First Regular Session of the 124th General Assembly (2025)

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 2024 Regular Session of the General Assembly.

HOUSE ENROLLED ACT No. 1003

AN ACT to amend the Indiana Code concerning health.

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

SECTION 1. IC 4-6-10-1.5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 1.5. The state Medicaid fraud control unit has the authority to:

(1) investigate, in accordance with federal law (42 U.S.C. 1396 et seq.):

(A) Medicaid fraud **(including provider fraud, insurer fraud, duplicate billing, and other instances of fraud that the state Medicaid fraud control unit determines may result in Medicaid fraud);**

(B) misappropriation of a Medicaid patient's private funds;

(C) abuse of Medicaid patients; and

(D) neglect of Medicaid patients; and

(2) investigate, in accordance with federal law (42 U.S.C. 1396 et seq.) and as allowed under 42 U.S.C. 1396b(q)(4)(A)(ii), abuse or neglect of patients in board and care facilities.

SECTION 2. IC 4-6-10-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 4. (a) The attorney general may execute a data sharing agreement with the:**

(1) department of state revenue;

(2) office of the secretary of family and social services;

(3) bureau of motor vehicles; and

(4) department of workforce development.

(b) The state Medicaid fraud control unit may analyze and review data received under subsection (a) to carry out its duties under section 1.5 of this chapter.

SECTION 3. IC 4-6-10-6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 6. All complaints made to the state Medicaid fraud control unit are confidential until an action is filed concerning the complaint.**

SECTION 4. IC 12-15-12-24 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 24. The office of the secretary shall establish:**

(1) metrics to assess:

(A) the quality of care provided under; and

(B) patient outcomes of; and

(2) transparency and accountability safeguards for;

the risk based managed care program for the covered population established by IC 12-15-13-1.8(c).

SECTION 5. IC 16-18-2-92.3, AS ADDED BY P.L.151-2021, SECTION 1 AND P.L.198-2021, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 92.3. (a) "De-identified maximum negotiated charge", for purposes of IC 16-21-17, has the meaning set forth in IC 16-21-17-0.3(a).

(b) "De-identified maximum negotiated charge", for purposes of IC 16-41-35.5, has the meaning set forth in IC 16-41-35.5-1.

~~(b)~~ **(c)** "De-identified minimum negotiated charge", for purposes of IC 16-21-17, has the meaning set forth in IC 16-21-17-0.3(b).

(d) "De-identified minimum negotiated charge", for purposes of IC 16-41-35.5, has the meaning set forth in IC 16-41-35.5-2.

SECTION 6. IC 16-18-2-94.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 94.5. "Diagnostic imaging facility", for purposes of IC 16-41-35.5, has the meaning set forth in IC 16-41-35.5-3.**

SECTION 7. IC 16-18-2-96.1, AS ADDED BY P.L.151-2021, SECTION 2 AND P.L.198-2021, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 96.1. **(a)** "Discounted cash price", for purposes of IC 16-21-17, has the meaning set forth in IC 16-21-17-0.3(c).

(b) "Discounted cash price", for purposes of IC 16-41-35.5, has

the meaning set forth in IC 16-41-35.5-4.

SECTION 8. IC 16-18-2-105.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 105.9. "Electronic health record", for purposes of IC 16-39-9, has the meaning set forth in IC 16-39-9-1.5.**

SECTION 9. IC 16-18-2-106.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 106.7. "Eligible facility", for purposes of IC 16-42-26.5, has the meaning set forth in IC 16-42-26.5-1.**

SECTION 10. IC 16-18-2-153.8, AS ADDED BY P.L.151-2021, SECTION 3 AND P.L.198-2021, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 153.8. **(a)** "Gross charge", for purposes of IC 16-21-17, has the meaning set forth in IC 16-21-17-0.3(d).

(b) "Gross charge", for purposes of IC 16-41-35.5, has the meaning set forth in IC 16-41-35.5-5.

SECTION 11. IC 16-18-2-188.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 188.6. "Individualized investigational treatment", for purposes of IC 16-42-26.5, has the meaning set forth in IC 16-42-26.5-2.**

SECTION 12. IC 16-18-2-194.7, AS ADDED BY P.L.151-2021, SECTION 4 AND P.L.198-2021, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 194.7. **(a)** "Item or service", for purposes of IC 16-21-17, has the meaning set forth in IC 16-21-17-0.3(e).

(b) "Item or service", for purposes of IC 16-41-35.5, has the meaning set forth in IC 16-41-35.5-6.

SECTION 13. IC 16-18-2-204.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 204.2. "Life threatening or severely debilitating disease", for purposes of IC 16-42-26.5, has the meaning set forth in IC 16-42-26.5-3.**

SECTION 14. IC 16-18-2-250.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 250.5. "Non-invasive treatment", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-8.5.**

SECTION 15. IC 16-18-2-272.5, AS ADDED BY P.L.151-2021, SECTION 5 AND P.L.198-2021, SECTION 8, IS AMENDED TO

READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 272.5. **(a)** "Payer-specific negotiated charge", for purposes of IC 16-21-17, has the meaning set forth in IC 16-21-17-0.3(f).

(b) "Payer-specific negotiated charge", for purposes of IC 16-41-35.5, has the meaning set forth in IC 16-41-35.5-7.

SECTION 16. IC 16-18-2-272.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 272.7. "Payor", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-9.5.**

SECTION 17. IC 16-18-2-328.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 328.7. "Services provided for the treatment of individuals with psychiatric disorders or chronic addiction disorders", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-10.5.**

SECTION 18. IC 16-18-2-337.5, AS ADDED BY P.L.151-2021, SECTION 6 AND P.L.198-2021, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 337.5. **(a)** "Standard charge", for purposes of IC 16-21-17 and IC 16-24.5-1, has the meaning set forth in IC 16-21-17-0.3(g).

(b) "Standard charge", for purposes of IC 16-41-35.5, has the meaning set forth in IC 16-41-35.5-8.

SECTION 19. IC 16-18-2-379 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 379. "X-ray film", for purposes of IC 16-39, ~~has the meaning set forth in IC 16-39-7-2.~~ **includes a microfilm copy of the x-ray film.**

SECTION 20. IC 16-18-2-379.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 379.5. "X-ray image", for purposes of IC 16-39-1-2 and IC 16-39-7-2, has the meaning set forth in IC 16-39-7-2.**

SECTION 21. IC 16-19-9-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 4. (a) As used in this section, "clinical laboratory" means a laboratory that:**

(1) provides clinical services;

(2) holds a federal Clinical Laboratory Improvement Act (CLIA) certificate of accreditation; and

(3) is not owned or operated by a hospital licensed under IC 16-21-2.

