



February 24, 2023

SENATE BILL No. 400

DIGEST OF SB 400 (Updated February 23, 2023 10:02 am - DI 129)

Citations Affected: IC 12-15; IC 16-21; IC 16-35; IC 25-0.5; IC 25-1; IC 25-4.5; IC 25-13; IC 25-14; IC 25-21.8; IC 25-22.5; IC 25-27.5; IC 25-34.5; IC 27-1; IC 27-8; IC 27-13; IC 35-52; noncode.

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 until a decision is made on a provider's credentialing application and allows for retroactive reimbursement. 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 granting of clinical privileges and 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 that a child who is blind is eligible for the Indiana Children's Special Health Care Services. Requires the legislative services agency to conduct an analysis of licensing fees and provide a report to the budget committee. Removes the dental compliance fee. Provides for the licensure of associate physicians. Allows the
(Continued next page)

Effective: Upon passage; July 1, 2023.

**Brown L, Charbonneau, Garten,
Johnson T, Rogers**

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

February 16, 2023, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.

February 23, 2023, amended, reported favorably — Do Pass.

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Digest Continued

commissioner of the department of insurance (commissioner) to issue an order to discontinue a violation of a law (current law specifies orders or rules). Requires the commissioner to consider specified information before approving or disapproving a premium rate increase. Requires a domestic stock insurer to file specified information with the department of insurance. Prohibits the state employee health plan from requiring prior authorization for certain specified services. Changes prior authorization time requirements for urgent care situations. 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: (1) provide a current reimbursement rate schedule to a participating provider; and (2) post certain information on the health plan's website. 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: (1) prior authorization exemptions for certain health care providers; and (2) whether Indiana should adopt an interstate mobility of occupational licensing.

SB 400—LS 7336/DI 141



February 24, 2023

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.

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

- 1 SECTION 1. IC 12-15-11-5, AS AMENDED BY P.L.195-2018,
2 SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2023]: Sec. 5. ~~(a) A provider who participates in the Medicaid~~
4 ~~program must comply with the enrollment requirements that are~~
5 ~~established under rules adopted under IC 4-22-2 by the secretary.~~
6 ~~(b) A provider who participates in the Medicaid program may be~~
7 ~~required to use the centralized credentials verification organization~~
8 ~~established in section 9 of this chapter.~~
9 SECTION 2. IC 12-15-11-9, AS AMENDED BY P.L.32-2021,
10 SECTION 31, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
11 JULY 1, 2023]: Sec. 9. ~~(a) The office shall implement a centralized~~
12 ~~credentials verification organization and credentialing process that:~~
13 ~~(1) uses a common application; as determined by provider type;~~
14 ~~(2) issues a single credentialing decision applicable to all~~
15 ~~Medicaid programs; except as determined by the office;~~

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

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

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

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

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

10 (2) does not contain an error; and

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

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

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

19 (2) concerns whether a provider is eligible to:

20 (A) provide health services to an individual eligible for
21 Medicaid services; and

22 (B) receive reimbursement for the health services;
23 under an agreement that is entered into between the provider
24 and managed care organization or contractor of the office.

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

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

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

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

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

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

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

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

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



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

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

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

11 (1) provide a description of the deficiency; and

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

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

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

20 (1) the provider is provisionally credentialed; and

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

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

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

42 (1) managed care organization; or



1 **(2) contractor of the office.**

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

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

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

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

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

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

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

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

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

28 SECTION 3. IC 16-21-1-7.1 IS ADDED TO THE INDIANA CODE
 29 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 30 1, 2023]: **Sec. 7.1. (a) A hospital's quality assessment and**
 31 **improvement program under 410 IAC 15-1.4-2 must include a**
 32 **process for determining and reporting the occurrence of serious**
 33 **reportable events, as identified by the National Quality Forum.**

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

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

39 SECTION 4. IC 16-21-1-7.2 IS ADDED TO THE INDIANA CODE
 40 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 41 1, 2023]: **Sec. 7.2. (a) The medical staff (as described in**
 42 **IC 16-21-2-7) may make recommendations on the granting of**



1 clinical privileges or the appointment or reappointment of an
 2 applicant to the governing board of the hospital for a period not to
 3 exceed thirty-six (36) months.

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

6 SECTION 5. IC 16-21-2-14.5 IS ADDED TO THE INDIANA
 7 CODE AS A NEW SECTION TO READ AS FOLLOWS
 8 [EFFECTIVE JULY 1, 2023]: **Sec. 14.5. A hospital with an**
 9 **emergency department must have at least one (1) physician on site**
 10 **and on duty who is responsible for the emergency department at all**
 11 **times the emergency department is open.**

12 SECTION 6. IC 16-35-2-11 IS ADDED TO THE INDIANA CODE
 13 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 14 1, 2023]: **Sec. 11. (a) An individual who is:**

15 (1) blind; and

16 (2) less than twenty-one (21) years of age;
 17 has an eligible medical condition under this chapter.

18 (b) The state department shall extend all care, services, and
 19 materials provided under this chapter to an individual described
 20 in subsection (a) who meets any additional eligibility criteria
 21 established by the state department under this chapter.

22 SECTION 7. IC 25-0.5-1-2.4 IS ADDED TO THE INDIANA
 23 CODE AS A NEW SECTION TO READ AS FOLLOWS
 24 [EFFECTIVE JULY 1, 2023]: **Sec. 2.4. IC 25-1-1.1-4 applies to an**
 25 **individual licensed or certified under IC 25-4.5 (associate**
 26 **physicians).**

27 SECTION 8. IC 25-0.5-10-1, AS AMENDED BY P.L.177-2015,
 28 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 29 JULY 1, 2023]: **Sec. 1. As used in IC 25-1-1.1, and IC 25-1-8-6, and**
 30 **IC 25-1-22, "board" means any of the entities described in this chapter.**

31 SECTION 9. IC 25-1-8-9 IS ADDED TO THE INDIANA CODE
 32 AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY
 33 1, 2023]: **Sec. 9. (a) The legislative services agency shall conduct an**
 34 **analysis of the fees established under section 2 of this chapter.**

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

39 (1) the amount of fees collected; and

40 (2) a description of how the proceeds from the collected fees
 41 were used;

42 during the two (2) most recent fiscal years.



- 1 **(c) This section expires July 1, 2026.**
 2 SECTION 10. IC 25-1-9-23, AS AMENDED BY P.L.165-2022,
 3 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 4 UPON PASSAGE]: Sec. 23. (a) This section does not apply to
 5 emergency services.
 6 (b) As used in this section, "covered individual" means an
 7 individual who is entitled to be provided health care services at a cost
 8 established according to a network plan.
 9 (c) As used in this section, "emergency services" means services
 10 that are:
 11 (1) furnished by a provider qualified to furnish emergency
 12 services; and
 13 (2) needed to evaluate or stabilize an emergency medical
 14 condition.
 15 (d) As used in this section, "in network practitioner" means a
 16 practitioner who is required under a network plan to provide health
 17 care services to covered individuals at not more than a preestablished
 18 rate or amount of compensation.
 19 (e) As used in this section, "network plan" means a plan under
 20 which facilities and practitioners are required by contract to provide
 21 health care services to covered individuals at not more than a
 22 preestablished rate or amount of compensation.
 23 (f) As used in this section, "out of network" means that the health
 24 care services provided by the practitioner to a covered individual are
 25 not subject to the covered individual's health carrier network plan.
 26 (g) As used in this section, "practitioner" means the following:
 27 (1) An individual who holds:
 28 (A) an unlimited license, certificate, or registration;
 29 (B) a limited or probationary license, certificate, or
 30 registration;
 31 (C) a temporary license, certificate, registration, or permit;
 32 (D) an intern permit; or
 33 (E) a provisional license;
 34 issued by the board (as defined in IC 25-0.5-11-1) regulating the
 35 profession in question.
 36 (2) An entity that:
 37 (A) is owned by, or employs; or
 38 (B) performs billing for professional health care services
 39 rendered by;
 40 an individual described in subdivision (1).
 41 The term does not include a dentist licensed under IC 25-14, an
 42 optometrist licensed under IC 25-24, or a provider facility (as defined



- 1 in IC 25-1-9.8-10).
- 2 (h) An in network practitioner who provides covered health care
3 services to a covered individual may not charge more for the covered
4 health care services than allowed according to the rate or amount of
5 compensation established by the individual's network plan.
- 6 (i) An out of network practitioner who provides health care services
7 at an in network facility to a covered individual may not be reimbursed
8 more for the health care services than allowed according to the rate or
9 amount of compensation established by the covered individual's
10 network plan unless all of the following conditions are met:
- 11 (1) At least five (5) business days before the health care services
12 are scheduled to be provided to the covered individual, the
13 practitioner provides to the covered individual, on a form separate
14 from any other form provided to the covered individual by the
15 practitioner, a statement in conspicuous type that meets the
16 following requirements:
- 17 (A) Includes a notice reading substantially as follows: "[Name
18 of practitioner] is an out of network practitioner providing
19 [type of care] with [name of in network facility], which is an
20 in network provider facility within your health carrier's plan.
21 [Name of practitioner] will not be allowed to bill you the
22 difference between the price charged by the practitioner and
23 the rate your health carrier will reimburse for the services
24 during your care at [name of in network facility] unless you
25 give your written consent to the charge."
- 26 (B) Sets forth the practitioner's good faith estimate of the
27 amount that the practitioner intends to charge for the health
28 care services provided to the covered individual.
- 29 (C) Includes a notice reading substantially as follows
30 concerning the good faith estimate set forth under clause (B):
31 "The estimate of our intended charge for [name or description
32 of health care services] set forth in this statement is provided
33 in good faith and is our best estimate of the amount we will
34 charge. If our actual charge for [name or description of health
35 care services] exceeds our estimate by the greater of:
- 36 (i) one hundred dollars (\$100); or
37 (ii) five percent (5%);
38 we will explain to you why the charge exceeds the estimate."
- 39 (2) The covered individual signs the statement provided under
40 subdivision (1), signifying the covered individual's consent to the
41 charge for the health care services being greater than allowed
42 according to the rate or amount of compensation established by



1 the network plan.

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

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

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

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

21 (2) five percent (5%);

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

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

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

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

35 ~~(1) is required to comply with; and~~

36 ~~(2) is in compliance with;~~

37 ~~45 CFR Part 149, Subparts E and G, as may be enforced and~~
38 ~~amended by the federal Department of Health and Human~~
39 ~~Services.~~

40 SECTION 11. IC 25-1-9.8-20, AS ADDED BY P.L.165-2022,
41 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
42 UPON PASSAGE]: Sec. 20. ~~A practitioner may satisfy~~ The



1 requirements of this chapter by complying with the requirements set
 2 forth in Section 2799B-6 of the federal Public Health Service Act, as
 3 added by Public Law 116-260: **do not apply to a practitioner that:**

4 **(1) is required to comply with; and**

5 **(2) is in compliance with;**

6 **45 CFR Part 149, Subparts E and G, as may be enforced and**
 7 **amended by the federal Department of Health and Human**
 8 **Services.**

9 SECTION 12. IC 25-4.5 IS ADDED TO THE INDIANA CODE AS
 10 A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1,
 11 2023]:

12 **ARTICLE 4.5. ASSOCIATE PHYSICIANS**

13 **Chapter 1. Definitions**

14 **Sec. 1. The definitions in this chapter apply throughout this**
 15 **article.**

16 **Sec. 2. "Associate physician" means an individual who:**

17 **(1) meets the qualifications under this article; and**

18 **(2) is licensed under this article.**

19 **Sec. 3. "Board" refers to the medical licensing board of Indiana.**

20 **Sec. 4. "Collaborating physician" means a physician licensed by**
 21 **the board who collaborates with and is responsible for an associate**
 22 **physician.**

23 **Sec. 5. (a) "Collaboration" means overseeing the activities of,**
 24 **and accepting responsibility for, the medical services rendered by**
 25 **an associate physician and that one (1) of the following conditions**
 26 **is met at all times that services are rendered or tasks are**
 27 **performed by the associate physician:**

28 **(1) The collaborating physician or the physician designee is**
 29 **physically present at the location at which services are**
 30 **rendered or tasks are performed by the associate physician.**

31 **(2) When the collaborating physician or the physician**
 32 **designee is not physically present at the location at which**
 33 **services are rendered or tasks are performed by the associate**
 34 **physician, the collaborating physician or the physician**
 35 **designee is able to personally ensure proper care of the**
 36 **patient and is:**

37 **(A) immediately available through the use of**
 38 **telecommunications or other electronic means; and**

39 **(B) able to see the person within a medically appropriate**
 40 **time frame;**

41 **for consultation, if requested by the patient or the associate**
 42 **physician.**



1 (b) The term includes the use of protocols, guidelines, and
 2 standing orders developed or approved by the collaborating
 3 physician.

4 Sec. 6. "Physician" means an individual who:

5 (1) holds the degree of doctor of medicine or doctor of
 6 osteopathy, or an equivalent degree; and

7 (2) holds an unlimited license under IC 25-22.5 to practice
 8 medicine or osteopathic medicine.

9 Chapter 2. Licensure

10 Sec. 1. (a) An individual must be licensed by the board before
 11 the individual may practice as an associate physician. The board
 12 may grant an associate physician license to an applicant who meets
 13 the following requirements:

14 (1) Submits an application on forms approved by the board.

15 (2) Pays the fee established by the board.

16 (3) Has:

17 (A) successfully completed the academic requirements for
 18 the degree of doctor of medicine or doctor of osteopathy
 19 from a medical school approved by the board but has not
 20 completed an approved postgraduate residency; and

21 (B) passed step two (2) of the United States Medical
 22 Licensing Examination, the Comprehensive Osteopathic
 23 Medical Licensing Exam, or an equivalent test approved
 24 by the board not more than three (3) years before
 25 graduating from a medical school and applying for
 26 licensure under this chapter.

27 (4) Agrees to practice only primary care services:

28 (A) in a medically underserved rural or urban area; or

29 (B) at a rural health clinic (as defined in 42 U.S.C.
 30 1396d(l)(1));

31 and under a collaborative agreement with a physician as
 32 required under this article.

33 (5) Submits to the board any other information the board
 34 considers necessary to evaluate the applicant's qualifications.

35 (6) Presents satisfactory evidence to the board that the
 36 individual has not been:

37 (A) engaged in an act that would constitute grounds for a
 38 disciplinary sanction under IC 25-1-9; or

39 (B) the subject of a disciplinary action by a licensing or
 40 certification agency of another state or jurisdiction on the
 41 grounds that the individual was not able to practice as an
 42 associate physician without endangering the public.



