adopted by the Indiana department of health under**
9 **IC 4-22-2-24 through IC 4-22-2-36.**
10 **(e) This SECTION expires July 1, 2024.**
11 SECTION 43. [EFFECTIVE JULY 1, 2023] **(a) 410**
12 **IAC 15-1.5-5(a)(3) is void. The publisher of the Indiana**
13 **Administrative Code and Indiana Register shall remove this**
14 **subsection from the Indiana Administrative Code.**
15 **(b) This SECTION expires July 1, 2025.**
16 SECTION 44. [EFFECTIVE UPON PASSAGE] **(a) The legislative**
17 **council is urged to assign to the appropriate interim study**
18 **committee the task of studying the issue of whether a health**
19 **insurer or a health maintenance organization should be required**
20 **to exempt a participating health care provider from needing to**
21 **receive prior authorization on a particular health care service if**
22 **the participating health care provider has continuously received**
23 **approval for the health care service for a determined number of**
24 **months.**
25 **(b) This SECTION expires January 1, 2024.**
26 SECTION 45. [EFFECTIVE UPON PASSAGE] **(a) The following**
27 **is appropriated from the tobacco master settlement agreement**
28 **fund established by IC 4-12-1-14.3 to be used by the Indiana**
29 **foundation for dentistry to provide donated dental services:**
30 **(1) Three hundred thousand dollars ($300,000) for the state**
31 **fiscal year beginning July 1, 2023, and ending June 30, 2024.**
32 **(2) Three hundred thousand dollars ($300,000) for the state**
33 **fiscal year beginning July 1, 2024, and ending June 30, 2025.**
34 **(b) This SECTION expires July 1, 2025.**
35 SECTION 46. **An emergency is declared for this act.**