(b) As used in this section, "de-identified maximum negotiated charge" means the highest charge that a clinical laboratory has

negotiated with any third party payer for an item or service.

(c) As used in this section, "de-identified minimum negotiated charge" means the lowest charge that a clinical laboratory has negotiated with any third party payer for an item or service.

(d) As used in this section, "discounted cash price" means the charge that applies to an individual who pays cash or the cash equivalent for a clinical laboratory item or service.

(e) As used in this section, "gross charge" means the charge for an individual item or service that is reflected on a clinical laboratory's chargemaster, absent any discounts.

(f) As used in this section, "item or service" means any item or service, including service packages, that could be provided by a clinical laboratory to a patient for which the clinical laboratory has established a standard charge. The term includes the following:

(1) Supplies.

(2) Procedures.

(3) Use of the facility and other facility fees.

(4) Services of employed physicians and non-physician practitioners, including professional charges.

(5) Anything that a clinical laboratory has established as a standard charge.

(g) As used in this section, "payer-specific negotiated charge" means the charge that a clinical laboratory has negotiated with a third party payer for an item or service.

(h) As used in this section, "standard charge" means the regular rate established by the clinical laboratory for an item or service provided to a specific group of paying patients. The term includes the following:

(1) Gross charge.

(2) Payer-specific negotiated charge.

(3) De-identified minimum negotiated charge.

(4) De-identified maximum negotiated charge.

(5) Discounted cash price.

(i) Not later than July 31, 2026, a clinical laboratory serving patients in Indiana shall post on the website of the clinical laboratory the following information and pricing, to the extent applicable, for the fifty (50) laboratory services designated by the department of insurance as shoppable for consumers who would be self paying for those services without the benefit of a health insurance plan or government subsidy:

(1) A description of the service in plain language.

(2) The discounted cash price.

(3) The de-identified minimum negotiated charge.

(4) The de-identified maximum negotiated charge.

(j) Not later than May 1, 2026, the department of insurance shall:

(1) determine the fifty (50) laboratory services to be disclosed as shoppable for consumers as required under this section; and

(2) post a list of the designated shoppable services on the department's website.

SECTION 22. IC 16-21-17-0.3, AS ADDED BY P.L.151-2021, SECTION 9 AND P.L.198-2021, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 0.3. (a) As used in this chapter, "de-identified maximum negotiated charge" means the highest charge that **a hospital or** an ambulatory outpatient surgical center has negotiated with any third party payer for an item or service.

(b) As used in this chapter, "de-identified minimum negotiated charge" means the lowest charge that **a hospital or** an ambulatory outpatient surgical center has negotiated with any third party payer for an item or service.

(c) As used in this chapter, "discounted cash price" means the charge that applies to an individual who pays cash or the cash equivalent for **a hospital or** an ambulatory outpatient surgical center item or service.

(d) As used in this chapter, "gross charge" means the charge for an individual item or service that is reflected on **a hospital's or** an ambulatory outpatient surgical center's chargemaster, absent any discounts.

(e) As used in this chapter, "item or service" means any item or service, including service packages, that could be provided by **a hospital or** an ambulatory outpatient surgical center to a patient for which the **hospital or** ambulatory outpatient surgical center has established a standard charge. The term includes the following:

(1) Supplies.

(2) Procedures.

(3) Use of the facility and other facility fees.

(4) Services of employed physicians and non-physician practitioners, including professional charges.

(5) Anything that **a hospital or** an ambulatory outpatient surgical center has established as a standard charge.

(f) As used in this chapter, "payer-specific negotiated charge" means the charge that **a hospital or** an ambulatory outpatient surgical center has negotiated with a third party payer for an item or service.

(g) As used in this chapter, "standard charge" means the regular rate established by the **hospital or** ambulatory outpatient surgical center for an item or service provided to a specific group of paying patients. The term includes the following:

(1) Gross charge.

(2) Payer-specific negotiated charge.

(3) De-identified minimum negotiated charge.

(4) De-identified maximum negotiated charge.

(5) Discounted cash price.

SECTION 23. IC 16-21-17-1, AS AMENDED BY P.L.151-2021, SECTION 11 AND P.L.198-2021, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 1. (a) Not later than December 31, ~~2021,~~ **2025, a hospital and** an ambulatory outpatient surgical center shall post on the ~~Internet web site~~ **website** of the **hospital or** ambulatory outpatient surgical center pricing and other information specified in this chapter for the following:

(1) For as many of the seventy (70) shoppable services specified in the final rule of the Centers for Medicare and Medicaid Services published in 84 FR 65524 that are provided by the **hospital or** ambulatory outpatient surgical center.

(2) In addition to the services specified in subdivision (1):

(A) the thirty (30) most common services that are provided by the **hospital or** ambulatory outpatient surgical center not included in subdivision (1); or

(B) if the **hospital or** ambulatory outpatient surgical center offers less than thirty (30) services not included under subdivision (1), all of the services provided by the **hospital or** ambulatory outpatient surgical center.

(b) The following information, to the extent applicable, must be included on the ~~Internet web site~~ **website** by **a hospital and** an ambulatory outpatient surgical center for the shoppable and common services described in subsection (a):

(1) A description of the shoppable and common service.

(2) The standard charge per item or service for each of the following categories:

(A) Any nongovernment sponsored health benefit plan or insurance plan provided by a health carrier in which the provider is in the network.

(B) Medicare, including fee for service and Medicare Advantage.

(C) Self-pay without charitable assistance from the **hospital or** ambulatory outpatient surgical center.

(D) ~~Self-pay with charitable assistance from~~ **The maximum charitable assistance allowed under the charity or financial assistance policy of** the **hospital or** ambulatory outpatient surgical center.

(E) Medicaid, including fee for service and risk based managed care.

~~(c) If:~~

~~(1) the federal Hospital Price Transparency Rule is repealed; or~~

~~(2) federal enforcement of the federal Hospital Price Transparency Rule is stopped;~~

~~the state health commissioner shall notify the legislative council of the occurrence referred to in subdivision (1) or (2) in an electronic format under IC 5-14-6.~~

~~(d) This subsection takes effect when the legislative council receives a notification from the state health commissioner under subsection (c). A hospital shall post pricing information in compliance with the federal Hospital Price Transparency Rule of the federal Centers for Medicare and Medicaid Services as published at 84 FR 65524 and in effect on January 1, 2021.~~

SECTION 24. IC 16-39-1-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 2. Upon a patient's written request and reasonable notice, a provider shall, ~~at the provider's actual costs,~~ **at no cost,** provide to the patient or the patient's designee:

(1) access to; or

(2) a copy of;

the patient's x-ray ~~film~~ **image** possessed by the provider.