- 1 (7) Is a resident and citizen of the United States or is a
- 2 lawfully admitted alien.
- 3 (8) Is proficient in English.
- 4 (9) Is of good moral character.
- 5 (b) The board may not require an applicant or an individual
- 6 licensed under this article to complete more continuing education
- 7 than that required of a physician licensed under IC 25-22.5.
- 8 Sec. 2. The board may refuse to issue a license or may issue a
- 9 probationary license to an individual if:
- 10 (1) the individual has been disciplined by an administrative
- 11 agency in another jurisdiction or been convicted for a crime
- 12 that has a direct bearing on the individual's ability to practice
- 13 competently; and
- 14 (2) the board determines that the act for which the individual
- 15 was disciplined or convicted has a direct bearing on the
- 16 individual's ability to practice as an associate physician.
- 17 Sec. 3. (a) If the board issues a probationary license under
- 18 section 2 of this chapter, the committee may require the individual
- 19 who holds the probationary license to meet at least one (1) of the
- 20 following conditions:
- 21 (1) Report regularly to the board upon a matter that is the
- 22 basis for the probation.
- 23 (2) Limit practice to services prescribed by the board.
- 24 (3) Continue or renew professional education.
- 25 (4) Engage in community restitution or service without
- 26 compensation for a number of hours specified by the board.
- 27 (5) Submit to care, counseling, or treatment by a physician
- 28 designated by the board for a matter that is the basis for the
- 29 probation.
- 30 (b) The board shall remove a limitation placed on a
- 31 probationary license if after a hearing the committee finds that the
- 32 deficiency that caused the limitation has been remedied.
- 33 Sec. 4. (a) Subject to IC 25-1-2-6(e), a license issued by the
- 34 board expires on a date established by the Indiana professional
- 35 licensing agency under IC 25-1-5-4 and that does not exceed one (1)
- 36 year from the date the license was issued.
- 37 (b) An individual may renew a license:
- 38 (1) not more than two (2) times; and
- 39 (2) by paying a renewal fee on or before the expiration date of
- 40 the license.
- 41 (c) If an individual fails to pay a renewal fee on or before the
- 42 expiration date of a license, the license becomes invalid and must



1 be returned to the board.

2 (d) Before the board may issue a renewal license, the board shall
3 ensure that the licensee is operating under a collaborative
4 agreement as required by this article.

5 Sec. 5. (a) If an individual surrenders a license to the board, the
6 board may reinstate the license upon written request by the
7 individual.

8 (b) If the board reinstates a license, the board may impose
9 conditions on the license appropriate to the reinstatement.

10 (c) An individual may not surrender a license without written
11 approval by the board if a disciplinary proceeding under this
12 article is pending against the individual.

13 Sec. 6. The board may do any of the following:

14 (1) Suspend or revoke a license of a licensee who commits a
15 serious violation of this article.

16 (2) Discipline a licensee for a less severe violation of this
17 chapter.

18 Chapter 3. Collaborative Agreements

19 Sec. 1. (a) In order to be licensed under this article, an associate
20 physician shall enter into a collaborative agreement with a
21 physician licensed under IC 25-22.5. The associate physician may
22 not practice independently from the collaborating physician.

23 (b) The collaborating physician is responsible at all times for the
24 oversight of the activities of, and accepts responsibility for,
25 primary care services provided by the associate physician.

26 (c) Except in an emergency situation, an associate physician
27 shall clearly identify to a patient that the patient is being treated by
28 an associate physician.

29 (d) If an associate physician determines that a patient needs to
30 be examined by a physician, the associate physician shall
31 immediately notify the collaborating physician or physician
32 designee.

33 (e) If an associate physician notifies the collaborating physician
34 that the collaborating physician should examine a patient, the
35 collaborating physician shall:

36 (1) schedule an examination of the patient unless the patient
37 declines; or

38 (2) arrange for another physician to examine the patient.

39 (f) A collaborating physician or an associate physician who does
40 not comply with this section is subject to discipline under
41 IC 25-1-9.

42 (g) An associate physician's collaborative agreement with a



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collaborating physician must:

- (1) be in writing;**
- (2) include the services delegated to the associate physician by the collaborating physician and limited to those allowed under this article;**
- (3) set forth the collaborative agreement for the associate physician, including the emergency procedures that the associate physician must follow; and**
- (4) specify the protocol the associate physician shall follow in prescribing a drug.**

(h) The collaborating physician shall submit the collaborative agreement to the board. Any amendment to the collaborative agreement must be resubmitted to the board.

(i) A collaborating physician or an associate physician who violates the collaborative agreement described in this section may be disciplined under IC 25-1-9.

Sec. 2. (a) Collaboration by the collaborating physician or the physician's designee must be continuous but does not require the physical presence of the collaborating physician at the time and the place that the services are rendered.

(b) A collaborating physician or physician's designee shall review patient encounters, including at least twenty percent (20%) of the charts in which the associate physician prescribes a controlled substance, not later than ten (10) business days, and within a reasonable time, as established in the collaborative agreement, after the associate physician has seen the patient, that is appropriate for the maintenance of quality medical care.

Sec. 3. (a) A physician collaborating with an associate physician must meet the following requirements:

- (1) Be licensed under IC 25-22.5.**
- (2) Register with the board the physician's intent to enter into a collaborative agreement with an associate physician.**
- (3) Not have a disciplinary action restriction that limits the physician's ability to collaborate with an associate physician.**
- (4) Maintain a written agreement with the associate physician that states the physician will:**
 - (A) work in collaboration with the associate physician in accordance with any rules adopted by the board; and**
 - (B) retain responsibility for the care rendered by the associate physician.**

The collaborative agreement must be signed by the physician and the associate physician, updated annually, and made



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- available to the board upon request.
- (b) Before initiating practice the collaborating physician and the associate physician must submit, on forms approved by the board, the following information:
 - (1) The name, the business address, and the telephone number of the collaborating physician.
 - (2) The name, the business address, and the telephone number of the associate physician.
 - (3) A list of all the locations in which the collaborating physician authorizes the associate physician to prescribe.
 - (4) A brief description of the setting in which the associate physician will practice.
 - (5) A description of the associate physician's controlled substance prescriptive authority in collaboration with the collaborating physician, including a list of the controlled substances the collaborating physician authorizes the associate physician to prescribe and documentation that the authority is consistent with the education, knowledge, skill, and competence of both parties.
 - (6) Any other information required by the board.
- (c) An associate physician shall notify the board of any changes or additions in practice sites or collaborating physicians not more than thirty (30) days after the change or addition.
- Sec. 4. (a) An associate physician who is granted controlled substances prescriptive authority by a collaborating physician under this chapter may prescribe, if agreed to by the collaborating physician:
 - (1) any controlled substance listed in Schedule III, Schedule IV, or Schedule V; and
 - (2) a limited authority of Schedule II controlled substances and only if the Schedule II controlled substance contains hydrocodone.
- (b) The collaborating physician shall specify in the collaborative agreement whether the associate physician has authorization to prescribe a controlled substance and any limitations on the prescribing placed by the collaborating physician.
- (c) An associate physician with prescriptive authority for prescribing controlled substances shall register with the United States Drug Enforcement Administration and include the issued registration number on prescriptions for controlled substances.
- (d) The board may adopt rules under IC 4-22-2 governing the prescribing of controlled substances by an associate physician.



1 **Sec. 5. If an associate physician is employed by a physician, a**
 2 **group of physicians, or another legal entity, the associate physician**
 3 **must be in collaboration with and be the legal responsibility of the**
 4 **collaborating physician. The legal responsibility for the associate**
 5 **physician's patient care activities are that of the collaborating**
 6 **physician, including when the associate physician provides care**
 7 **and treatment for patients in health care facilities.**

8 **Sec. 6. A collaborating physician may not enter into a**
 9 **collaborative practice agreement with a total of more than six (6)**
 10 **associate physicians and physician assistants under IC 25-27.5.**

11 **Sec. 7. The board may adopt rules under IC 4-22-2 specifying**
 12 **requirements and regulation of the use of collaborative agreements**
 13 **under this article.**

14 **Chapter 4. Unauthorized Practice; Penalties; Sanctions**

15 **Sec. 1. An individual may not:**

16 (1) **profess to be an associate physician; or**

17 (2) **use the title "associate physician";**

18 **unless the individual is licensed under this article.**

19 **Sec. 2. An individual who violates this chapter commits a Class**
 20 **B misdemeanor.**

21 **Sec. 3. In addition to the penalty under section 2 of this chapter,**
 22 **an associate physician who violates this article is subject to the**
 23 **sanctions under IC 25-1-9.**

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

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

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

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

41 ~~(B) a compliance fee of twenty dollars (\$20) to be deposited in~~
 42 ~~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 14. 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.



- 1 The fund shall be administered by the Indiana professional licensing
2 agency.
- 3 (b) The expenses of administering the fund shall be paid from the
4 money in the fund. The fund consists of ~~(1) compliance fees paid under~~
5 ~~IC 25-13-1-8 and section 10(a) of this chapter; and (2) fines and civil~~
6 ~~penalties collected through investigations of violations of:~~
7 ~~(A) (1) IC 25-1-9 concerning individuals licensed under IC 25-13~~
8 ~~or this article;~~
9 ~~(B) (2) IC 25-13; and~~
10 ~~(C) (3) this article;~~
11 conducted by the board or the attorney general.
- 12 (c) The treasurer of state shall invest the money in the fund not
13 currently needed to meet the obligations of the fund in the same
14 manner as other public money may be invested.
- 15 (d) Money in the fund at the end of a state fiscal year does not revert
16 to the state general fund.
- 17 (e) The attorney general and the Indiana professional licensing
18 agency shall enter into a memorandum of understanding to provide the
19 attorney general with funds to conduct investigations and pursue
20 enforcement action against violators of:
21 (1) IC 25-1-9 if the individual is licensed under IC 25-13 or this
22 article;
23 (2) IC 25-13; and
24 (3) this article.
- 25 (f) The attorney general and the Indiana professional licensing
26 agency shall present any memorandum of understanding under
27 subsection (e) annually to the board for review.
- 28 SECTION 15. IC 25-14-1-10, AS AMENDED BY P.L.78-2017,
29 SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
30 JULY 1, 2023]: Sec. 10. (a) Subject to IC 25-1-2-6(e), unless renewed,
31 a license issued by the board expires on a date specified by the agency
32 under IC 25-1-5-4(1). An applicant for renewal shall pay the renewal
33 fee set by the board under section 13 of this chapter on or before the
34 renewal date specified by the agency. ~~In addition to the renewal fee set~~
35 ~~by the board, an applicant for renewal shall pay a compliance fee of~~
36 ~~twenty dollars (\$20) to be deposited in the dental compliance fund~~
37 ~~established by section 3.7 of this chapter.~~
- 38 (b) The license shall be properly displayed at all times in the office
39 of the person named as the holder of the license, and a person may not
40 be considered to be in legal practice if the person does not possess the
41 license and renewal card.
- 42 (c) If a holder of a dental license does not renew the license on or



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

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

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

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

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

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

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

24 SECTION 16. IC 25-21.8-4-5, AS ADDED BY P.L.267-2017,
 25 SECTION 16, IS AMENDED TO READ AS FOLLOWS: Sec. 5. This
 26 article does not prohibit the following:

27 (1) An individual who has a license, registration, certificate, or
 28 permit from the state from acting within the scope of the
 29 individual's license, registration, certificate, or permit.

30 (2) An individual who participates in an approved training
 31 program for the purpose of acquiring a license, registration,
 32 certificate, or permit from the state from performing activities
 33 within the scope of the approved training program.

34 (3) A student of an approved massage therapy school from
 35 performing massage therapy under the supervision of the
 36 approved massage therapy school, if the student does not profess
 37 to be a licensed massage therapist.

38 (4) An individual's practice in one (1) or more of the following
 39 areas that does not involve intentional soft tissue manipulation:

40 (A) Alexander Technique.

41 (B) Feldenkrais.

42 (C) Reiki.



- 1 (D) Therapeutic Touch.
- 2 (5) An individual's practice in which the individual provides
- 3 service marked bodywork approaches that involve intentional soft
- 4 tissue manipulation, including:
- 5 (A) Rolfing;
- 6 (B) Trager Approach;
- 7 (C) Polarity Therapy;
- 8 (D) Ortho-bionomy; and
- 9 (E) Reflexology;
- 10 if the individual is approved by a governing body based on a
- 11 minimum level of training, demonstration of competency, and
- 12 adherence to ethical standards.
- 13 (6) The practice of massage therapy by a person either actively
- 14 licensed as a massage therapist in another state or currently
- 15 certified by the National Certification Board of Therapeutic
- 16 Massage and Bodywork or other national certifying body if the
- 17 person's state does not license massage therapists, if the
- 18 individual is performing duties for a non-Indiana based team or
- 19 organization, or for a national athletic event held in Indiana, so
- 20 long as the individual restricts the individual's practice to the
- 21 individual's team or organization during the course of the
- 22 individual's or the individual's team's or the individual's
- 23 organization's stay in Indiana or for the duration of the event.
- 24 (7) Massage therapists from other states or countries providing
- 25 educational programs in Indiana for a period not to exceed thirty
- 26 (30) days within a calendar year.
- 27 (8) An employee of a physician or a group of physicians from
- 28 performing an act, a duty, or a function to which the exception
- 29 described in ~~IC 25-22.5-1-2(a)(20)~~ **IC 25-22.5-1-2(a)(21)** applies.
- 30 (9) An employee of a chiropractor from performing an act, duty,
- 31 or function authorized under IC 25-10-1-13.
- 32 (10) An employee of a podiatrist or a group of podiatrists from
- 33 performing an act, duty, or function to which the exception
- 34 described in IC 25-29-1-0.5(a)(13) applies.
- 35 (11) A dramatic portrayal or some other artistic performance or
- 36 expression involving the practice of massage therapy.
- 37 (12) The practice of massage therapy by a member of an
- 38 emergency response team during a period of active emergency
- 39 response.

40 SECTION 17. IC 25-22.5-1-2, AS AMENDED BY P.L.128-2022,
 41 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 42 JULY 1, 2023]: Sec. 2. (a) This article, as it relates to the unlawful or



1 unauthorized practice of medicine or osteopathic medicine, does not
2 apply to any of the following:

3 (1) A student in training in a medical school approved by the
4 board, or while performing duties as an intern or a resident in a
5 hospital under the supervision of the hospital's staff or in a
6 program approved by the medical school.

7 (2) A person who renders service in case of emergency where no
8 fee or other consideration is contemplated, charged, or received.

