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.

SENATE ENROLLED ACT No. 140

AN ACT to amend the Indiana Code concerning insurance.

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

SECTION 1. IC 27-1-24.2 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]:

Chapter 24.2. Pharmacy Benefits

Sec. 1. (a) This chapter applies to a policy or contract that is issued, delivered, entered into, renewed, or amended after December 31, 2025.

(b) This chapter does not apply to the following:

(1) Medicaid or a managed care organization (as defined in IC 12-7-2-126.9).

(2) Except as provided in section 18 of this chapter, a state employee health plan (as defined in IC 5-10-8-6.7).

Sec. 1.5. As used in this chapter, "actual acquisition cost" means the purchase price of a drug paid by a pharmacy net of all discounts, rebates, chargebacks, and other adjustments to the price of the drug. The term does not include professional fees.

Sec. 2. As used in this chapter, "actual overpayment" means the portion of any amount paid for pharmacy or pharmacist services that:

(1) is duplicative because the pharmacy or pharmacist has already been paid for the services; or

(2) was erroneously paid because the services were not rendered in accordance with the prescriber's order, in which

case only the amount paid for the portion of the prescription that was filled incorrectly or in excess of the prescriber's order is deemed an actual overpayment.

Sec. 3. As used in this chapter, "common control" includes:

(1) sharing common management or managers; and

(2) having common members on boards of directors.

Sec. 4. As used in this chapter, "cost sharing" means the cost to an insured under a health plan according to any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirements imposed by the health plan.

Sec. 5. (a) As used in this chapter, "health plan" means the following:

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(2) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(3) Any other plan or program that provides payment, reimbursement, or indemnification to a covered individual for the cost of prescription drugs.

(b) The term does not include the following:

(1) A self-insured health plan provided by a hospital or health system to its employees and dependents of employees if the hospital or health system owns a pharmacy.

(2) A prescription drug plan established under Medicare Part D.

Sec. 6. As used in this chapter, "insured" means an individual covered under a health plan.

Sec. 7. As used in this chapter, "insurer" means any of the following that offer or issue a health plan:

(1) An insurance company.

(2) A health maintenance organization.

(3) A limited health service organization.

(4) A self-insurer, including a governmental plan, church plan, or multiple employer welfare arrangement.

(5) A provider sponsored integrated health delivery network.

(6) A self-insured employer organized association.

(7) A nonprofit hospital, medical-surgical, dental, and health service corporation.

(8) Any other third party payor that is:

(A) authorized to transact health insurance business in Indiana; or

(B) not exempt by federal law from regulation under the insurance laws of Indiana.

Sec. 8. As used in this chapter, "national drug code number" means the unique national drug code number that identifies:

(1) a specific approved drug;

(2) the manufacturer of the drug; and

(3) the package presentation of the drug.

Sec. 9. As used in this chapter, "net amount" means the amount paid to a pharmacy or pharmacist by the insurer, pharmacy benefit manager, or other administrator minus:

(1) any fees;

(2) any price concessions; and

(3) all other revenue;

passing from the pharmacy or pharmacist to the insurer, pharmacy benefit manager, or other administrator.

Sec. 10. As used in this chapter, "pharmacy" has the meaning set forth in IC 25-26-13-2.

Sec. 11. As used in this chapter, "pharmacy affiliate" means a pharmacy, including a specialty pharmacy, that directly or indirectly, through one (1) or more intermediaries:

(1) owns or controls;

(2) is owned or controlled by; or

(3) is under common ownership or common control with;

an insurer, a pharmacy benefit manager, or other administrator of pharmacy benefits.

Sec. 12. As used in this chapter, "pharmacy benefit manager" has the meaning set forth in IC 27-1-24.5-12.

Sec. 13. (a) As used in this chapter, "pharmacy or pharmacist services" means any:

(1) health care procedures or treatments within the scope of practice of a pharmacist; or

(2) services provided by a pharmacy or pharmacist.

(b) The term includes the sale and provision of the following by a pharmacy or pharmacist:

(1) Prescription drugs.

(2) Home medical equipment (as defined in IC 25-26-21-2).

Sec. 14. (a) An insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits that utilizes a network to provide pharmacy or pharmacist services under a health plan shall ensure that the network is reasonably adequate and accessible

with respect to the provision of pharmacy or pharmacist services.

(b) A reasonably adequate and accessible network with respect to the provision of pharmacy or pharmacist services must, at a minimum:

(1) offer an adequate number of accessible pharmacies that are not mail order pharmacies; and

(2) provide convenient access to pharmacies that are not mail order pharmacies within a reasonable distance of not more than thirty (30) miles from each insured's residence, to the extent that pharmacy or pharmacist services are available.