SECTION 25. IC 16-39-7-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 2. (a) This section does not apply to original mammograms, which are governed by section 3 of this chapter.

(b) As used in this section, "x-ray ~~film~~" **image"** includes a microfilm copy of ~~the~~ **an** x-ray film **and a digital image of an x-ray.**

(c) A provider shall maintain a patient's x-ray ~~film~~ **image** for at least five (5) years.

(d) At the time an x-ray ~~film~~ **image** is taken, the provider shall do one (1) of the following:

(1) Inform the patient in writing of the following:

(A) The patient's x-ray ~~film~~ **image** will be kept on file by the provider for at least five (5) years.

(B) If the patient would like a copy of the x-ray ~~film~~ **image** during that period, the provider will provide the patient with a copy of the x-ray ~~film~~ **image** at ~~the actual~~ **no** cost, ~~to the~~

~~provider,~~ as provided in IC 16-39-1-2.

(2) Have posted conspicuously in the x-ray examination area a sign informing patients of the following:

(A) All x-ray ~~films~~ **images** will be kept on file by a provider for at least five (5) years.

(B) On request during that time, the provider will provide the patient a copy of the patient's x-ray ~~film~~ **image** at ~~the actual~~ **no** cost to the provider.

(e) A provider is immune from civil liability for destroying or otherwise failing to maintain an x-ray ~~film~~ **image** in violation of this section if the destruction or failure to maintain the x-ray ~~film~~ **image** is inadvertent and not done in bad faith. However, this subsection does not prevent the imposition of disciplinary sanctions against the provider, as described in subsection (f).

(f) A provider who violates this section commits an offense for which a board may impose disciplinary sanctions against the provider under the statute that governs the provider's licensure, registration, or certification under this title or IC 25.

SECTION 26. IC 16-39-9-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 1.5. (a) As used in this chapter, "electronic health record" means a record of an individual's medical history that is created, generated, sent, communicated, received, or stored by electronic means.**

(b) For purposes of this chapter, the term includes billing statements and other administrative records that may be provided through electronic means.

SECTION 27. IC 16-39-9-2, AS AMENDED BY P.L.173-2007, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 2. A provider may not charge a person for:

(1) providing a digital copy or digital access through an interoperability platform of an individual's electronic health record; or

(2) making and providing **paper** copies of medical records **at** an amount greater than the amount set in rules adopted by the department of insurance under section 4 of this chapter.

SECTION 28. IC 16-39-9-4, AS AMENDED BY P.L.173-2007, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 4. (a) As used in this section, "department" refers to the department of insurance created by IC 27-1-1-1.

(b) The department may adopt rules under IC 4-22-2 to set the amounts that may be charged for copying **and providing paper copies**

of medical records under this chapter.

(c) In adopting rules under this section, the department shall consider the following factors relating to the costs of copying medical records:

(1) The following labor costs:

(A) Verification of requests.

(B) Logging requests.

(C) Retrieval.

(D) Copying.

(E) Refiling.

(2) Software costs for logging requests.

(3) Expense costs for copying.

(4) Capital costs for copying.

(5) Billing and bad debt expenses.

(6) Space costs.

SECTION 29. IC 16-41-35.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 35.5. Diagnostic Imaging Facility: Health Care Pricing Information

Sec. 1. As used in this chapter, "de-identified maximum negotiated charge" means the highest charge that a diagnostic imaging facility has negotiated with any third party payer for an item or service.

Sec. 2. As used in this chapter, "de-identified minimum negotiated charge" means the lowest charge that a diagnostic imaging facility has negotiated with any third party payer for an item or service.

Sec. 3. (a) As used in this chapter, "diagnostic imaging facility" means an entity that:

(1) provides diagnostic imaging to an individual for the purpose of health care; and

(2) is not owned or operated by a hospital licensed under IC 16-21-2.

(b) The term does not include the following offices where an x-ray or imaging service is exclusively used by the office:

(1) A dental office.

(2) An optometrist office.

(3) A practitioner's office.

Sec. 4. As used in this chapter, "discounted cash price" means the charge that applies to an individual who pays cash or the cash equivalent for a diagnostic imaging facility item or service.

Sec. 5. As used in this chapter, "gross charge" means the charge for an individual item or service that is reflected on a diagnostic imaging facility's chargemaster, absent any discounts.

Sec. 6. As used in this chapter, "item or service" means any item or service, including service packages, that could be provided by a diagnostic imaging facility to a patient for which the diagnostic imaging facility has established a standard charge. The term includes the following:

(1) Supplies.

(2) Procedures.

(3) Use of the facility and other facility fees.

(4) Services of employed physicians and non-physician practitioners, including professional charges.

(5) Anything that a diagnostic imaging facility has established as a standard charge.

Sec. 7. As used in this chapter, "payer-specific negotiated charge" means the charge that a diagnostic imaging facility has negotiated with a third party payer for an item or service.

Sec. 8. As used in this chapter, "standard charge" means the regular rate established by the diagnostic imaging facility for an item or service provided to a specific group of paying patients. The term includes the following:

(1) Gross charge.

(2) Payer-specific negotiated charge.

(3) De-identified minimum negotiated charge.

(4) De-identified maximum negotiated charge.

(5) Discounted cash price.

Sec. 9. Not later than July 31, 2026, a diagnostic imaging facility serving patients in Indiana shall post on the diagnostic imaging facility's website the following information and pricing, to the extent applicable, for the fifty (50) diagnostic imaging services designated by the department of insurance as shoppable for consumers who would be self paying for those services without the benefit of a health insurance plan or government subsidy:

(1) A description of the service in plain language.

(2) The discounted cash price.

(3) The de-identified minimum negotiated charge.

(4) The de-identified maximum negotiated charge.

Sec. 10. Not later than May 1, 2026, the department of insurance shall:

(1) determine the fifty (50) diagnostic imaging services to be disclosed as shoppable for consumers as required under this

section; and

(2) post a list of the designated shoppable services on the department's website.