9 (3) A paramedic (as defined in IC 16-18-2-266), an advanced
10 emergency medical technician (as defined in IC 16-18-2-6.5), an
11 emergency medical technician (as defined in IC 16-18-2-112), or
12 a person with equivalent certification from another state who
13 renders advanced life support (as defined in IC 16-18-2-7), or
14 basic life support (as defined in IC 16-18-2-33.5):

15 (A) during a disaster emergency declared by the governor
16 under IC 10-14-3-12 in response to an act that the governor in
17 good faith believes to be an act of terrorism (as defined in
18 IC 35-31.5-2-329); and

19 (B) in accordance with the rules adopted by the Indiana
20 emergency medical services commission or the disaster
21 emergency declaration of the governor.

22 (4) Commissioned medical officers or medical service officers of
23 the armed forces of the United States, the United States Public
24 Health Service, and medical officers of the United States
25 Department of Veterans Affairs in the discharge of their official
26 duties in Indiana.

27 (5) An individual who is not a licensee who resides in another
28 state or country and is authorized to practice medicine or
29 osteopathic medicine there, who is called in for consultation by an
30 individual licensed to practice medicine or osteopathic medicine
31 in Indiana.

32 (6) A person administering a domestic or family remedy to a
33 member of the person's family.

34 (7) A member of a church practicing the religious tenets of the
35 church if the member does not make a medical diagnosis,
36 prescribe or administer drugs or medicines, perform surgical or
37 physical operations, or assume the title of or profess to be a
38 physician.

39 (8) A school corporation and a school employee who acts under
40 IC 34-30-14 (or IC 34-4-16.5-3.5 before its repeal).

41 **(9) An associate physician practicing in compliance with**
42 **IC 25-4.5 and under a collaborative agreement.**



- 1 ~~(9)~~ **(10)** A chiropractor practicing the chiropractor's profession
 2 under IC 25-10 or to an employee of a chiropractor acting under
 3 the direction and supervision of the chiropractor under
 4 IC 25-10-1-13.
 5 ~~(10)~~ **(11)** A dental hygienist practicing the dental hygienist's
 6 profession under IC 25-13.
 7 ~~(11)~~ **(12)** A dentist practicing the dentist's profession under
 8 IC 25-14.
 9 ~~(12)~~ **(13)** A hearing aid dealer practicing the hearing aid dealer's
 10 profession under IC 25-20.
 11 ~~(13)~~ **(14)** A nurse practicing the nurse's profession under
 12 IC 25-23. However, a certified registered nurse anesthetist (as
 13 defined in IC 25-23-1-1.4) may administer anesthesia if the
 14 certified registered nurse anesthetist acts under the direction of
 15 and in the immediate presence of a physician.
 16 ~~(14)~~ **(15)** An optometrist practicing the optometrist's profession
 17 under IC 25-24.
 18 ~~(15)~~ **(16)** A pharmacist practicing the pharmacist's profession
 19 under IC 25-26.
 20 ~~(16)~~ **(17)** A physical therapist practicing the physical therapist's
 21 profession under IC 25-27.
 22 ~~(17)~~ **(18)** A podiatrist practicing the podiatrist's profession under
 23 IC 25-29.
 24 ~~(18)~~ **(19)** A psychologist practicing the psychologist's profession
 25 under IC 25-33.
 26 ~~(19)~~ **(20)** A speech-language pathologist or audiologist practicing
 27 the pathologist's or audiologist's profession under IC 25-35.6.
 28 ~~(20)~~ **(21)** An employee of a physician or group of physicians who
 29 performs an act, a duty, or a function that is customarily within
 30 the specific area of practice of the employing physician or group
 31 of physicians, if the act, duty, or function is performed under the
 32 direction and supervision of the employing physician or a
 33 physician of the employing group within whose area of practice
 34 the act, duty, or function falls. An employee may not make a
 35 diagnosis or prescribe a treatment and must report the results of
 36 an examination of a patient conducted by the employee to the
 37 employing physician or the physician of the employing group
 38 under whose supervision the employee is working. An employee
 39 may not administer medication without the specific order of the
 40 employing physician or a physician of the employing group.
 41 Unless an employee is licensed or registered to independently
 42 practice in a profession described in subdivisions ~~(9)~~ **(10)** through



- 1 ~~(18)~~ **(19)**, nothing in this subsection grants the employee
 2 independent practitioner status or the authority to perform patient
 3 services in an independent practice in a profession.
 4 ~~(21)~~ **(22)** A hospital licensed under IC 16-21 or IC 12-25.
 5 ~~(22)~~ **(23)** A health care organization whose members,
 6 shareholders, or partners are individuals, partnerships,
 7 corporations, facilities, or institutions licensed or legally
 8 authorized by this state to provide health care or professional
 9 services as:
 10 (A) a physician;
 11 (B) a psychiatric hospital;
 12 (C) a hospital;
 13 (D) a health maintenance organization or limited service
 14 health maintenance organization;
 15 (E) a health facility;
 16 (F) a dentist;
 17 (G) a registered or licensed practical nurse;
 18 (H) a certified nurse midwife or a certified direct entry
 19 midwife;
 20 (I) an optometrist;
 21 (J) a podiatrist;
 22 (K) a chiropractor;
 23 (L) a physical therapist; or
 24 (M) a psychologist.
 25 ~~(23)~~ **(24)** A physician assistant practicing the physician assistant
 26 profession under IC 25-27.5.
 27 ~~(24)~~ **(25)** A physician providing medical treatment under section
 28 2.1 of this chapter.
 29 ~~(25)~~ **(26)** An attendant who provides attendant care services (as
 30 defined in IC 16-18-2-28.5).
 31 ~~(26)~~ **(27)** A personal services attendant providing authorized
 32 attendant care services under IC 12-10-17.1.
 33 ~~(27)~~ **(28)** A respiratory care practitioner practicing the
 34 practitioner's profession under IC 25-34.5.
 35 (b) A person described in subsection (a)(9) through ~~(a)(18)~~ **(a)(19)**
 36 is not excluded from the application of this article if:
 37 (1) the person performs an act that an Indiana statute does not
 38 authorize the person to perform; and
 39 (2) the act qualifies in whole or in part as the practice of medicine
 40 or osteopathic medicine.
 41 (c) An employment or other contractual relationship between an
 42 entity described in subsection ~~(a)(21)~~ **(a)(22)** through ~~(a)(22)~~ **(a)(23)**



1 and a licensed physician does not constitute the unlawful practice of
 2 medicine or osteopathic medicine under this article if the entity does
 3 not direct or control independent medical acts, decisions, or judgment
 4 of the licensed physician. However, if the direction or control is done
 5 by the entity under IC 34-30-15 (or IC 34-4-12.6 before its repeal), the
 6 entity is excluded from the application of this article as it relates to the
 7 unlawful practice of medicine or osteopathic medicine.

8 (d) This subsection does not apply to a prescription or drug order for
 9 a legend drug that is filled or refilled in a pharmacy owned or operated
 10 by a hospital licensed under IC 16-21. A physician licensed in Indiana
 11 who permits or authorizes a person to fill or refill a prescription or drug
 12 order for a legend drug except as authorized in IC 16-42-19-11 through
 13 IC 16-42-19-19 is subject to disciplinary action under IC 25-1-9. A
 14 person who violates this subsection commits the unlawful practice of
 15 medicine or osteopathic medicine under this chapter.

16 (e) A person described in subsection (a)(8) shall not be authorized
 17 to dispense contraceptives or birth control devices.

18 (f) Nothing in this section allows a person to use words or
 19 abbreviations that indicate or induce an individual to believe that the
 20 person is engaged in the practice of medicine or osteopathic medicine.

21 SECTION 18. IC 25-27.5-5-1, AS AMENDED BY P.L.247-2019,
 22 SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 23 JULY 1, 2023]: Sec. 1. (a) This chapter does not apply to the practice
 24 of other health care professionals set forth under IC 25-22.5-1-2(a)(1)
 25 through ~~IC 25-22.5-1-2(a)(19)~~. **IC 25-22.5-1-2(a)(20)**.

26 (b) This chapter does not exempt a physician assistant from the
 27 requirements of IC 16-41-35-29.

28 SECTION 19. IC 25-27.5-5-2, AS AMENDED BY P.L.247-2019,
 29 SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 30 JULY 1, 2023]: Sec. 2. (a) A physician assistant:

31 (1) must engage in a dependent practice with a collaborating
 32 physician; and

33 (2) may not be independent from the collaborating physician,
 34 including any of the activities of other health care providers set
 35 forth under IC 25-22.5-1-2(a)(1) through ~~IC 25-22.5-1-2(a)(19)~~.

36 **IC 25-22.5-1-2(a)(20)**.

37 A physician assistant may perform, under a collaborative agreement,
 38 the duties and responsibilities that are delegated by the collaborating
 39 physician and that are within the collaborating physician's scope of
 40 practice, including prescribing and dispensing drugs and medical
 41 devices. A patient may elect to be seen, examined, and treated by the
 42 collaborating physician.



1 (b) If a physician assistant determines that a patient needs to be
 2 examined by a physician, the physician assistant shall immediately
 3 notify the collaborating physician or physician designee.

4 (c) If a physician assistant notifies the collaborating physician that
 5 the physician should examine a patient, the collaborating physician
 6 shall:

7 (1) schedule an examination of the patient unless the patient
 8 declines; or

9 (2) arrange for another physician to examine the patient.

10 (d) A collaborating physician or physician assistant who does not
 11 comply with subsections (b) and (c) is subject to discipline under
 12 IC 25-1-9.

13 (e) A physician assistant's collaborative agreement with a
 14 collaborating physician must:

15 (1) be in writing;

16 (2) include all the tasks delegated to the physician assistant by the
 17 collaborating physician;

18 (3) set forth the collaborative agreement for the physician
 19 assistant, including the emergency procedures that the physician
 20 assistant must follow; and

21 (4) specify the protocol the physician assistant shall follow in
 22 prescribing a drug.

23 (f) The physician shall submit the collaborative agreement to the
 24 board. The physician assistant may prescribe a drug under the
 25 collaborative agreement unless the board denies the collaborative
 26 agreement. Any amendment to the collaborative agreement must be
 27 resubmitted to the board, and the physician assistant may operate under
 28 any new prescriptive authority under the amended collaborative
 29 agreement unless the agreement has been denied by the board.

30 (g) A physician or a physician assistant who violates the
 31 collaborative agreement described in this section may be disciplined
 32 under IC 25-1-9.

33 SECTION 20. IC 25-34.5-3-7, AS AMENDED BY THE
 34 TECHNICAL CORRECTIONS BILL OF THE 2023 GENERAL
 35 ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 36 JULY 1, 2023]: Sec. 7. This article does not affect the applicability of
 37 ~~IC 25-22.5-1-2(a)(20)~~. **IC 25-22.5-1-2(a)(21)**.

38 SECTION 21. IC 27-1-3-19 IS AMENDED TO READ AS
 39 FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 19. (a) Whenever the
 40 commissioner determines that any insurance company to which this
 41 article is applicable:

42 (1) is conducting its business contrary to law or in an unsafe or



1 unauthorized manner;

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

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

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

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

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

32 SECTION 22. IC 27-1-3.5-6.2 IS ADDED TO THE INDIANA
33 CODE AS A NEW SECTION TO READ AS FOLLOWS
34 [EFFECTIVE JULY 1, 2023]: **Sec. 6.2. (a) As used in this section,**
35 **"domestic stock insurer" means a person that:**

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

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

39 (3) is a publicly traded stock corporation.

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

42 (1) Not later than March 1 of each calendar year, the domestic



- 1 stock insurer's annual financial statement from the previous
 2 calendar year.
 3 **(2) Not later than May 15 of each calendar year, the domestic**
 4 **stock insurer's first quarter financial statement from the**
 5 **current calendar year.**
 6 **(3) Not later than August 15 of each calendar year, the**
 7 **domestic stock insurer's second quarter financial statement**
 8 **from the current calendar year.**
 9 **(4) Not later than November 15 of each calendar year, the**
 10 **domestic stock insurer's third quarter financial statement**
 11 **from the current calendar year.**

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

16 SECTION 23. IC 27-1-37.5-1, AS ADDED BY P.L.77-2018,
 17 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 18 JULY 1, 2023]: Sec. 1. (a) Except as provided in sections 10, 11, 12,
 19 ~~and~~ 13, **and 13.5** of this chapter, this chapter applies beginning
 20 September 1, 2018.

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

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

26 SECTION 24. IC 27-1-37.5-1.5 IS ADDED TO THE INDIANA
 27 CODE AS A NEW SECTION TO READ AS FOLLOWS
 28 [EFFECTIVE JULY 1, 2023]: **Sec. 1.5. As used in this chapter,**
 29 **"adverse determination" means a denial of a request for benefits**
 30 **on the grounds that the health service or item:**

- 31 **(1) is not medically necessary, appropriate, effective, or**
 32 **efficient;**
 33 **(2) is not being provided in or at an appropriate health care**
 34 **setting or level of care; or**
 35 **(3) is experimental or investigational.**

36 SECTION 25. IC 27-1-37.5-1.7 IS ADDED TO THE INDIANA
 37 CODE AS A NEW SECTION TO READ AS FOLLOWS
 38 [EFFECTIVE JULY 1, 2023]: **Sec. 1.7. As used in this chapter,**
 39 **"clinical peer" means a practitioner or other health care provider**
 40 **who either:**

- 41 **(1) holds a current and valid license in any United States**
 42 **jurisdiction;**



- 1 **(2) has been granted reciprocity in the state, if reciprocity**
 2 **exists; or**
 3 **(3) holds a license that is part of a compact in which the state**
 4 **has entered.**

5 SECTION 26. IC 27-1-37.5-11, AS ADDED BY P.L.77-2018,
 6 SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 7 JULY 1, 2023]: Sec. 11. (a) This section applies to a prior authorization
 8 request delivered to a health plan after December 31, 2019.

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

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

14 (2) If the request is for an urgent care situation, the health plan
 15 shall respond with a prior authorization determination not more
 16 than ~~seventy-two (72)~~ **forty-eight (48)** hours after receiving the
 17 request.

18 (3) If the request is for a nonurgent care situation, the health plan
 19 shall respond with a prior authorization determination not more
 20 than ~~seven (7)~~ **five (5)** business days after receiving the request.

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

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

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

31 (3) if the request is for an urgent care situation, the health care
 32 provider shall respond to the request for additional information
 33 not more than ~~seventy-two (72)~~ **forty-eight (48)** hours after the
 34 health care provider receives the response under subdivision (1).

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

39 SECTION 27. IC 27-1-37.5-13.5 IS ADDED TO THE INDIANA
 40 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
 41 [EFFECTIVE JULY 1, 2023]: **Sec. 13.5. (a) This section applies only**
 42 **to the state employee health plan (as defined in IC 5-10-8-6.7(a)).**



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

- 4 (1) 11200.
- 5 (2) 11201.
- 6 (3) 17311.
- 7 (4) 17312.
- 8 (5) 17313.
- 9 (6) 17314.
- 10 (7) 44140.
- 11 (8) 44160.
- 12 (9) 44970.
- 13 (10) 49505.
- 14 (11) 70450.
- 15 (12) 70551.
- 16 (13) 70552.
- 17 (14) 70553.
- 18 (15) 71250.
- 19 (16) 71260.
- 20 (17) 71275.
- 21 (18) 72141.
- 22 (19) 72148.
- 23 (20) 72158.
- 24 (21) 73221.
- 25 (22) 73721.
- 26 (23) 74150.
- 27 (24) 74160.
- 28 (25) 74176.
- 29 (26) 74177.
- 30 (27) 74178.
- 31 (28) 74179.
- 32 (29) 74181.
- 33 (30) 74183.
- 34 (31) 78452.
- 35 (32) 92507.
- 36 (33) 92526.
- 37 (34) 92609.
- 38 (35) 93303.
- 39 (36) 93306.
- 40 (37) 95044.
- 41 (38) 95806.
- 42 (39) 95810.



- 1 (40) 97110.
- 2 (41) 97112.
- 3 (42) 97116.
- 4 (43) 97129.
- 5 (44) 97130.
- 6 (45) 97140.
- 7 (46) 97530.
- 8 (47) V5010.
- 9 (48) V5256.
- 10 (49) V5261.
- 11 (50) V5275.

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

14 (d) Before November 1, 2025, the:

- 15 (1) interim study committee on public health, behavioral
- 16 health, and human services; and
- 17 (2) interim study committee on financial institutions and
- 18 insurance;

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

22 (e) This section expires June 30, 2026.

23 SECTION 28. IC 27-1-37.5-17 IS ADDED TO THE INDIANA
 24 CODE AS A NEW SECTION TO READ AS FOLLOWS
 25 [EFFECTIVE JULY 1, 2023]: Sec. 17. (a) As used in this section,
 26 "necessary information" includes the results of any face-to-face
 27 clinical evaluation, second opinion, or other clinical information
 28 that is directly applicable to the requested service that may be
 29 required.

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

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

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

- 40 (1) the health plan's clinical peer and the covered individual's
- 41 health care provider or the health care provider's designee
- 42 shall make every effort to provide the peer to peer review not



1 later than seven (7) business days from the date of receipt by
 2 the health plan of the request by the covered individual's
 3 health care provider for a peer to peer review if the health
 4 plan has received the necessary information for the peer to
 5 peer review; and

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

9 SECTION 29. IC 27-1-44.5-2, AS AMENDED BY P.L.165-2022,
 10 SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 11 JULY 1, 2023]: Sec. 2. As used in this chapter, "health payer" includes
 12 the following:

13 (1) Medicare.

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

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

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

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

23 (C) Automobile medical payment insurance.

24 (D) A specified disease policy.

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

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

29 (ii) gaps for deductibles or copayments.

30 (F) Worker's compensation or similar insurance.

31 (G) A student health plan.

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

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

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

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

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

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



1 (8) (9) Any other person identified by the commissioner for
2 participation in the data base described in this chapter.

3 SECTION 30. IC 27-1-45-10, AS ADDED BY P.L.165-2022,
4 SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
5 UPON PASSAGE]: Sec. 10. ~~A facility or a practitioner may satisfy~~ The
6 requirements of this chapter by ~~complying with the requirements set~~
7 ~~forth in Section 2799B-6 of the federal Public Health Service Act, as~~
8 ~~added by Public Law 116-260. do not apply to a facility or~~
9 ~~practitioner that:~~

- 10 (1) is required to comply with; and
- 11 (2) is in compliance with;
- 12 **45 CFR Part 149, Subparts E and G, as may be enforced and**
- 13 **amended by the federal Department of Health and Human**
- 14 **Services.**

15 SECTION 31. IC 27-1-46-18, AS ADDED BY P.L.165-2022,
16 SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
17 UPON PASSAGE]: Sec. 18. ~~A provider facility may satisfy~~ The
18 requirements of this chapter by ~~complying with the requirements set~~
19 ~~forth in Section 2799B-6 of the federal Public Health Service Act, as~~
20 ~~added by Public Law 116-260. do not apply to a facility or~~
21 ~~practitioner that:~~

- 22 (1) is required to comply with; and
- 23 (2) is in compliance with;
- 24 **45 CFR Part 149, Subparts E and G, as may be enforced and**
- 25 **amended by the federal Department of Health and Human**
- 26 **Services.**

27 SECTION 32. IC 27-1-48 IS ADDED TO THE INDIANA CODE
28 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE
29 JULY 1, 2023]:

30 **Chapter 48. Health Plan Notices**

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

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

37 **Sec. 3. (a) As used in this chapter, "health care service" means**
38 **a health care related service or product rendered or sold by a**
39 **health care provider within the scope of the health care provider's**
40 **license or legal authorization, including hospital, medical, surgical,**
41 **mental health, and substance abuse services or products.**

42 **(b) The term does not include the following:**



- 1 (1) Dental services.
 2 (2) Vision services.
 3 (3) Long term rehabilitation treatment.
 4 (4) Pharmaceutical services or products.
- 5 **Sec. 4. (a) As used in this chapter, "health plan" means any of**
 6 **the following that provides coverage for health care services:**
 7 (1) A policy of accident and sickness insurance (as defined in
 8 IC 27-8-5-1). However, the term does not include the
 9 coverages described in IC 27-8-5-2.5(a).
 10 (2) A contract with a health maintenance organization (as
 11 defined in IC 27-13-1-19) that provides coverage for basic
 12 health care services (as defined in IC 27-13-1-4).
 13 (3) The Medicaid risk based managed care program under
 14 IC 12-15.
- 15 **(b) The term includes a person that administers any of the**
 16 **following:**
 17 (1) A policy described in subsection (a)(1).
 18 (2) A contract described in subsection (a)(2).
 19 (3) Medicaid risk based managed care.
- 20 **Sec. 5. As used in this chapter, "participating provider" refers**
 21 **to the following:**
 22 (1) A health care provider that has entered into an agreement
 23 with an insurer under IC 27-8-11-3.
 24 (2) A participating provider (as defined in IC 27-13-1-24).
- 25 **Sec. 6. As used in this chapter, "prior authorization" means a**
 26 **practice implemented by a health plan through which coverage of**
 27 **a health care service is dependent on the covered individual or**
 28 **health care provider obtaining approval from the health plan**
 29 **before the health care service is rendered. The term includes**
 30 **prospective or utilization review procedures conducted before a**
 31 **health care service is rendered.**
- 32 **Sec. 7. A health plan must:**
 33 (1) offer an alternative method for submission of a claim for
 34 when the health plan has technical difficulties with the health
 35 plan's claims submission system; and
 36 (2) post notice of the alternative method for claims submission
 37 on the health plan's website.
- 38 **Sec. 8. (a) Not later than February 1 of each calendar year, a**
 39 **health plan must post on the health plan's website:**
 40 (1) the thirty (30) most frequently submitted CPT codes that
 41 were submitted by participating providers for prior
 42 authorization during the previous calendar year; and



- 1 **(2) the percentage of the thirty (30) most frequently submitted**
 2 **CPT codes that were approved in the previous calendar year,**
 3 **disaggregated by CPT code.**
 4 **(b) A health plan must maintain the information required under**
 5 **subsection (a) on the health plan's website, organized by year and**
 6 **on a single and easily accessible web page.**
 7 SECTION 33. IC 27-8-5-1.5, AS AMENDED BY P.L.124-2018,
 8 SECTION 76, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 9 JULY 1, 2023]: Sec. 1.5. (a) This section applies to a policy of accident
 10 and sickness insurance issued on an individual, a group, a franchise, or
 11 a blanket basis, including a policy issued by an assessment company or
 12 a fraternal benefit society.
 13 (b) As used in this section, "commissioner" refers to the insurance
 14 commissioner appointed under IC 27-1-1-2.
 15 (c) As used in this section, "grossly inadequate filing" means a
 16 policy form filing:
 17 (1) that fails to provide key information, including state specific
 18 information, regarding a product, policy, or rate; or
 19 (2) that demonstrates an insufficient understanding of applicable
 20 legal requirements.
 21 (d) As used in this section, "policy form" means a policy, a contract,
 22 a certificate, a rider, an endorsement, an evidence of coverage, or any
 23 amendment that is required by law to be filed with the commissioner
 24 for approval before use in Indiana.
 25 (e) As used in this section, "type of insurance" refers to a type of
 26 coverage listed on the National Association of Insurance
 27 Commissioners Uniform Life, Accident and Health, Annuity and Credit
 28 Product Coding Matrix under the heading "Continuing Care Retirement
 29 Communities", "Health", "Long Term Care", or "Medicare
 30 Supplement".
 31 (f) Each person having a role in the filing process described in
 32 subsection (i) shall act in good faith and with due diligence in the
 33 performance of the person's duties.
 34 (g) A policy form, including a policy form of a policy, contract,
 35 certificate, rider, endorsement, evidence of coverage, or amendment
 36 that is issued through a health benefit exchange (as defined in
 37 IC 27-19-2-8), may not be issued or delivered in Indiana unless the
 38 policy form has been filed with and approved by the commissioner.
 39 (h) The commissioner shall do the following:
 40 (1) Create a document containing a list of all product filing
 41 requirements for each type of insurance, with appropriate
 42 citations to the law, administrative rule, or bulletin that specifies



- 1 the requirement, including the citation for the type of insurance
 2 to which the requirement applies.
- 3 (2) Make the document described in subdivision (1) available on
 4 the department of insurance Internet site.
- 5 (3) Update the document described in subdivision (1) at least
 6 annually and not more than thirty (30) days following any change
 7 in a filing requirement.
- 8 (i) The filing process is as follows:
- 9 (1) A filer shall submit a policy form filing that:
- 10 (A) includes a copy of the document described in subsection
 11 (h);
- 12 (B) indicates the location within the policy form or supplement
 13 that relates to each requirement contained in the document
 14 described in subsection (h); and
- 15 (C) certifies that the policy form meets all requirements of
 16 state law.
- 17 (2) The commissioner shall review a policy form filing and, not
 18 more than thirty (30) days after the commissioner receives the
 19 filing under subdivision (1):
- 20 (A) approve the filing; or
- 21 (B) provide written notice of a determination:
- 22 (i) that deficiencies exist in the filing; or
- 23 (ii) that the commissioner disapproves the filing.
- 24 A written notice provided by the commissioner under clause (B)
 25 must be based only on the requirements set forth in the document
 26 described in subsection (h) and must cite the specific
 27 requirements not met by the filing. A written notice provided by
 28 the commissioner under clause (B)(i) must state the reasons for
 29 the commissioner's determination in sufficient detail to enable the
 30 filer to bring the policy form into compliance with the
 31 requirements not met by the filing.
- 32 (3) A filer may resubmit a policy form that:
- 33 (A) was determined deficient under subdivision (2) and has
 34 been amended to correct the deficiencies; or
- 35 (B) was disapproved under subdivision (2) and has been
 36 revised.
- 37 A policy form resubmitted under this subdivision must meet the
 38 requirements set forth as described in subdivision (1) and must be
 39 resubmitted not more than thirty (30) days after the filer receives
 40 the commissioner's written notice of deficiency or disapproval. If
 41 a policy form is not resubmitted within thirty (30) days after
 42 receipt of the written notice, the commissioner's determination



1 regarding the policy form is final.

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

5 (A) approve the resubmitted policy form; or

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

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

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

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

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

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



- 1 (2) the filer has materially modified a substantive provision of the
- 2 policy form in the resubmission;
- 3 (3) there has been a change in requirements applying to the policy
- 4 form; or
- 5 (4) there has been reviewer error and the written disapproval fails
- 6 to state a specific requirement with which the policy form does
- 7 not comply.
- 8 (k) The commissioner may return a grossly inadequate filing to the
- 9 filer without triggering a deadline set forth in this section.
- 10 (l) The commissioner may disapprove a policy form if:
- 11 (1) the benefits provided under the policy form are not reasonable
- 12 in relation to the premium charged; or
- 13 (2) the policy form contains provisions that are unjust, unfair,
- 14 inequitable, misleading, or deceptive, or that encourage
- 15 misrepresentation of the policy.
- 16 **(m) Before approving or disapproving a premium rate increase**
- 17 **or decrease, the commissioner shall consider the following:**
- 18 **(1) The products affected, by line of business.**
- 19 **(2) The number of covered lives affected.**
- 20 **(3) Whether the product is open or closed to new members in**
- 21 **the product block.**
- 22 **(4) Applicable median cost sharing for the product, as allowed**
- 23 **by state or federal law.**
- 24 **(5) The benefits provided and the underlying costs of the**
- 25 **health services rendered.**
- 26 **(6) The implementation date of the increase or decrease.**
- 27 **(7) The overall percent premium rate increase or decrease**
- 28 **that is requested.**
- 29 **(8) The actual percent premium rate increase or decrease to**
- 30 **be approved.**
- 31 **(9) Incurred claims paid each year for the past three (3) years,**
- 32 **if applicable.**
- 33 **(10) Earned premiums for each of the past three (3) years, if**
- 34 **applicable.**
- 35 **(11) Projected medical cost trends in the geographic service**
- 36 **region, if the product for which a rate increase or decrease is**
- 37 **requested is not a product offered statewide.**
- 38 **(12) If applicable, historical rebates paid to the policyholder**
- 39 **from the most recent health plan year under the federal**
- 40 **Patient Protection and Affordable Care Act (P.L. 111-148), as**
- 41 **amended by the federal Health Care and Education**
- 42 **Reconciliation Act of 2010 (P.L. 111-152).**



1 **(13) The median cost sharing amount for an individual**
 2 **covered by the product, or the actuarial value information as**
 3 **required under the Patient Protection and Affordable Care**
 4 **Act, if applicable.**

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

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

15 **(p) When considering whether to approve a premium rate**
 16 **increase, the commissioner shall consider whether the current rate**
 17 **is appropriate for achieving the insurer's target loss ratio.**

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

- 21 **(1) consider network adequacy;**
 22 **(2) conduct form review to ensure:**
 23 **(A) minimum essential health benefits; and**
 24 **(B) nondiscriminatory benefit design;**
 25 **(3) perform accreditation confirmation; and**
 26 **(4) confirm quality measures.**

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

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

- 32 **(1) retroactively disapprove the policy form; or**
 33 **(2) examine the filer of the policy form during a routine or**
 34 **targeted market conduct examination for compliance with a policy**
 35 **form filing requirement that was not in existence at the time the**
 36 **policy form was filed.**

37 **SECTION 34. IC 27-8-5.7-2.5 IS ADDED TO THE INDIANA**
 38 **CODE AS A NEW SECTION TO READ AS FOLLOWS**
 39 **[EFFECTIVE JULY 1, 2023]: Sec. 2.5. As used in this chapter, "CPT**
 40 **code" refers to the medical billing code that applies to a specific**
 41 **health care service, as published in the Current Procedural**
 42 **Terminology code set maintained by the American Medical**



1 **Association.**

2 SECTION 35. IC 27-8-5.7-5 IS AMENDED TO READ AS
3 FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 5. (a) An insurer shall
4 pay or deny each clean claim in accordance with ~~section~~ **sections 6 and**
5 **6.5** of this chapter.