SECTION 30. IC 16-42-26.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 26.5. Individualized Investigational Treatment

Sec. 1. As used in this chapter, "eligible facility" means an entity that operates under the Federalwide Assurance for the Protection of Human Subjects in accordance with 42 U.S.C. 289(a) and 45 CFR 46.

Sec. 2. As used in this chapter, "individualized investigational treatment" means a drug, biological product, or device that is unique to and produced exclusively for use by an individual patient, based on the individual's own genetic profile. The term includes individualized gene therapy, antisense oligonucleotides (ASO), and individualized neoantigen vaccines.

Sec. 3. As used in this chapter, "life threatening or severely debilitating disease" has the meaning described in 21 CFR 312.81.

Sec. 4. An individual must meet the following requirements in order to qualify as an eligible patient under this chapter:

(1) Has been diagnosed with a life threatening or severely debilitating disease, as attested by the individual's physician.

(2) Has considered other treatment options currently approved by the United States Food and Drug Administration.

(3) Has received a recommendation from the individual's physician for an individualized investigational treatment based on analysis of the patient's genomic sequence, human chromosomes, deoxyribonucleic acid, ribonucleic acid, genes, gene products, or metabolites.

(4) Has given written informed consent as set forth in section 5 of this chapter for the use of the individualized investigational treatment.

(5) Has documentation from the individual's physician that the individual meets the requirements of this section.

Sec. 5. (a) Written informed consent as required under section 4(4) of this chapter must include the following:

(1) An explanation of the currently approved products and treatments for the individual's disease or condition.

(2) An attestation by the individual of the individual's debilitating condition and that the individual concurs with the

individual's physician that all currently approved treatments are unlikely to prolong the individual's life or improve the individual's debilitating condition.

(3) A clear identification of the specific individualized investigational treatment proposed to be used to treat the individual.

(4) A description of the best and worst outcomes, including the most likely outcome, resulting from use of the individualized investigational treatment of the individual's life threatening or severely debilitating illness.

(5) A statement acknowledging that new, unanticipated, different, or worse symptoms or death may result from the proposed treatment.

(6) A statement that the individual's health insurance may not be obligated to pay for any care or treatment and that the patient may be liable for all expenses of the treatment unless specifically required to do so by contract or law.

(7) A statement that eligibility for hospice care may be withdrawn if the individual begins individualized investigational treatment and does not meet hospice care eligibility requirements.

(8) A statement that the individual or the individual's legal guardian consents to the individualized investigational treatment for the life threatening or severely debilitating illness.

(b) The description of outcomes described in subsection (a)(4) must be based on the treating physician's knowledge of both the individualized investigational treatment and the individual's life threatening or severely debilitating disease.

Sec. 6. (a) A manufacturer operating within an eligible facility and in accordance with federal law may make available to an eligible patient the manufacturer's individualized investigational treatment from an eligible facility.

(b) Nothing in this chapter may be construed to require a manufacturer of an individualized investigational treatment to make the individualized investigational treatment available to an eligible patient.

(c) A manufacturer of an individualized investigational treatment may do any of the following:

(1) Provide an individualized investigational treatment to an eligible patient without receiving compensation.

(2) Require an eligible patient to pay the costs of or associated

with the manufacture of the individualized investigational treatment.

(d) This chapter does not create a cause of action against a manufacturer of an individualized investigational treatment for any harm to an eligible patient resulting from use of an individualized investigational treatment.

Sec. 7. If an eligible patient dies while being treated with an individualized investigational treatment, the eligible patient's heirs are not liable for any outstanding debt related to the individualized investigational treatment.

Sec. 8. The medical licensing board of Indiana may not revoke, suspend, fail to renew, or take any other disciplinary action against a physician licensed under IC 25-22.5 based solely on the physician's recommendations to an eligible patient concerning access to or treatment with an individualized investigational treatment.

Sec. 9. This chapter does not affect coverage for clinical trials set forth in IC 5-10-8-15, IC 12-15-5-9.2, IC 27-8-25, or IC 27-13-7-20.2.

SECTION 31. IC 16-51-1-8.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 8.5. As used in this chapter, "non-invasive treatment" means a treatment that is not included in the definition of surgery or other invasive procedure under 410 IAC 15-1.1-22.**

SECTION 32. IC 16-51-1-9, AS ADDED BY P.L.203-2023, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 9. **(a)** As used in this chapter, "office setting" means a location of a qualified provider where health care services are provided and that:

(1) is located more than two hundred fifty (250) yards from the main building of any hospital owned in whole or in part by the Indiana nonprofit hospital system; and

(2) is where a qualified provider routinely provides health examinations, diagnosis, or non-invasive treatment of illness or injury on an ambulatory basis.

(b) The term does not include the following:

(1) A location within the campus (as defined in 42 CFR 413.65(a)(2)) of a hospital.

(2) A location not more than two hundred fifty (250) yards from the main building of a remote location of a hospital (as defined in 42 CFR 413.65(a)(2)).

SECTION 33. IC 16-51-1-9.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 9.5. As used in this chapter, "payor" means an insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services provided by a qualified provider.**

SECTION 34. IC 16-51-1-10, AS ADDED BY P.L.203-2023, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 10. As used in this chapter, "qualified provider" means an individual or entity ~~owned in whole or in part~~ **employed** by an Indiana nonprofit hospital system and that is duly licensed or legally authorized to provide health care services.

SECTION 35. IC 16-51-1-10.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 10.5. As used in this chapter, "services provided for the treatment of individuals with psychiatric disorders or chronic addiction disorders" means services to diagnose or treat a mental illness or substance-related or addictive disorder diagnosis under the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, published by the American Psychiatric Association (DSM V-TR).**

SECTION 36. IC 16-51-1-11, AS ADDED BY P.L.203-2023, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 11. **(a) As used in this section, "physician fee schedule" refers to the negotiated agreement between a payor and a qualified provider specifying reimbursement for services furnished in an office setting and billed on a CMS 1500 form or its electronic equivalent.**

~~(a)~~ **(b)** A bill for health care services provided by a qualified provider in an office setting:

(1) may not be submitted on an institutional provider form; and

(2) must be submitted on an individual provider form.

~~(b)~~ **(c)** ~~An insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services provided by a qualified provider in an office setting~~ **A payor** shall not accept a bill for ~~the~~ health care services that is submitted on an institutional provider form.

(d) A qualified provider in an office setting may not bill health care services with a place of service code 21 or 22, as published in the place of service code set maintained by the federal Centers for Medicare and Medicaid Services.