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

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

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

10 and describe any remedy necessary to establish a clean claim.

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

13 SECTION 36. IC 27-8-5.7-6.5 IS ADDED TO THE INDIANA
14 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
15 [EFFECTIVE JULY 1, 2023]: **Sec. 6.5. (a) An insurer may not:**

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

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

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

20 **(b) An insurer may not alter a clean claim to only pay for the**
21 **CPT codes necessary for an individual's final diagnosis, if the CPT**
22 **codes billed were deemed medically necessary to reach the final**
23 **diagnosis.**

24 SECTION 37. IC 27-8-11-3 IS AMENDED TO READ AS
25 FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 3. (a) An insurer may:

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

32 (2) issue or administer policies in this state that include incentives
33 for the insured to utilize the services of a provider that has entered
34 into an agreement with the insurer under subdivision (1); and

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

39 (b) Before entering into any agreement under subsection (a)(1), an
40 insurer shall establish terms and conditions that must be met by
41 providers wishing to enter into an agreement with the insurer under
42 subsection (a)(1). These terms and conditions may not discriminate



1 unreasonably against or among providers. For the purposes of this
 2 subsection, neither differences in prices among hospitals or other
 3 institutional providers produced by a process of individual negotiation
 4 nor price differences among other providers in different geographical
 5 areas or different specialties constitutes unreasonable discrimination.
 6 Upon request by a provider seeking to enter into an agreement with an
 7 insurer under subsection (a)(1), the insurer shall make available to the
 8 provider a written statement of the terms and conditions that must be
 9 met by providers wishing to enter into an agreement with the insurer
 10 under subsection (a)(1).

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

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

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

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

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

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

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

31 Nor shall such a cause of action arise against any person or provider for
 32 furnishing personal or privileged information to an insurer. However,
 33 this subsection provides no immunity for disclosing or furnishing false
 34 information with malice or willful intent to injure any person, provider,
 35 or insurer.

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

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

42 (1) every two (2) years; and



- 1 **(2) when three (3) or more CPT code (as defined in**
 2 **IC 27-1-37.5-3) rates under the agreement are changed in a**
 3 **twelve (12) month period.**
- 4 SECTION 38. IC 27-8-11-7, AS AMENDED BY P.L.195-2018,
 5 SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 6 JULY 1, 2023]: Sec. 7. (a) This section applies to an insurer that issues
 7 or administers a policy that provides coverage for basic health care
 8 services (as defined in IC 27-13-1-4).
- 9 **(b) As used in this section, "clean credentialing application"**
 10 **means an application for network participation that:**
 11 **(1) is submitted by a provider under this section;**
 12 **(2) does not contain an error; and**
 13 **(3) may be processed by the insurer without returning the**
 14 **application to the provider for a revision or clarification.**
- 15 **(c) As used in this section, "credentialing" means a process by**
 16 **which an insurer makes a determination that:**
 17 **(1) is based on criteria established by the insurer; and**
 18 **(2) concerns whether a provider is eligible to:**
 19 **(A) provide health services to an individual eligible for**
 20 **coverage; and**
 21 **(B) receive reimbursement for the health services;**
 22 **under an agreement that is entered into between the provider**
 23 **and the insurer.**
- 24 **(d) As used in this section, "unclean credentialing application"**
 25 **means an application for network participation that:**
 26 **(1) is submitted by a provider under this section;**
 27 **(2) contains at least one (1) error; and**
 28 **(3) must be returned to the provider to correct the error.**
- 29 ~~(b)~~ **(e) The department of insurance shall prescribe the credentialing**
 30 **application form used by the Council for Affordable Quality Healthcare**
 31 **(CAQH) in electronic or paper format, which must be used by:**
 32 **(1) a provider who applies for credentialing by an insurer; and**
 33 **(2) an insurer that performs credentialing activities.**
- 34 ~~(c)~~ **(e) An insurer shall notify a provider concerning a deficiency on a**
 35 **completed credentialing application form submitted by the provider not**
 36 **later than thirty (30) business days after the insurer receives the**
 37 **completed credentialing application form.**
- 38 ~~(d)~~ **(e) An insurer shall notify a provider concerning the status of the**
 39 **provider's completed credentialing application not later than:**
 40 **(1) sixty (60) days after the insurer receives the completed**
 41 **credentialing application form; and**
 42 **(2) every thirty (30) days after the notice is provided under**



- 1 subdivision (1); until the insurer makes a final credentialing
 2 determination concerning the provider.
- 3 (e) Notwithstanding subsection (d), if an insurer fails to issue a
 4 credentialing determination within thirty (30) days after receiving a
 5 completed credentialing application form from a provider; the insurer
 6 shall provisionally credential the provider if the provider meets the
 7 following criteria:
- 8 (1) The provider has submitted a completed and signed
 9 credentialing application form and any required supporting
 10 material to the insurer.
- 11 (2) The provider was previously credentialed by the insurer in
 12 Indiana and in the same scope of practice for which the provider
 13 has applied for provisional credentialing.
- 14 (3) The provider is a member of a provider group that is
 15 credentialed and a participating provider with the insurer.
- 16 (4) The provider is a network provider with the insurer.
- 17 (f) The criteria for issuing provisional credentialing under
 18 subsection (e) may not be less stringent than the standards and
 19 guidelines governing provisional credentialing from the National
 20 Committee for Quality Assurance or its successor organization.
- 21 (g) Once an insurer fully credentials a provider that holds
 22 provisional credentialing, reimbursement payments under the contract
 23 shall be retroactive to the date of the provisional credentialing. The
 24 insurer shall reimburse the provider at the rates determined by the
 25 contract between the provider and the insurer.
- 26 (h) If an insurer does not fully credential a provider that is
 27 provisionally credentialed under subsection (e), the provisional
 28 credentialing is terminated on the date the insurer notifies the provider
 29 of the adverse credentialing determination. The insurer is not required
 30 to reimburse for services rendered while the provider was provisionally
 31 credentialed.
- 32 (f) **An insurer shall notify a provider concerning a deficiency on**
 33 **a completed unclean credentialing application form submitted by**
 34 **the provider not later than five (5) business days after the entity**
 35 **receives the completed unclean credentialing application form. A**
 36 **notice described in this subsection must:**
- 37 (1) provide a description of the deficiency; and
 38 (2) state the reason why the application was determined to be
 39 an unclean credentialing application.
- 40 (g) **A provider shall respond to the notification required under**
 41 **subsection (f) not later than five (5) business days after receipt of**
 42 **the notice.**



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

- 3 **(1) the provider is provisionally credentialed; and**
 4 **(2) the insurer makes a final credentialing determination**
 5 **concerning the provider.**

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

15 **(j) Once an insurer fully credentials a provider that holds**
 16 **provisional credentialing and a network provider agreement has**
 17 **been executed, then reimbursement payments under the contract**
 18 **shall be paid retroactive to the later of:**

- 19 **(1) the date the provider was provisionally credentialed; or**
 20 **(2) the effective date of the provider agreement.**

21 **The insurer shall reimburse the provider at the rates determined**
 22 **by the contract between the provider and the insurer.**

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

29 **SECTION 39. IC 27-13-15-1 IS AMENDED TO READ AS**
 30 **FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 1. (a) A contract**
 31 **between a health maintenance organization and a participating provider**
 32 **of health care services:**

- 33 **(1) must be in writing;**
 34 **(2) may not prohibit the participating provider from disclosing:**
 35 **(A) the terms of the contract as it relates to financial or other**
 36 **incentives to limit medical services by the participating**
 37 **provider; or**
 38 **(B) all treatment options available to an insured, including**
 39 **those not covered by the insured's policy;**
 40 **(3) may not provide for a financial or other penalty to a provider**
 41 **for making a disclosure permitted under subdivision (2); and**
 42 **(4) must provide that in the event the health maintenance**



- 1 organization fails to pay for health care services as specified by
 2 the contract, the subscriber or enrollee is not liable to the
 3 participating provider for any sums owed by the health
 4 maintenance organization.
- 5 (b) An enrollee is not entitled to coverage of a health care service
 6 under a group or an individual contract unless that health care service
 7 is included in the enrollee's contract.
- 8 (c) A provider is not entitled to payment under a contract for health
 9 care services provided to an enrollee unless the provider has a contract
 10 or an agreement with the carrier.
- 11 ~~(d) This section applies to a contract entered, renewed, or modified~~
 12 ~~after June 30, 1996.~~
- 13 **(d) This subsection does not apply to a rate schedule maintained**
 14 **by state or federal government payers. A health maintenance**
 15 **organization that enters into a contract with a participating**
 16 **provider must provide the participating provider with a current**
 17 **reimbursement rate schedule:**
- 18 (1) every two (2) years; and
 19 (2) when three (3) or more CPT code (as defined in
 20 IC 27-1-37.5-3) rates under the contract change in a twelve
 21 (12) month period.
- 22 SECTION 40. IC 27-13-20-1.5 IS ADDED TO THE INDIANA
 23 CODE AS A NEW SECTION TO READ AS FOLLOWS
 24 [EFFECTIVE JULY 1, 2023]: **Sec. 1.5. (a) Before approving or**
 25 **disapproving an increase or decrease in the rates to be used by a**
 26 **health maintenance organization, the commissioner shall review**
 27 **the following:**
- 28 (1) The products affected, by line of business.
 29 (2) The number of covered lives affected.
 30 (3) Whether the product is open or closed to new members in
 31 the product block.
 32 (4) Applicable median cost sharing for the product, as allowed
 33 by state or federal law.
 34 (5) The benefits provided and the underlying costs of the
 35 health services rendered.
 36 (6) The implementation date of the increase or decrease.
 37 (7) The overall percent premium rate increase or decrease
 38 that is requested.
 39 (8) The actual percent premium rate increase or decrease to
 40 be approved.
 41 (9) Incurred claims paid each year for the past three (3) years,
 42 if applicable.



- 1 **(10) Earned premiums for each of the past three (3) years, if**
 2 **applicable.**
- 3 **(11) Projected medical cost trends in the geographic service**
 4 **region, if the product for which a rate increase or decrease is**
 5 **requested is not a product offered statewide.**
- 6 **(12) If applicable, historical rebates paid to the enrollee from**
 7 **the most recent health plan year under the federal Patient**
 8 **Protection and Affordable Care Act (P.L. 111-148), as**
 9 **amended by the federal Health Care and Education**
 10 **Reconciliation Act of 2010 (P.L. 111-152).**
- 11 **(13) The median cost sharing amount for a member enrolled**
 12 **in the product, or the actuarial value information as required**
 13 **under the Patient Protection and Affordable Care Act, if**
 14 **applicable.**
- 15 **(b) The commissioner shall not approve a rate increase or**
 16 **decrease for an existing product unless the commissioner has, at a**
 17 **minimum, considered the matters set forth in subsection (a)(1)**
 18 **through (a)(13).**
- 19 **(c) The information compiled, prepared, and considered by the**
 20 **commissioner under subsection (a)(1) through (a)(13) is subject to**
 21 **the requirements of IC 5-14-3. However, the commissioner's**
 22 **approval of a rate increase or decrease may take effect before the**
 23 **information compiled, prepared, and considered by the**
 24 **commissioner under subsection (a)(1) through (a)(13) is made**
 25 **accessible to the public under IC 5-14-3.**
- 26 **(d) When considering whether to approve a premium rate**
 27 **increase, the commissioner shall consider whether the current rate**
 28 **is appropriate for achieving the target loss ratio of the health**
 29 **maintenance organization.**
- 30 **(e) To the extent authorized by the Patient Protection and**
 31 **Affordable Care Act and other federal law, the commissioner,**
 32 **under this section, may:**
- 33 **(1) consider network adequacy;**
 34 **(2) conduct form review to ensure:**
 35 **(A) minimum essential health benefits; and**
 36 **(B) nondiscriminatory benefit design;**
 37 **(3) perform accreditation confirmation; and**
 38 **(4) confirm quality measures.**
- 39 **SECTION 41. IC 27-13-36.2-4.5 IS ADDED TO THE INDIANA**
 40 **CODE AS A NEW SECTION TO READ AS FOLLOWS**
 41 **[EFFECTIVE JULY 1, 2023]: Sec. 4.5. (a) A health maintenance**
 42 **organization may not:**



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

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

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

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

13 SECTION 42. IC 27-13-43-2, AS AMENDED BY P.L.1-2006,
14 SECTION 489, IS AMENDED TO READ AS FOLLOWS
15 [EFFECTIVE JULY 1, 2023]: Sec. 2. (a) As used in this section,
16 "clean credentialing application" means an application for
17 network participation that:

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

19 (2) does not contain an error; and

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

23 (b) As used in this section, "credentialing" means a process by
24 which a health maintenance organization makes a determination
25 that:

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

28 (2) concerns whether a provider is eligible to:

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

31 (B) receive reimbursement for the health services;

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

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

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

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

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

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

42 (1) a provider who applies for credentialing by a health



1 maintenance organization; and

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

4 (b) A health maintenance organization shall notify a provider
5 concerning a deficiency on a completed credentialing application form
6 submitted by the provider not later than thirty (30) business days after
7 the health maintenance organization receives the completed
8 credentialing application form:

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

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

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

17 (e) An insurer shall notify a provider concerning a deficiency on
18 a completed unclean credentialing application form submitted by
19 the provider not later than five (5) business days after the entity
20 receives the completed unclean credentialing application form. A
21 notice described in this subsection must:

22 (1) provide a description of the deficiency; and

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

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

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

30 (1) the provider is provisionally credentialed; and

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

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

42 (i) Once an insurer fully credentials a provider that holds



1 provisional credentialing and a network provider agreement has
 2 been executed, then reimbursement payments under the contract
 3 shall be paid retroactive to the later of:

- 4 (1) the date the provider was provisionally credentialed; or
 5 (2) the effective date of the provider agreement.

6 The insurer shall reimburse the provider at the rates determined
 7 by the contract between the provider and the insurer.

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

14 SECTION 43. IC 27-13-43-3 IS REPEALED [EFFECTIVE JULY
 15 1, 2023]. Sec. 3: (a) Notwithstanding section 2 of this chapter, if a
 16 health maintenance organization fails to issue a credentialing
 17 determination within thirty (30) days after receiving a completed
 18 credentialing application form from a provider, the health maintenance
 19 organization shall provisionally credential the provider if the provider
 20 meets the following criteria:

21 (1) The provider has submitted a completed and signed
 22 credentialing application form and any required supporting
 23 material to the health maintenance organization:

24 (2) The provider was previously credentialed by the health
 25 maintenance organization in Indiana and in the same scope of
 26 practice for which the provider has applied for provisional
 27 credentialing:

28 (3) The provider is a member of a provider group that is
 29 credentialed and a participating provider with the health
 30 maintenance organization:

31 (4) The provider is a network provider with the health
 32 maintenance organization:

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

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



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

8 SECTION 44. IC 35-52-25-2.8 IS ADDED TO THE INDIANA
 9 CODE AS A NEW SECTION TO READ AS FOLLOWS
 10 [EFFECTIVE JULY 1, 2023]: **Sec. 2.8. IC 25-4.5-4-2 defines a crime**
 11 **concerning associate physicians.**

12 SECTION 45. [EFFECTIVE JULY 1, 2023] (a) 410
 13 IAC 15-1.4-2.2(a) is void. The publisher of the Indiana
 14 Administrative Code and Indiana Register shall remove this
 15 subsection from the Indiana Administrative Code.

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

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

21 (d) Notwithstanding IC 4-22-2-37.1(g), an emergency rule
 22 adopted by the Indiana department of health under this SECTION
 23 expires on the date on which a rule that supersedes the emergency
 24 rule is adopted by the Indiana department of health under
 25 IC 4-22-2-24 through IC 4-22-2-36.

26 (e) This SECTION expires July 1, 2024.

27 SECTION 46. [EFFECTIVE JULY 1, 2023] (a) 410
 28 IAC 15-1.5-5(a)(3) is void. The publisher of the Indiana
 29 Administrative Code and Indiana Register shall remove this
 30 subsection from the Indiana Administrative Code.

31 (b) This SECTION expires July 1, 2025.

32 SECTION 47. [EFFECTIVE UPON PASSAGE] (a) The legislative
 33 council is urged to assign to the appropriate interim study
 34 committee the task of studying the issue of whether a health
 35 insurer or a health maintenance organization should be required
 36 to exempt a participating health care provider from needing to
 37 receive prior authorization on a particular health care service if
 38 the participating health care provider has continuously received
 39 approval for the health care service for a determined number of
 40 months.

41 (b) This SECTION expires January 1, 2024.

42 SECTION 48. [EFFECTIVE UPON PASSAGE] (a) The legislative



1 council is urged to assign to the appropriate interim study
2 committee the task of studying the issue of whether Indiana should
3 adopt an interstate mobility of occupational licensing to allow
4 individuals who hold current and valid occupational licenses or
5 government certifications in another state in a lawful occupation
6 with a similar scope of practice as Indiana to practice in Indiana
7 under certain conditions.

8 (b) This SECTION expires January 1, 2024.
9 SECTION 49. An emergency is declared for this act.



COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 400, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, delete lines 1 through 15.

Delete pages 2 through 3.

Page 4, delete lines 1 through 6.

Page 4, delete lines 15 through 42, begin a new paragraph and insert:

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

- (1) is submitted by a provider under this section;
- (2) does not contain an error; and
- (3) may be processed by the managed care organization or contractor of the office without returning the application to the provider for a revision or clarification.

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

- (1) is based on criteria established by the managed care organization or contractor of the office; and
- (2) concerns whether a provider is eligible to:
 - (A) provide health services to an individual eligible for Medicaid services; and
 - (B) receive reimbursement for the health services; under an agreement that is entered into between the provider and managed care organization or contractor of the office.



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

- (1) is submitted by a provider under this section;
- (2) contains at least one (1) error; and
- (3) must be returned to the provider to correct the error.

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

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

- (1) issue a final credentialing determination not later than sixty (60) calendar days after the date in which the provider was provisionally credentialed; and
- (2) except as provided in subsection (l), provide retroactive reimbursement under subsection (k).

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

- (1) a provider who applies for credentialing by a managed care organization or a contractor of the office; and
- (2) a managed care organization or a contractor of the office that performs credentialing activities.

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

- (1) provide a description of the deficiency; and
- (2) state the reason why the application was determined to be an unclean credentialing application.

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

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

- (1) the provider is provisionally credentialed; and
- (2) the entity makes a final credentialing determination concerning the provider.

(j) If the managed care organization or contractor of the office fails to issue a credentialing determination within fifteen (15) days



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

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

- (1) managed care organization; or
- (2) contractor of the office.

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

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

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

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

- (1) send representatives to meetings and participate in the credentialing process as determined by the office; and
- (2) not require additional credentialing information from a provider if a non-network credentialed provider is used.

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



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

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

Delete pages 5 through 11.

Page 12, delete lines 1 through 3.

Page 12, line 19, after "the" insert "**granting of clinical privileges or the**".

Page 12, line 21, after "board" insert "**of the hospital**".

Page 12, line 26, delete "(a) This section does not".

Page 12, delete lines 27 through 28.

Page 12, line 29, delete "(b)".

Page 12, after line 42, begin a new paragraph and insert:

"SECTION 16. IC 25-0.5-1-2.4 IS ADDED TO THE INDIANA CODE AS A **NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 2.4. IC 25-1-1.1-4 applies to an individual licensed or certified under IC 25-4.5 (associate physicians).**".

Page 13, delete lines 18 through 42, begin a new paragraph and insert:

"SECTION 18. IC 25-1-9-23, AS AMENDED BY P.L.165-2022, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 23. (a) This section does not apply to emergency services.

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

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

- (1) furnished by a provider qualified to furnish emergency services; and
- (2) needed to evaluate or stabilize an emergency medical condition.

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

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

(f) As used in this section, "out of network" means that the health care services provided by the practitioner to a covered individual are



not subject to the covered individual's health carrier network plan.

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

(1) An individual who holds:

- (A) an unlimited license, certificate, or registration;
- (B) a limited or probationary license, certificate, or registration;
- (C) a temporary license, certificate, registration, or permit;
- (D) an intern permit; or
- (E) a provisional license;

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

(2) An entity that:

- (A) is owned by, or employs; or
- (B) performs billing for professional health care services rendered by;

an individual described in subdivision (1).

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

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

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

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

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



give your written consent to the charge."

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

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

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

(ii) five percent (5%);

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

(2) The covered individual signs the statement provided under subdivision (1), signifying the covered individual's consent to the charge for the health care services being greater than allowed according to the rate or amount of compensation established by the network plan.

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

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

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

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

(2) five percent (5%);

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

(m) An in network practitioner is not required to provide a covered



individual with the good faith estimate if the nonemergency health care service is scheduled to be performed by the practitioner within five (5) business days after the health care service is ordered.

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

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

(1) is required to comply with; and

(2) is in compliance with;

45 CFR Part 149, Subparts E and G.

SECTION 19. IC 25-1-9.8-20, AS ADDED BY P.L.165-2022, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 20. ~~A practitioner may satisfy~~ The requirements of this chapter by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260. **do not apply to a practitioner that:**

(1) is required to comply with; and

(2) is in compliance with;

45 CFR Part 149, Subparts E and G."

Delete pages 14 through 16.

Page 17, delete lines 1 through 23, begin a new paragraph and insert:

"SECTION 20. IC 25-4.5 IS ADDED TO THE INDIANA CODE AS A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

ARTICLE 4.5. ASSOCIATE PHYSICIANS

Chapter 1. Definitions

Sec. 1. The definitions in this chapter apply throughout this article.

Sec. 2. "Associate physician" means an individual who:

(1) meets the qualifications under this article; and

(2) is licensed under this article.

Sec. 3. "Board" refers to the medical licensing board of Indiana.

Sec. 4. "Collaborating physician" means a physician licensed by the board who collaborates with and is responsible for an associate physician.

Sec. 5. (a) "Collaboration" means overseeing the activities of, and accepting responsibility for, the medical services rendered by an associate physician and that one (1) of the following conditions



is met at all times that services are rendered or tasks are performed by the associate physician:

(1) The collaborating physician or the physician designee is physically present at the location at which services are rendered or tasks are performed by the associate physician.

(2) When the collaborating physician or the physician designee is not physically present at the location at which services are rendered or tasks are performed by the associate physician, the collaborating physician or the physician designee is able to personally ensure proper care of the patient and is:

(A) immediately available through the use of telecommunications or other electronic means; and

(B) able to see the person within a medically appropriate time frame;

for consultation, if requested by the patient or the associate physician.

(b) The term includes the use of protocols, guidelines, and standing orders developed or approved by the collaborating physician.

Sec. 6. "Physician" means an individual who:

(1) holds the degree of doctor of medicine or doctor of osteopathy, or an equivalent degree; and

(2) holds an unlimited license under IC 25-22.5 to practice medicine or osteopathic medicine.

Chapter 2. Licensure

Sec. 1. (a) An individual must be licensed by the board before the individual may practice as an associate physician. The board may grant an associate physician license to an applicant who meets the following requirements:

(1) Submits an application on forms approved by the board.

(2) Pays the fee established by the board.

(3) Has:

(A) successfully completed the academic requirements for the degree of doctor of medicine or doctor of osteopathy from a medical school approved by the board but has not completed an approved postgraduate residency; and

(B) passed step two (2) of the United States Medical Licensing Examination or the equivalent test approved by the board not more than three (3) years before graduating from a medical school and applying for licensure under this chapter.



- (4) Agrees to practice only primary care services:**
(A) in a medically underserved rural or urban area; or
(B) at a rural health clinic (as defined in 42 U.S.C. 1396d(l)(1));
and under a collaborative agreement with a physician as required under this article.
- (5) Submits to the board any other information the board considers necessary to evaluate the applicant's qualifications.**
- (6) Presents satisfactory evidence to the board that the individual has not been:**
(A) engaged in an act that would constitute grounds for a disciplinary sanction under IC 25-1-9; or
(B) the subject of a disciplinary action by a licensing or certification agency of another state or jurisdiction on the grounds that the individual was not able to practice as an associate physician without endangering the public.
- (7) Is a resident and citizen of the United States or is a lawfully admitted alien.**
- (8) Is proficient in English.**
- (9) Is of good moral character.**

(b) The board may not require an applicant or an individual licensed under this article to complete more continuing education than that required of a physician licensed under IC 25-22.5.

Sec. 2. The board may refuse to issue a license or may issue a probationary license to an individual if:

- (1) the individual has been disciplined by an administrative agency in another jurisdiction or been convicted for a crime that has a direct bearing on the individual's ability to practice competently; and**
- (2) the board determines that the act for which the individual was disciplined or convicted has a direct bearing on the individual's ability to practice as an associate physician.**

Sec. 3. (a) If the board issues a probationary license under section 2 of this chapter, the committee may require the individual who holds the probationary license to meet at least one (1) of the following conditions:

- (1) Report regularly to the board upon a matter that is the basis for the probation.**
- (2) Limit practice to services prescribed by the board.**
- (3) Continue or renew professional education.**
- (4) Engage in community restitution or service without compensation for a number of hours specified by the board.**



(5) Submit to care, counseling, or treatment by a physician designated by the board for a matter that is the basis for the probation.

(b) The board shall remove a limitation placed on a probationary license if after a hearing the committee finds that the deficiency that caused the limitation has been remedied.

Sec. 4. (a) Subject to IC 25-1-2-6(e), a license issued by the board expires on a date established by the Indiana professional licensing agency under IC 25-1-5-4 and that does not exceed one (1) year from the date the license was issued.

(b) An individual may renew a license:

(1) not more than two (2) times; and

(2) by paying a renewal fee on or before the expiration date of the license.

(c) If an individual fails to pay a renewal fee on or before the expiration date of a license, the license becomes invalid and must be returned to the board.

(d) Before the board may issue a renewal license, the board shall ensure that the licensee is operating under a collaborative agreement as required by this article.

Sec. 5. (a) If an individual surrenders a license to the board, the board may reinstate the license upon written request by the individual.

(b) If the board reinstates a license, the board may impose conditions on the license appropriate to the reinstatement.

(c) An individual may not surrender a license without written approval by the board if a disciplinary proceeding under this article is pending against the individual.

Sec. 6. The board may do any of the following:

(1) Suspend or revoke a license of a licensee who commits a serious violation of this article.

(2) Discipline a licensee for a less severe violation of this chapter.

Chapter 3. Collaborative Agreements

Sec. 1. (a) In order to be licensed under this article, an associate physician shall enter into a collaborative agreement with a physician licensed under IC 25-22.5. The associate physician may not practice independently from the collaborating physician.

(b) The collaborating physician is responsible at all times for the oversight of the activities of, and accepts responsibility for, primary care services provided by the associate physician.

(c) Except in an emergency situation, an associate physician



shall clearly identify to a patient that the patient is being treated by an associate physician.

(d) If an associate physician determines that a patient needs to be examined by a physician, the associate physician shall immediately notify the collaborating physician or physician designee.

(e) If an associate physician notifies the collaborating physician that the collaborating physician should examine a patient, the collaborating physician shall:

- (1) schedule an examination of the patient unless the patient declines; or
- (2) arrange for another physician to examine the patient.

(f) A collaborating physician or an associate physician who does not comply with this section is subject to discipline under IC 25-1-9.

(g) An associate physician's collaborative agreement with a collaborating physician must:

- (1) be in writing;
- (2) include the services delegated to the associate physician by the collaborating physician and limited to those allowed under this article;
- (3) set forth the collaborative agreement for the associate physician, including the emergency procedures that the associate physician must follow; and
- (4) specify the protocol the associate physician shall follow in prescribing a drug.

(h) The collaborating physician shall submit the collaborative agreement to the board. Any amendment to the collaborative agreement must be resubmitted to the board.

(i) A collaborating physician or an associate physician who violates the collaborative agreement described in this section may be disciplined under IC 25-1-9.

Sec. 2. (a) Collaboration by the collaborating physician or the physician's designee must be continuous but does not require the physical presence of the collaborating physician at the time and the place that the services are rendered.

(b) A collaborating physician or physician's designee shall review patient encounters, including at least twenty percent (20%) of the charts in which the associate physician prescribes a controlled substance, not later than ten (10) business days, and within a reasonable time, as established in the collaborative agreement, after the associate physician has seen the patient, that



is appropriate for the maintenance of quality medical care.

Sec. 3. (a) A physician collaborating with an associate physician must meet the following requirements:

- (1) Be licensed under IC 25-22.5.**
- (2) Register with the board the physician's intent to enter into a collaborative agreement with an associate physician.**
- (3) Not have a disciplinary action restriction that limits the physician's ability to collaborate with an associate physician.**
- (4) Maintain a written agreement with the associate physician that states the physician will:**
 - (A) work in collaboration with the associate physician in accordance with any rules adopted by the board; and**
 - (B) retain responsibility for the care rendered by the associate physician.**

The collaborative agreement must be signed by the physician and the associate physician, updated annually, and made available to the board upon request.