(e) Beginning January 1, 2026, a payor shall pay the claims

incurred by an in-network qualified provider based on the physician fee schedule.

SECTION 37. IC 16-51-1-11.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 11.1. (a) If, after making payment for health care services provided by a qualified provider, a payor discovers that a bill was submitted in violation of section 11 of this chapter, the payor may utilize the remedies set forth in either:**

(1) the contract or other arrangement between the payor and qualified provider; or

(2) IC 27-8-5.7-10.

(b) If a qualified provider disagrees with a determination made by a payor that a bill was submitted in violation of section 11 of this chapter, the qualified provider may use the dispute resolution process set forth in the contract or other arrangement between the payor and qualified provider.

SECTION 38. IC 16-51-1-11.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 11.3. (a) Before July 1, 2025, and every two (2) years with licensure renewal, an Indiana nonprofit hospital system shall submit a complete list of facilities within the Indiana nonprofit hospital system that:**

(1) qualify as an institutional provider; and

(2) may submit a bill on an institutional provider form under this chapter;

to the state department, in a manner prescribed by the state department. The list submitted under this section must include for each listed facility the appropriate place of service code, as published in the place of service code set maintained by the federal Centers for Medicaid and Medicare Services.

(b) An Indiana nonprofit hospital system shall notify the state department of:

(1) a new facility that:

(A) qualifies as an institutional provider; and

(B) may submit a bill on an institutional provider form under this chapter; or

(2) the closure or change of location of a facility that:

(A) qualifies as an institutional provider; and

(B) may submit a bill on an institutional provider form under this chapter.

The notice under this subsection must be provided not later than thirty (30) days after an event under subdivision (1) or (2) occurs.

(c) The state department shall post on the state department's website a list of the facilities, as identified under subsection (a) or (b), that:

(1) qualify as an institutional provider; and

(2) may submit a bill on an institutional provider form under this chapter.

SECTION 39. IC 16-51-1-11.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 11.5. (a) A payor or an Indiana nonprofit hospital system may report a violation of this chapter to the state department on a form prescribed by the state department.**

(b) The state department may assess a civil penalty of one thousand dollars ($1,000) per day against a qualified provider for a violation of this chapter.

SECTION 40. IC 16-51-1-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 13. Nothing in this chapter is intended to change any other billing or coding requirements that are not specifically addressed in this chapter.**

SECTION 41. IC 25-1-9-23, AS AMENDED BY P.L.93-2024, SECTION 180, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: 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)~~ **two (2)** business days after the health care service is ordered.

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

(o) The requirements of this section do not apply to a practitioner who:

(1) is required to comply with; and

(2) is in compliance with;

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

SECTION 42. IC 25-1-9.8-11, AS ADDED BY P.L.93-2020, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 11. (a) This section does not apply to an individual who is a Medicaid recipient.

(b) An individual for whom a nonemergency health care service has been ordered, scheduled, or referred may request from the practitioner who may provide the nonemergency health care service a good faith estimate of the total price the practitioner will charge for providing the nonemergency health care service.

(c) A practitioner who receives a request from a patient under subsection (b) shall, not more than ~~five (5)~~ **two (2)** business days after receiving relevant information from the individual, provide to the individual a good faith estimate of the price that the practitioner will charge for providing the nonemergency health care service.

(d) A practitioner must ensure that a good faith estimate provided to an individual under this section is accompanied by a notice stating that:

(1) an estimate provided under this section is not binding on the practitioner;

(2) the price the practitioner charges the individual may vary from the estimate based on the individual's medical needs; and

(3) the estimate provided under this section is only valid for thirty (30) days.

(e) A practitioner may not charge an individual for information provided under this section.

SECTION 43. IC 25-1-9.8-16, AS AMENDED BY P.L.202-2021, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 16. (a) A practitioner that has scheduled or ordered for an individual a nonemergency health care service shall provide to the individual an electronic or paper copy of a written notice

that states the following, or words to the same effect: "A patient may ask a health care provider for an estimate of the price the health care providers and health facility will charge for providing a nonemergency health care service. The law requires that the estimate be provided within ~~5 business~~ **2 business** days of scheduling the nonemergency health care service unless the nonemergency health care service is scheduled to be performed by the practitioner within ~~5 business~~ **2 business** days of the date of the patient's request.".

(b) The appropriate board (as defined in IC 25-1-9-1) may adopt rules under IC 4-22-2 to establish requirements for practitioners to provide additional charging information under this section.

SECTION 44. IC 25-1-9.8-17, AS ADDED BY P.L.93-2020, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 17. If:

(1) a practitioner receives a request for a good faith estimate under this chapter; and

(2) the patient is eligible for Medicare coverage;

the practitioner shall provide a good faith estimate to the patient within ~~five (5)~~ **two (2)** business days based on available Medicare rates.

SECTION 45. IC 25-1-9.8-18, AS AMENDED BY P.L.202-2021, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 18. (a) Each provider must make diligent attempts to ensure that the patient is aware of the patient's right to request a good faith estimate under this chapter. The communication by each provider of information to the patient concerning the right to a good faith estimate must be conspicuous and must be provided by at least three (3) of the following means:

(1) Notice on the provider's ~~Internet web site.~~ **website.**

(2) On hold messaging.

(3) Waiting room notification.

(4) Preappointment reminders, including through electronic mail (email) or text messaging.

(5) During appointment or services check in.

(6) During appointment or services check out.

(7) During patient financial services or billing department inquiries.

(8) Through an electronic medical and patient communication portal.

(b) The communication required under subsection (a) must state the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency medical service provided in our office. The law requires that an

estimate be provided within ~~5 business~~ **2 business** days of scheduling the nonemergency health care service unless the nonemergency health care service is scheduled to be performed by the practitioner within ~~5 business~~ **2 business** days of the date of the patient's request.".

SECTION 46. IC 27-1-3-36 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 36. (a) As used in this section, "prior authorization" means a practice implemented by a health plan through which coverage of a health care service is dependent on the covered individual or health care provider obtaining approval from the health plan before the health care service is rendered. The term includes prospective or utilization review procedures conducted before a health care service is rendered.**

(b) The department may enter into partnerships and joint ventures to encourage best practices in the appropriate and effective use of prior authorization in health care.

SECTION 47. IC 27-1-24.5-25, AS AMENDED BY P.L.152-2024, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 25. (a) A contract holder may, one (1) time in a calendar year and not earlier than six (6) months following a previously requested audit, request an audit of compliance with the contract. If requested by the contract holder, the audit shall include full disclosure of the following data specific to the contract holder:

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

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

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

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

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

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

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

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

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

(3) Pharmaceutical and device claims payments or electronic funds transfer or remittance advice notices provided by the pharmacy benefit manager as ASC X12N 835 files or a successor format. The files may be modified as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). ~~or to redact a trade secret (as defined in IC 24-2-3-2).~~ In the event that paper claims are provided, the pharmacy benefit manager shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

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

(b) A pharmacy benefit manager may not impose the following:

(1) Fees for:

(A) requesting an audit under this section; or

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

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

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

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

(i) does not have a conflict of interest;

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

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

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

(c) A pharmacy benefit manager shall disclose, upon request from a contract holder, to the contract holder the actual amounts directly or indirectly paid by the pharmacy benefit manager to the pharmacist or pharmacy for the drug and for pharmacist services related to the drug.

(d) A pharmacy benefit manager shall provide notice to a contract holder contracting with the pharmacy benefit manager of any consideration, including direct or indirect remuneration, that the pharmacy benefit manager receives from a pharmaceutical manufacturer or group purchasing organization for formulary placement or any other reason.

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

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

(g) A pharmacy benefit manager shall:

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

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

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

SECTION 48. IC 27-1-37-0.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 0.1. As used in this chapter, "administrative denial" means the denial by a health carrier for nonmedical reasons of a health provider facility's or provider's claim for reimbursement.**

SECTION 49. IC 27-1-37-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 7.5. (a) This section applies to a health provider contract entered into, amended, or renewed after June 30, 2025.**

(b) When a health carrier is in the process of negotiating a health provider contract with a health provider facility or provider, the health carrier must provide to the health provider facility or provider the following:

(1) A current fee schedule that must include the following information:

(A) The proposed reimbursement for each covered service under the proposed health provider contract.

(B) The twenty-fifth percentile, fiftieth percentile, and seventy-fifth percentile reimbursement amounts in Indiana for each covered service under the proposed health provider contract.

(2) The current criteria that the health carrier uses when determining whether to issue an administrative denial.

(c) When a health provider facility or provider is in the process

of negotiating a health provider contract with a health carrier, the health provider facility or provider shall provide the health carrier with the twenty-fifth percentile, fiftieth percentile, and seventy-fifth percentile reimbursement amounts that the health provider facility or provider receives for each covered service under the proposed health provider contract.

SECTION 50. IC 27-1-37-8, AS ADDED BY P.L.198-2021, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 8. (a) This section applies to a health provider contract entered into, amended, or renewed after June 30, ~~2021.~~ **2025.**

(b) A health provider contract, including a contract with a pharmacy benefit manager, may not contain a provision that does any of the following:

(1) Limits the ability of ~~either~~ the health carrier, ~~or~~ the health provider facility, **or the provider** to disclose the allowed amount and fees of services to any insured (as defined in IC 27-8-5.8-3) or enrollee (as defined in IC 27-13-1-12), or to the treating health provider facility or ~~physician~~ **provider** of the insured or enrollee.

(2) Limits the ability of ~~either~~ the health carrier, ~~or~~ the health provider facility, **or the provider** to disclose out-of-pocket costs to an insured (as defined in IC 27-8-5.8-3) or an enrollee (as defined in IC 27-13-1-12).

(3) Limits the ability of the health carrier to introduce or modify a select network plan or tiered network plan by granting the provider a guaranteed right of participation.

(4) Requires the health carrier to place all facilities in the same tier of a tiered network plan.

(5) Requires the health carrier to include all facilities in a select network plan on an all-or-nothing basis.

(6) Requires a provider to participate in a new select network or tiered network plan that the health carrier introduces without granting the provider the right to opt out of the new plan at least sixty (60) days before the new plan is submitted to the commissioner for approval.

(c) Any provision of a health provider contract that includes a provision described in subsection (b) in violation of this section is severable and the provision in violation is null and void. The remaining provisions of the health provider contract, excluding the provision in violation of this section, remain in effect and are enforceable.

(d) The attorney general may issue a civil investigative demand to obtain information from a party of, or pertaining to, a health provider contract and compliance of this section.

SECTION 51. IC 27-1-37-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 10. (a) This section applies to a health provider contract in which at least one (1) of the parties is a health provider facility.**

(b) A health provider contract that:

(1) requires the parties to commence negotiations to amend the terms of the contract if there is a change in law; or

(2) guarantees that the health carrier or provider will be made whole for the financial effects of a law or regulation;

is against public policy and is void and unenforceable.

SECTION 52. IC 27-1-37-11 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 11. The department shall do the following:**

(1) Require health carriers to meet network adequacy standards that are no less stringent than the network adequacy standards established by the Centers for Medicare and Medicaid Services.

(2) When assessing whether a health carrier has met the network adequacy standards, consider the availability and variety of independent specialty providers that provide services within in network provider facilities in the health carrier's network.

SECTION 53. IC 27-1-37.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 37.7. Reporting of Prior Authorization Disputes

Sec. 1. As used in this chapter, "department" refers to the department of insurance created by IC 27-1-1-1.

Sec. 2. As used in this chapter, "health plan" has the meaning set forth in IC 27-1-37.5-5.

Sec. 3. As used in this chapter, "prior authorization" has the meaning set forth in IC 27-1-37.5-7.

Sec. 4. A health care provider or health plan may submit information concerning a dispute between a health care provider and a health plan regarding prior authorization to the department.

Sec. 5. (a) The department may:

(1) receive;

(2) categorize; and

(3) maintain;

any information provided by a health care provider or a health

plan under this chapter.

(b) The department may not adjudicate or otherwise mediate any of the disputes between health care providers and health plans.

Sec. 6. If the department receives information under section 4 of this chapter from a health care provider or health plan, the department shall keep the following information of the individual who submitted the information confidential:

(1) Name.

(2) Address.

(3) Telephone number.

(4) Electronic mail address.

(5) Personal health information.

(6) Any other information that could identify the individual.

Sec. 7. (a) Before December 1, 2026, the department shall provide a report in an electronic format under IC 5-14-6 to the general assembly with any findings and recommendations related to the information received under section 4 of this chapter.

(b) This section expires July 1, 2027.