(b) Before initiating practice the collaborating physician and the associate physician must submit, on forms approved by the board, the following information:

- (1) The name, the business address, and the telephone number of the collaborating physician.**
- (2) The name, the business address, and the telephone number of the associate physician.**
- (3) A list of all the locations in which the collaborating physician authorizes the associate physician to prescribe.**
- (4) A brief description of the setting in which the associate physician will practice.**
- (5) A description of the associate physician's controlled substance prescriptive authority in collaboration with the collaborating physician, including a list of the controlled substances the collaborating physician authorizes the associate physician to prescribe and documentation that the authority is consistent with the education, knowledge, skill, and competence of both parties.**
- (6) Any other information required by the board.**

(c) An associate physician shall notify the board of any changes or additions in practice sites or collaborating physicians not more than thirty (30) days after the change or addition.

Sec. 4. (a) An associate physician who is granted controlled substances prescriptive authority by a collaborating physician under this chapter may prescribe, if agreed to by the collaborating



physician:

- (1) any controlled substance listed in Schedule III, Schedule IV, or Schedule V; and**
- (2) a limited authority of Schedule II controlled substances and only if the Schedule II controlled substance contains hydrocodone.**

(b) The collaborating physician shall specify in the collaborative agreement whether the associate physician has authorization to prescribe a controlled substance and any limitations on the prescribing placed by the collaborating physician.

(c) An associate physician with prescriptive authority for prescribing controlled substances shall register with the United States Drug Enforcement Administration and include the issued registration number on prescriptions for controlled substances.

(d) The board may adopt rules under IC 4-22-2 governing the prescribing of controlled substances by an associate physician.

Sec. 5. If an associate physician is employed by a physician, a group of physicians, or another legal entity, the associate physician must be in collaboration with and be the legal responsibility of the collaborating physician. The legal responsibility for the associate physician's patient care activities are that of the collaborating physician, including when the associate physician provides care and treatment for patients in health care facilities.

Sec. 6. A collaborating physician may not enter into a collaborate practice agreement with a total of more than six (6) associate physicians and physician assistants under IC 25-27.5.

Sec. 7. The board may adopt rules under IC 4-22-2 specifying requirements and regulation of the use of collaborative agreements under this article.

Chapter 4. Unauthorized Practice; Penalties; Sanctions

Sec. 1. An individual may not:

- (1) profess to be an associate physician; or**
- (2) use the title "associate physician";**

unless the individual is licensed under this article.

Sec. 2. An individual who violates this chapter commits a Class B misdemeanor.

Sec. 3. In addition to the penalty under section 2 of this chapter, an associate physician who violates this article is subject to the sanctions under IC 25-1-9."

Page 20, between lines 23 and 24, begin a new paragraph and insert:
 "SECTION 25. IC 25-22.5-1-2, AS AMENDED BY P.L.128-2022, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE



JULY 1, 2023]: Sec. 2. (a) This article, as it relates to the unlawful or unauthorized practice of medicine or osteopathic medicine, does not apply to any of the following:

(1) A student in training in a medical school approved by the board, or while performing duties as an intern or a resident in a hospital under the supervision of the hospital's staff or in a program approved by the medical school.

(2) A person who renders service in case of emergency where no fee or other consideration is contemplated, charged, or received.

(3) A paramedic (as defined in IC 16-18-2-266), an advanced emergency medical technician (as defined in IC 16-18-2-6.5), an emergency medical technician (as defined in IC 16-18-2-112), or a person with equivalent certification from another state who renders advanced life support (as defined in IC 16-18-2-7), or basic life support (as defined in IC 16-18-2-33.5):

(A) during a disaster emergency declared by the governor under IC 10-14-3-12 in response to an act that the governor in good faith believes to be an act of terrorism (as defined in IC 35-31.5-2-329); and

(B) in accordance with the rules adopted by the Indiana emergency medical services commission or the disaster emergency declaration of the governor.

(4) Commissioned medical officers or medical service officers of the armed forces of the United States, the United States Public Health Service, and medical officers of the United States Department of Veterans Affairs in the discharge of their official duties in Indiana.

(5) An individual who is not a licensee who resides in another state or country and is authorized to practice medicine or osteopathic medicine there, who is called in for consultation by an individual licensed to practice medicine or osteopathic medicine in Indiana.

(6) A person administering a domestic or family remedy to a member of the person's family.

(7) A member of a church practicing the religious tenets of the church if the member does not make a medical diagnosis, prescribe or administer drugs or medicines, perform surgical or physical operations, or assume the title of or profess to be a physician.

(8) A school corporation and a school employee who acts under IC 34-30-14 (or IC 34-4-16.5-3.5 before its repeal).

(9) An associate physician practicing in compliance with



IC 25-4.5 and under a collaborative agreement.

~~(9)~~ **(10)** A chiropractor practicing the chiropractor's profession under IC 25-10 or to an employee of a chiropractor acting under the direction and supervision of the chiropractor under IC 25-10-1-13.

~~(10)~~ **(11)** A dental hygienist practicing the dental hygienist's profession under IC 25-13.

~~(11)~~ **(12)** A dentist practicing the dentist's profession under IC 25-14.

~~(12)~~ **(13)** A hearing aid dealer practicing the hearing aid dealer's profession under IC 25-20.

~~(13)~~ **(14)** A nurse practicing the nurse's profession under IC 25-23. However, a certified registered nurse anesthetist (as defined in IC 25-23-1-1.4) may administer anesthesia if the certified registered nurse anesthetist acts under the direction of and in the immediate presence of a physician.

~~(14)~~ **(15)** An optometrist practicing the optometrist's profession under IC 25-24.

~~(15)~~ **(16)** A pharmacist practicing the pharmacist's profession under IC 25-26.

~~(16)~~ **(17)** A physical therapist practicing the physical therapist's profession under IC 25-27.

~~(17)~~ **(18)** A podiatrist practicing the podiatrist's profession under IC 25-29.

~~(18)~~ **(19)** A psychologist practicing the psychologist's profession under IC 25-33.

~~(19)~~ **(20)** A speech-language pathologist or audiologist practicing the pathologist's or audiologist's profession under IC 25-35.6.

~~(20)~~ **(21)** An employee of a physician or group of physicians who performs an act, a duty, or a function that is customarily within the specific area of practice of the employing physician or group of physicians, if the act, duty, or function is performed under the direction and supervision of the employing physician or a physician of the employing group within whose area of practice the act, duty, or function falls. An employee may not make a diagnosis or prescribe a treatment and must report the results of an examination of a patient conducted by the employee to the employing physician or the physician of the employing group under whose supervision the employee is working. An employee may not administer medication without the specific order of the employing physician or a physician of the employing group. Unless an employee is licensed or registered to independently



practice in a profession described in subdivisions (9) through (18), nothing in this subsection grants the employee independent practitioner status or the authority to perform patient services in an independent practice in a profession.

~~(21)~~ **(22)** A hospital licensed under IC 16-21 or IC 12-25.

~~(22)~~ **(23)** A health care organization whose members, shareholders, or partners are individuals, partnerships, corporations, facilities, or institutions licensed or legally authorized by this state to provide health care or professional services as:

- (A) a physician;
- (B) a psychiatric hospital;
- (C) a hospital;
- (D) a health maintenance organization or limited service health maintenance organization;
- (E) a health facility;
- (F) a dentist;
- (G) a registered or licensed practical nurse;
- (H) a certified nurse midwife or a certified direct entry midwife;
- (I) an optometrist;
- (J) a podiatrist;
- (K) a chiropractor;
- (L) a physical therapist; or
- (M) a psychologist.

~~(23)~~ **(24)** A physician assistant practicing the physician assistant profession under IC 25-27.5.

~~(24)~~ **(25)** A physician providing medical treatment under section 2.1 of this chapter.

~~(25)~~ **(26)** An attendant who provides attendant care services (as defined in IC 16-18-2-28.5).

~~(26)~~ **(27)** A personal services attendant providing authorized attendant care services under IC 12-10-17.1.

~~(27)~~ **(28)** A respiratory care practitioner practicing the practitioner's profession under IC 25-34.5.

(b) A person described in subsection (a)(9) through ~~(a)(18)~~ **(a)(19)** is not excluded from the application of this article if:

- (1) the person performs an act that an Indiana statute does not authorize the person to perform; and
 - (2) the act qualifies in whole or in part as the practice of medicine or osteopathic medicine.
- (c) An employment or other contractual relationship between an



entity described in subsection ~~(a)(21)~~ **(a)(22)** through ~~(a)(22)~~ **(a)(23)** and a licensed physician does not constitute the unlawful practice of medicine or osteopathic medicine under this article if the entity does not direct or control independent medical acts, decisions, or judgment of the licensed physician. However, if the direction or control is done by the entity under IC 34-30-15 (or IC 34-4-12.6 before its repeal), the entity is excluded from the application of this article as it relates to the unlawful practice of medicine or osteopathic medicine.

(d) This subsection does not apply to a prescription or drug order for a legend drug that is filled or refilled in a pharmacy owned or operated by a hospital licensed under IC 16-21. A physician licensed in Indiana who permits or authorizes a person to fill or refill a prescription or drug order for a legend drug except as authorized in IC 16-42-19-11 through IC 16-42-19-19 is subject to disciplinary action under IC 25-1-9. A person who violates this subsection commits the unlawful practice of medicine or osteopathic medicine under this chapter.

(e) A person described in subsection (a)(8) shall not be authorized to dispense contraceptives or birth control devices.

(f) Nothing in this section allows a person to use words or abbreviations that indicate or induce an individual to believe that the person is engaged in the practice of medicine or osteopathic medicine."

Page 22, delete lines 2 through 8, begin a new paragraph and insert:

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

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

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

Page 22, delete lines 24 through 25, begin a new line block indented and insert:

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

Page 22, delete lines 30 through 42.

Page 23, delete lines 1 through 34.

Page 24, line 4, strike "seventy-two (72)" and insert "**forty-eight (48)**".

Page 24, line 20, strike "seventy-two (72)" and insert "**forty-eight**".



(48)".

Page 24, between lines 25 and 26, begin a new paragraph and insert:

"SECTION 32. IC 27-1-37.5-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW SECTION** TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 13.5. (a) A health plan may not require a participating provider to obtain prior authorization for the following CPT codes:**

- (1) 11200.
- (2) 11201.
- (3) 17311.
- (4) 17312.
- (5) 17313.
- (6) 17314.
- (7) 44140.
- (8) 44160.
- (9) 44970.
- (10) 49505.
- (11) 70450.
- (12) 70551.
- (13) 70552.
- (14) 70553.
- (15) 71250.
- (16) 71260.
- (17) 71275.
- (18) 72141.
- (19) 72148.
- (20) 72158.
- (21) 73221.
- (22) 73721.
- (23) 74150.
- (24) 74160.
- (25) 74176.
- (26) 74177.
- (27) 74178.
- (28) 74179.
- (29) 74181.
- (30) 74183.
- (31) 78452.
- (32) 92507.
- (33) 92526.
- (34) 92609.
- (35) 93303.



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

(b) A health plan may not issue a retroactive denial for a CPT code listed in subsection (a).

(c) Before November 1, 2025, the:

- (1) interim study committee on public health, behavioral health, and human services; and**
- (2) interim study committee on financial institutions and insurance;**

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

(d) This section expires June 30, 2026."

Page 24, line 28, after "(a)" insert "As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation, second opinion, or other clinical information that is directly applicable to the requested service that may be required.

(b)".

Page 24, line 34, delete "(b)" and insert "(c)".

Page 24, line 37, delete "(c)" and insert "(d)".

Page 24, line 38, delete "section, the health plan must:" and insert "section:

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



plan has received the necessary information for the peer to peer review; and".

Page 24, delete lines 39 through 42.

Page 25, line 1, after "(2)" insert "**the health plan must**".

Page 25, line 3, delete "provider." and insert "**provider or the provider's designee.**".

Page 25, between lines 39 and 40, begin a new paragraph and insert:

"SECTION 35. IC 27-1-45-10, AS ADDED BY P.L.165-2022, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 10. ~~A facility or a practitioner may satisfy~~ The requirements of this chapter ~~by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.~~ **do not apply to a facility or practitioner that:**

(1) is required to comply with; and

(2) is in compliance with;

45 CFR Part 149, Subparts E and G.

SECTION 36. IC 27-1-46-18, AS ADDED BY P.L.165-2022, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 18. ~~A provider facility may satisfy~~ The requirements of this chapter ~~by complying with the requirements set forth in Section 2799B-6 of the federal Public Health Service Act, as added by Public Law 116-260.~~ **do not apply to a facility or practitioner that:**

(1) is required to comply with; and

(2) is in compliance with;

45 CFR Part 149, Subparts E and G."

Page 27, delete lines 3 through 11, begin a new paragraph and insert:

"Sec. 7. A health plan must:

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

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

Page 27, delete lines 23 through 42, begin a new paragraph and insert:

"SECTION 32. IC 27-8-5-1.5, AS AMENDED BY P.L.124-2018, SECTION 76, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 1.5. (a) This section applies to a policy of accident and sickness insurance issued on an individual, a group, a franchise, or a blanket basis, including a policy issued by an assessment company or



a fraternal benefit society.

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

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

- (1) that fails to provide key information, including state specific information, regarding a product, policy, or rate; or
- (2) that demonstrates an insufficient understanding of applicable legal requirements.

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

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

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

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

(h) The commissioner shall do the following:

- (1) Create a document containing a list of all product filing requirements for each type of insurance, with appropriate citations to the law, administrative rule, or bulletin that specifies the requirement, including the citation for the type of insurance to which the requirement applies.
- (2) Make the document described in subdivision (1) available on the department of insurance Internet site.
- (3) Update the document described in subdivision (1) at least annually and not more than thirty (30) days following any change in a filing requirement.

(i) The filing process is as follows:

- (1) A filer shall submit a policy form filing that:
 - (A) includes a copy of the document described in subsection (h);



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

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

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

(A) approve the filing; or

(B) provide written notice of a determination:

(i) that deficiencies exist in the filing; or

(ii) that the commissioner disapproves the filing.

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

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

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

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

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

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

(A) approve the resubmitted policy form; or

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

A written notice of disapproval provided by the commissioner under clause (B) must be based only on the requirements set forth in the document described in subsection (h), must cite the specific requirements not met by the filing, and must state the reasons for



the commissioner's determination in detail. The commissioner's approval or disapproval of a resubmitted policy form under this subdivision is final, except that the commissioner may allow the filer to resubmit a further revised policy form if the filer, in the filer's resubmission under subdivision (3), introduced new provisions or materially modified a substantive provision of the policy form. If the commissioner allows a filer to resubmit a further revised policy form under this subdivision, the filer must resubmit the further revised policy form not more than thirty (30) days after the filer receives notice under clause (B), and the commissioner shall issue a final determination on the further revised policy form not more than thirty (30) days after the commissioner receives the further revised policy form.