SECTION 54. IC 27-1-44.5-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 3.5. (a) Not later than September 1, 2025, the department shall issue a request for information in compliance with IC 5-23-4.5 concerning ways to better enable medical consumers to compare and shop for medical and health care services using real time price and health quality information from respected sources approved by the advisory board, including claims data maintained by the data base.**

(b) The request for information must consider:

(1) the convenience of medical consumers, including whether and how to develop, procure, or license one (1) or more services into a single application that is available on both desktop and mobile; and

(2) whether and how to benchmark price and health quality comparison shopping by medical consumers in Indiana.

(c) The department shall set the deadline for submissions of the request for information under this section that may not be later than December 1, 2025.

SECTION 55. IC 27-1-45-7, AS AMENDED BY P.L.165-2022, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 7. ~~(a) This section is effective beginning January 1, 2022.~~

~~(b)~~ A facility or a practitioner is not required to provide the good

faith estimate if the health care service to be provided to the covered individual is scheduled to be performed within ~~five (5)~~ **two (2)** business days after the health care service is ordered.

SECTION 56. IC 27-1-46-11, AS AMENDED BY P.L.202-2021, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 11. (a) This section does not:

(1) apply to an individual who is a Medicaid recipient; or

(2) limit the authority of a legal representative of the patient.

(b) An individual for whom a nonemergency health care service has been ordered, scheduled, or referred may request from the provider facility in which the nonemergency health care service will be provided a good faith estimate of the price that will be charged for the nonemergency health care service.

(c) A provider facility that receives a request from an individual under subsection (b) shall, not more than ~~five (5)~~ **two (2)** business days after receiving relevant information from the individual, provide to the individual a good faith estimate of:

(1) the price that the provider facility in which the health care service will be performed will charge for:

(A) the use of the provider facility to care for the individual for the nonemergency health care service;

(B) the services rendered by the employed or contracted staff of the provider facility in connection with the nonemergency health care service; and

(C) medication, supplies, equipment, and material items to be provided to or used by the individual while the individual is present in the provider facility in connection with the nonemergency health care service; and

(2) the price charged for the services of all practitioners, support staff, and other persons who provide professional health services:

(A) who may provide services to or for the individual during the individual's presence in the provider facility for the nonemergency health care service; and

(B) for whose services the individual will be charged separately from the charge of the provider facility.

(d) The price that must be included in a good faith estimate under this section includes all services under subsection (c)(1) or (c)(2) for imaging, laboratory services, diagnostic services, therapy, observation services, and other services expected to be provided to the individual for the episode of care.

(e) A provider facility shall ensure that a good faith estimate states that:

(1) an estimate provided under this section is not binding on the provider facility;

(2) the price the provider facility charges the individual may vary from the estimate based on the individual's medical needs; and

(3) the estimate provided under this section is only valid for thirty (30) days.

(f) A provider facility may not charge a patient for information provided under this section.

SECTION 57. IC 27-1-46-15, AS AMENDED BY P.L.202-2021, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 15. (a) Each provider must make diligent attempts to ensure that the patient is aware of the patient's right to request a good faith estimate under this chapter. The communication by a provider to the patient concerning the right to a good faith estimate must be conspicuous and must be provided by at least three (3) of the following means:

(1) Notice on the provider's ~~Internet web site.~~ **website.**

(2) On hold messaging.

(3) Waiting room notification.

(4) Preappointment reminders, including through electronic mail (email) or text messaging.

(5) During appointment or services check in.

(6) During appointment or services check out.

(7) During patient financial services or billing department inquiries.

(8) Through an electronic medical and patient communication portal.

(b) The communication required under subsection (a) must state the following, or words to the same effect: "A patient may ask for an estimate of the amount the patient will be charged for a nonemergency health care service provided in our facility. The law requires that an estimate be provided within ~~5 business~~ **2 business** days.".

SECTION 58. IC 27-1-46-16, AS AMENDED BY P.L.202-2021, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 16. If:

(1) a provider facility receives a request for a good faith estimate under this chapter; and

(2) the patient is eligible for Medicare coverage;

the provider facility shall provide a good faith estimate to the patient within ~~five (5)~~ **two (2)** business days based on available Medicare cost sharing rates.

SECTION 59. IC 27-2-25-12, AS ADDED BY P.L.93-2020,

SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 12. (a) A covered individual may request from the health carrier a good faith estimate of:

(1) the amount of the cost of the nonemergency health care service that the health carrier will:

(A) pay for; or

(B) reimburse to;

the covered individual; or

(2) the applicable benefit limitations of the ordered nonemergency health care service a covered individual is entitled to receive from the health carrier.

(b) If:

(1) a health carrier provides coverage to a covered individual through a network plan; and

(2) the health carrier receives a request for a good faith estimate from a covered individual for whom a nonemergency health care service has been ordered;

the health carrier shall inform the covered individual whether the provider facility in which the nonemergency health care service will be provided is in network and whether each scheduled practitioner who may provide the nonemergency health care service is in network.

(c) A health carrier that receives a request from a covered individual patient under subsection (b) shall, not more than ~~five (5)~~ **two (2)** business days after receiving relevant information, provide to the individual a good faith estimate as described in section 14 of this chapter.

(d) A health carrier must ensure that a good faith estimate states that the estimate provided under this section is only valid for thirty (30) days and that:

(1) the amount that the health carrier will:

(A) pay; or

(B) reimburse;

for or to the covered individual for the nonemergency health care services the individual receives; and

(2) the applicable benefit limitations of the nonemergency health care services the individual will receive;

may vary from the health carrier's good faith estimate based on the individual's medical needs.

(e) A health carrier may not charge an individual for information provided under this section.

(f) A practitioner and provider facility shall provide a health carrier with the information needed by the health carrier to comply with the

requirements under this chapter not more than two (2) business days after receiving the request.

SECTION 60. IC 27-2-25-15, AS ADDED BY P.L.93-2020, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 15. A health carrier that provides ~~an Internet web site~~ **a website** for the use of its covered individuals shall ensure that the ~~Internet web site~~ **website** includes a printed notice that:

(1) is designed, lettered, and featured on the ~~Internet web site~~ **website** so as to be conspicuous to and readable by any individual with normal vision who visits the ~~Internet web site;~~ **website;** and

(2) states the following, or words to the same effect: "A covered individual may at any time ask the health carrier for an estimate of the amount the health carrier will pay for or reimburse to a covered individual for nonemergency health care services that have been ordered for the covered individual or the applicable benefit limitations of the ordered nonemergency health care services a covered individual is entitled to receive from the health carrier. The law requires that an estimate be provided within ~~5 business~~ **2 business** days.".

SECTION 61. IC 27-2-25.5-3, AS ADDED BY P.L.152-2024, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 3. (a) This section applies to a contract entered into, issued, amended, or renewed after June 30, 2024.

(b) A contract:

(1) between a:

(A) third party administrator; and

(B) plan sponsor;

(2) between a:

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

(B) plan sponsor; or

(3) between:

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

(B) either a:

(i) plan sponsor; or

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

must provide that the plan sponsor owns the claims data relating to the contract. ~~However, a plan sponsor's ownership of the claims data under this section may not be construed to require the pharmacy benefit~~

~~manager or third party administrator to disclose a trade secret (as defined in IC 24-2-3-2).~~

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

SECTION 62. IC 27-2-25.5-4, AS ADDED BY P.L.152-2024, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 4. (a) A plan sponsor that contracts with a third party administrator, the office of the secretary of family and social services that contracts with a managed care organization (as defined in IC 12-7-2-126.9) to provide services to a Medicaid recipient, or the state personnel department that contracts with a prepaid health care delivery plan under IC 5-10-8-7(c) to provide group health coverage for state employees may, one (1) time in a calendar year and not earlier than six (6) months following a previously requested audit, request an audit of compliance with the contract. If requested by the plan sponsor, office of the secretary of family and social services, or state personnel department, the audit shall include full disclosure of the following concerning data specific to the plan sponsor, office of the secretary, or state personnel department:

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

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

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

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

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

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

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

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

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

(3) Claims payments, electronic funds transfer, or remittance advice notices provided by the third party administrator, managed care organization, or prepaid health care delivery plan as ASC X12N 835 files or a successor format. The files may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). ~~or to~~

~~redact a trade secret (as defined in IC 24-2-3-2).~~ In the event that paper claims are provided, the third party administrator, managed care organization, or prepaid health care delivery plan shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

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

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

(1) fees for:

(A) requesting an audit under this section; or

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

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

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

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

(i) does not have a conflict of interest;

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

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

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

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

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

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

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

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

SECTION 63. IC 27-8-5.7-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 12. (a) This section applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2025.**

(b) An insurer may not deny a claim for reimbursement for a covered service or item provided to an insured on the sole basis that the referring provider is an out of network provider.

SECTION 64. IC 27-8-11-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 13.5. (a) As used in this section, "physician" refers to an individual who:**

(1) is licensed under IC 25-22.5;

(2) has been granted reciprocity by the medical licensing board of Indiana under IC 25-1-21 before July 1, 2026; or

(3) is licensed in a state that has enacted the interstate medical licensure compact.

(b) If a physician who is fully credentialed by an insurer:

(1) leaves the employment of an employer and becomes employed with another employer in Indiana; or

(2) establishes or relocates a medical practice in Indiana;

the insurer shall provisionally credential the physician for the time frame set forth in subsection (c).

(c) A physician under subsection (b) must be provisionally credentialed:

(1) for sixty (60) days after the physician's separation from employment or the establishment or relocation of the medical practice; or

(2) until the physician is fully credentialed by the insurer;

whichever is earlier.

(d) Notwithstanding section 7(k) of this chapter, an insurer shall reimburse a physician who is provisionally credentialed under this section for services rendered while the physician was provisionally credentialed at the rates determined by:

(1) the agreement between the physician's new employer and the insurer under section 3 of this chapter; or

(2) if:

(A) the physician's new employer has not entered into an agreement with the insurer under section 3 of this chapter; or

(B) the physician established or relocated a medical practice;

the agreement between the physician and the insurer under section 3 of this chapter that was in effect at the time of the physician's separation from employment or the establishment or relocation of the medical practice.

SECTION 65. IC 27-13-36.2-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 10. (a) This section applies to an individual contract and a group contract that is entered into, delivered, amended, or renewed after June 30, 2025.**

(b) A health maintenance organization may not deny a claim for reimbursement for a covered service or item provided to an enrollee on the sole basis that the referring provider is an out of network provider.

SECTION 66. IC 27-13-43-5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 5. (a) As used in this section, "physician" refers to an individual who:**

(1) is licensed under IC 25-22.5;

(2) has been granted reciprocity by the medical licensing board of Indiana under IC 25-1-21 before July 1, 2026; or

(3) is licensed in a state that has enacted the interstate medical licensure compact.

(b) If a physician who is fully credentialed by a health maintenance organization:

(1) leaves the employment of an employer and becomes employed with another employer in Indiana; or

(2) establishes or relocates a medical practice in Indiana;

the health maintenance organization shall provisionally credential the physician for the time frame set forth in subsection (c).

(c) A physician under subsection (b) must be provisionally credentialed:

(1) for sixty (60) days after the physician's separation from employment or the establishment or relocation of the medical practice; or

(2) until the physician is fully credentialed by the health maintenance organization;

whichever is earlier.

(d) Notwithstanding section 2(j) of this chapter, a health maintenance organization shall reimburse a physician who is provisionally credentialed under this section for services rendered

while the physician was provisionally credentialed at the rates determined by:

(1) the agreement between the physician's new employer and the health maintenance organization relating to terms and conditions of reimbursement; or

(2) if:

(A) the physician's new employer has not entered into an agreement with the health maintenance organization relating to the terms and conditions of reimbursement; or

(B) the physician established or relocated a medical practice;

the agreement between the physician and the health maintenance organization relating to terms and conditions of reimbursement that was in effect at the time of the physician's separation from employment or the establishment or relocation of the medical practice.

SECTION 67. IC 34-30-2.1-240, AS ADDED BY P.L.105-2022, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 240. IC 16-39-7-2 (Concerning medical care providers for maintenance of x-ray ~~film).~~ **images).**

SECTION 68. [EFFECTIVE JULY 1, 2025] **(a) The Indiana department of health, in consultation with the office of technology established by IC 4-13.1-2-1, shall study the feasibility of developing and implementing standards for health providers concerning the following:**

(1) Medical record interoperability.

(2) Medical data security.

(3) Patient control over the access and use of the patient's medical information, including the ability to opt out or rescind authorization to share the patient's medical information.

(4) Notification to individuals of any unauthorized access or disclosure of the individual's medical information.

(5) Compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) concerning safety and patient's information.

(b) Not later than November 1, 2025, the Indiana department of health shall submit a report to the legislative council in an electronic format under IC 5-14-6 concerning the study conducted under subsection (a) and any findings or recommendations as a result of the study.

(c) This SECTION expires December 31, 2025.

SECTION 69. **An emergency is declared for this act.**

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: _____ Time: _____