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

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

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

- (1) the filer has introduced a new provision in the resubmission;
- (2) the filer has materially modified a substantive provision of the policy form in the resubmission;
- (3) there has been a change in requirements applying to the policy form; or
- (4) there has been reviewer error and the written disapproval fails to state a specific requirement with which the policy form does not comply.

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

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

- (1) the benefits provided under the policy form are not reasonable



in relation to the premium charged; or

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

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

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

(2) The number of covered lives affected.

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

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

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

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

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

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

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

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

(11) Projected medical cost trends in the geographic service region, if the product for which a rate increase or decrease is requested is not a product offered statewide.

(12) If applicable, historical rebates paid to the policyholder from the most recent health plan year under the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

(13) The median cost sharing amount for an individual covered by the product, or the actuarial value information as required under the Patient Protection and Affordable Care Act, if applicable.

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

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



effect before the information compiled, prepared, and considered by the commissioner under subsection (m)(1) through (m)(13) is made accessible to the public under IC 5-14-3.

(p) When considering whether to approve a premium rate increase, the commissioner shall consider whether the current rate is appropriate for achieving the insurer's target loss ratio.

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

- (1) consider network adequacy;
- (2) conduct form review to ensure:
 - (A) minimum essential health benefits; and
 - (B) nondiscriminatory benefit design;
- (3) perform accreditation confirmation; and
- (4) confirm quality measures.

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

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

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

Delete page 28.

Page 29, delete lines 1 through 12.

Page 31, delete lines 21 through 42, begin a new paragraph and insert:

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

- (1) is submitted by a provider under this section;
- (2) does not contain an error; and
- (3) may be processed by the insurer without returning the application to the provider for a revision or clarification.

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



- (1) is based on criteria established by the insurer; and
- (2) concerns whether a provider is eligible to:
 - (A) provide health services to an individual eligible for coverage; and
 - (B) receive reimbursement for the health services; under an agreement that is entered into between the provider and the insurer.

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

- (1) is submitted by a provider under this section;
- (2) contains at least one (1) error; and
- (3) must be returned to the provider to correct the error.

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

- (1) a provider who applies for credentialing by an insurer; and
- (2) an insurer that performs credentialing activities.

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

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

- (1) sixty (60) days after the insurer receives the completed credentialing application form; and
- (2) every thirty (30) days after the notice is provided under subdivision (1), until the insurer makes a final credentialing determination concerning the provider.

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

- (1) The provider has submitted a completed and signed credentialing application form and any required supporting material to the insurer.
- (2) The provider was previously credentialed by the insurer in Indiana and in the same scope of practice for which the provider has applied for provisional credentialing.
- (3) The provider is a member of a provider group that is credentialed and a participating provider with the insurer.
- (4) The provider is a network provider with the insurer.



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

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

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

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

- (1) provide a description of the deficiency; and**
- (2) state the reason why the application was determined to be an unclean credentialing application.**

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

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

- (1) the provider is provisionally credentialed; and**
- (2) the insurer makes a final credentialing determination concerning the provider.**

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

(j) Once an insurer fully credentials a provider that holds provisional credentialing and a network provider agreement has



been executed, then reimbursement payments under the contract shall be paid retroactive to the later of:

- (1) the date the provider was provisionally credentialed; or
- (2) the effective date of the provider agreement.

The insurer shall reimburse the provider at the rates determined by the contract between the provider and the insurer.

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

Page 32, delete lines 1 through 39.

Page 33, between lines 31 and 32, begin a new paragraph and insert:

"SECTION 33. IC 27-13-20-1.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 1.5. (a) Before approving or disapproving an increase or decrease in the rates to be used by a health maintenance organization, the commissioner shall review the following:**

- (1) The products affected, by line of business.
- (2) The number of covered lives affected.
- (3) Whether the product is open or closed to new members in the product block.
- (4) Applicable median cost sharing for the product, as allowed by state or federal law.
- (5) The benefits provided and the underlying costs of the health services rendered.
- (6) The implementation date of the increase or decrease.
- (7) The overall percent premium rate increase or decrease that is requested.
- (8) The actual percent premium rate increase or decrease to be approved.
- (9) Incurred claims paid each year for the past three (3) years, if applicable.
- (10) Earned premiums for each of the past three (3) years, if applicable.
- (11) Projected medical cost trends in the geographic service region, if the product for which a rate increase or decrease is requested is not a product offered statewide.
- (12) If applicable, historical rebates paid to the enrollee from the most recent health plan year under the federal Patient



Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

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

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

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

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

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

- (1) consider network adequacy;
- (2) conduct form review to ensure:
 - (A) minimum essential health benefits; and
 - (B) nondiscriminatory benefit design;
- (3) perform accreditation confirmation; and
- (4) confirm quality measures."

Page 34, delete lines 6 through 42, begin a new paragraph and insert:

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

- (1) is submitted by a provider under this section;
- (2) does not contain an error; and
- (3) may be processed by the health maintenance organization without returning the application to the provider for a



revision or clarification.

(b) As used in this section, "credentialing" means a process by which a health maintenance organization makes a determination that:

- (1) is based on criteria established by the health maintenance organization; and**
- (2) concerns whether a provider is eligible to:**
 - (A) provide health services to an individual eligible for coverage; and**
 - (B) receive reimbursement for the health services; under an agreement that is entered into between the provider and the health maintenance organization.**

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

- (1) is submitted by a provider under this section;**
- (2) contains at least one (1) error; and**
- (3) must be returned to the provider to correct the error.**

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

- (1) a provider who applies for credentialing by a health maintenance organization; and**
- (2) a health maintenance organization that performs credentialing activities.**

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

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

- (1) sixty (60) days after the health maintenance organization receives the completed credentialing application form; and**
- (2) every thirty (30) days after the notice is provided under subdivision (1); until the health maintenance organization makes a final credentialing determination concerning the provider.**

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



- (1) provide a description of the deficiency; and
- (2) state the reason why the application was determined to be an unclean credentialing application.

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

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

- (1) the provider is provisionally credentialed; and
- (2) the insurer makes a final credentialing determination concerning the provider.

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

(i) Once an insurer fully credentials a provider that holds provisional credentialing and a network provider agreement has been executed, then reimbursement payments under the contract shall be paid retroactive to the later of:

- (1) the date the provider was provisionally credentialed; or
- (2) the effective date of the provider agreement.

The insurer shall reimburse the provider at the rates determined by the contract between the provider and the insurer.

(j) If an insurer does not fully credential a provider that is provisionally credentialed under subsection (h), 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 41. IC 27-13-43-3 IS REPEALED [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) 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:"

Page 35, delete lines 1 through 37, begin a new paragraph and insert:

"SECTION 45. IC 35-52-25-2.8 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 2.8. IC 25-4.5-4-2 defines a crime concerning associate physicians.**"

Page 36, between lines 25 and 26, begin a new paragraph and insert:

"SECTION 44. [EFFECTIVE UPON PASSAGE] **(a) The legislative council is urged to assign to the appropriate interim study committee the task of studying the issue of whether Indiana should adopt an interstate mobility of occupational licensing to allow individuals who hold current and valid occupational licenses or government certifications in another state in a lawful occupation with a similar scope of practice as Indiana to practice in Indiana**



under certain conditions.

(b) This SECTION expires January 1, 2024."

Renumber all SECTIONS consecutively.

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

(Reference is to SB 400 as introduced.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 10, Nays 0.

COMMITTEE REPORT

Madam President: The Senate Committee on Appropriations, to which was referred Senate Bill No. 400, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Delete the title and insert the following:

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

Page 2, line 33, delete "(m)," and insert "(j),".

Page 8, line 37, delete "G." and insert "**G, as may be enforced and amended by the federal Department of Health and Human Services.**".

Page 9, line 4, delete "G." and insert "**G, as may be enforced and amended by the federal Department of Health and Human Services.**".

Page 10, line 18, delete "Examination or the" and insert "**Examination, the Comprehensive Osteopathic Medical Licensing Exam, or an**".

Page 15, line 4, delete "collaborate" and insert "**collaborative**".

Page 18, between lines 18 and 19, begin a new paragraph and insert: "SECTION 6. IC 25-21.8-4-5, AS ADDED BY P.L.267-2017, SECTION 16, IS AMENDED TO READ AS FOLLOWS: Sec. 5. This article does not prohibit the following:

- (1) An individual who has a license, registration, certificate, or permit from the state from acting within the scope of the individual's license, registration, certificate, or permit.
- (2) An individual who participates in an approved training

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program for the purpose of acquiring a license, registration, certificate, or permit from the state from performing activities within the scope of the approved training program.

(3) A student of an approved massage therapy school from performing massage therapy under the supervision of the approved massage therapy school, if the student does not profess to be a licensed massage therapist.

(4) An individual's practice in one (1) or more of the following areas that does not involve intentional soft tissue manipulation:

(A) Alexander Technique.

(B) Feldenkrais.

(C) Reiki.

(D) Therapeutic Touch.

(5) An individual's practice in which the individual provides service marked bodywork approaches that involve intentional soft tissue manipulation, including:

(A) Rolfing;

(B) Trager Approach;

(C) Polarity Therapy;

(D) Ortho-bionomy; and

(E) Reflexology;

if the individual is approved by a governing body based on a minimum level of training, demonstration of competency, and adherence to ethical standards.

(6) The practice of massage therapy by a person either actively licensed as a massage therapist in another state or currently certified by the National Certification Board of Therapeutic Massage and Bodywork or other national certifying body if the person's state does not license massage therapists, if the individual is performing duties for a non-Indiana based team or organization, or for a national athletic event held in Indiana, so long as the individual restricts the individual's practice to the individual's team or organization during the course of the individual's or the individual's team's or the individual's organization's stay in Indiana or for the duration of the event.

(7) Massage therapists from other states or countries providing educational programs in Indiana for a period not to exceed thirty (30) days within a calendar year.

(8) An employee of a physician or a group of physicians from performing an act, a duty, or a function to which the exception described in ~~IC 25-22.5-1-2(a)(20)~~ **IC 25-22.5-1-2(a)(21)** applies.

(9) An employee of a chiropractor from performing an act, duty,



or function authorized under IC 25-10-1-13.

(10) An employee of a podiatrist or a group of podiatrists from performing an act, duty, or function to which the exception described in IC 25-29-1-0.5(a)(13) applies.

(11) A dramatic portrayal or some other artistic performance or expression involving the practice of massage therapy.

(12) The practice of massage therapy by a member of an emergency response team during a period of active emergency response."

Page 20, line 21, strike "(9)" and insert "(10)".

Page 20, line 22, strike "(18)" and insert "(19)".

Page 21, between lines 41 and 42, begin a new paragraph and insert:

"SECTION 17. IC 25-27.5-5-1, AS AMENDED BY P.L.247-2019, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 1. (a) This chapter does not apply to the practice of other health care professionals set forth under IC 25-22.5-1-2(a)(1) through ~~IC 25-22.5-1-2(a)(19)~~. **IC 25-22.5-1-2(a)(20)**.

(b) This chapter does not exempt a physician assistant from the requirements of IC 16-41-35-29.

SECTION 18. IC 25-27.5-5-2, AS AMENDED BY P.L.247-2019, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 2. (a) A physician assistant:

(1) must engage in a dependent practice with a collaborating physician; and

(2) may not be independent from the collaborating physician, including any of the activities of other health care providers set forth under IC 25-22.5-1-2(a)(1) through ~~IC 25-22.5-1-2(a)(19)~~.

IC 25-22.5-1-2(a)(20).

A physician assistant may perform, under a collaborative agreement, the duties and responsibilities that are delegated by the collaborating physician and that are within the collaborating physician's scope of practice, including prescribing and dispensing drugs and medical devices. A patient may elect to be seen, examined, and treated by the collaborating physician.

(b) If a physician assistant determines that a patient needs to be examined by a physician, the physician assistant shall immediately notify the collaborating physician or physician designee.

(c) If a physician assistant notifies the collaborating physician that the physician should examine a patient, the collaborating physician shall:

(1) schedule an examination of the patient unless the patient declines; or



(2) arrange for another physician to examine the patient.

(d) A collaborating physician or physician assistant who does not comply with subsections (b) and (c) is subject to discipline under IC 25-1-9.

(e) A physician assistant's collaborative agreement with a collaborating physician must:

- (1) be in writing;
- (2) include all the tasks delegated to the physician assistant by the collaborating physician;
- (3) set forth the collaborative agreement for the physician assistant, including the emergency procedures that the physician assistant must follow; and
- (4) specify the protocol the physician assistant shall follow in prescribing a drug.

(f) The physician shall submit the collaborative agreement to the board. The physician assistant may prescribe a drug under the collaborative agreement unless the board denies the collaborative agreement. Any amendment to the collaborative agreement must be resubmitted to the board, and the physician assistant may operate under any new prescriptive authority under the amended collaborative agreement unless the agreement has been denied by the board.

(g) A physician or a physician assistant who violates the collaborative agreement described in this section may be disciplined under IC 25-1-9.

SECTION 19. IC 25-34.5-3-7, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2023 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 7. This article does not affect the applicability of ~~IC 25-22.5-1-2(a)(20)~~. **IC 25-22.5-1-2(a)(21)**."

Page 25, line 3, delete "A health plan" and insert "**This section applies only to the state employee health plan (as defined in IC 5-10-8-6.7(a)).**

(b) The state employee health plan".

Page 26, line 14, delete "(b) A health plan" and insert "**(c) The state employee health plan**".

Page 26, line 15, delete "(a)." and insert "**(b)**".

Page 26, line 16, delete "(c)" and insert "**(d)**".

Page 26, line 23, delete "(a)." and insert "**(b)**".

Page 26, line 24, delete "(d)" and insert "**(e)**".

Page 28, line 14, delete "G." and insert "**G, as may be enforced and amended by the federal Department of Health and Human Services**".



Page 28, line 24, delete "G." and insert "**G, as may be enforced and amended by the federal Department of Health and Human Services.**".

Page 36, line 36, after "(g)" insert "**This subsection does not apply to a rate schedule maintained by state or federal government payers.**".

Page 40, line 10, after "(d)" insert "**This subsection does not apply to a rate schedule maintained by state or federal government payers.**".

Page 46, delete lines 5 through 13.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 400 as printed February 17, 2023.)

MISHLER, Chairperson

Committee Vote: Yeas 12, Nays 1.