(c) An insurer, a pharmacy benefit manager, and any other administrator of pharmacy benefits shall file an annual report with the commissioner in a manner and form prescribed by the commissioner. The annual report must describe the networks of the insurer, pharmacy benefit manager, or other administrator that are utilized for the provision of pharmacy or pharmacist services under a health plan.

(d) The commissioner shall review each network reported under subsection (c) to ensure that the network complies with this section.

(e) All information and data acquired by the department under this section that is generally recognized as confidential or proprietary is confidential for the purposes of IC 5-14-3-4 and may not be disclosed by the department. However, the department may publicly disclose aggregated information that is not descriptive of any readily identifiable person or entity.

Sec. 15. (a) A contract between a pharmacy or pharmacist and an insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits for the provision of pharmacy or pharmacist services under a health plan, either directly or through a pharmacy services administrative organization or group purchasing organization, must include provisions that do the following:

(1) Outline the terms and conditions for the provision of pharmacy or pharmacist services.

(2) Subject to subsection (b), prohibit the insurer, pharmacy benefit manager, or other administrator from retroactively denying, reducing reimbursement for, or seeking any refunds or recoupments for a claim for pharmacy or pharmacist services, in whole or in part, from the pharmacy or pharmacist after returning a paid claim response as part of the adjudication of the claim, including claims for the cost of a medication or dispensed product and claims for pharmacy

or pharmacist services that are deemed ineligible for coverage, unless:

(A) the original claim was submitted fraudulently; or

(B) the pharmacy or pharmacist received an actual overpayment.

(3) Prohibit the insurer, pharmacy benefit manager, or other administrator from reimbursing the pharmacy or pharmacist for a prescription drug or other service at a net amount that is less than the greater of the following:

(A) The amount the insurer, pharmacy benefit manager, or other administrator reimburses itself or a pharmacy affiliate for the same prescription drug by national drug code number or service.

(B) The following amount, as applicable:

(i) If the prescription drug or service is administered, dispensed, or provided at a pharmacy that is a licensed premises (as defined in IC 7.1-1-3-20), the actual acquisition cost for the prescription drug or service plus a fair and reasonable dispensing fee.

(ii) If the prescription drug or service is administered, dispensed, or provided at a pharmacy not described in item (i), the national average drug acquisition cost (NADAC) for the prescription drug or service, as determined by the federal Centers for Medicare and Medicaid Services at the time the prescription drug or service is administered, dispensed, or provided plus a professional dispensing fee equal to the Medicaid fee for service dispensing fee under 405 IAC 5-24-6.

(b) An insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits may not request a refund or make a recoupment of a dispensing fee paid to the pharmacy if the correct medication was dispensed to the patient.

Sec. 16. (a) Except as provided in section 15 of this chapter, with respect to the provision of pharmacy or pharmacist services under a health plan, an insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits may not:

(1) prohibit a pharmacy or pharmacist from, or impose a penalty on a pharmacy or pharmacist for:

(A) selling a lower cost alternative to an insured, if a lower cost alternative is available; or

(B) providing information to an insured under subsection (c);

(2) discriminate against any pharmacy or pharmacist that is:

(A) located within the geographic coverage area of the health plan; and

(B) willing to agree to, or accept, terms and conditions established for participation in the insurer's, pharmacy benefit manager's, other administrator's, or health plan's network;

(3) impose limits, including quantity limits or refill frequency limits, on an insured's access to medication from a pharmacy that are more restrictive than those existing for a pharmacy affiliate;

(4) except as provided in subsection (b), require an insured to receive pharmacy or pharmacist services from a pharmacy affiliate, including:

(A) requiring an insured to obtain a specialty drug from a pharmacy affiliate; and

(B) charging less cost sharing to insureds that use pharmacy affiliates than what is charged to insureds that use nonaffiliated pharmacies;

(5) require a pharmacy or pharmacist to enter into an additional contract with an affiliate of the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits as a condition of entering into a contract with this insurer, pharmacy benefit manager, or administrator; or

(6) require a pharmacy or pharmacist to, as a condition of a contract, agree to payment rates for any affiliate of the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits that is not a party to the contract.

(b) Subsection (a)(4):

(1) does not apply to a mail order pharmacy; and

(2) may not be construed to prohibit:

(A) communications to insureds regarding networks and prices if the communication is accurate and includes information about all eligible nonaffiliated pharmacies; or

(B) an insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits from providing financial incentives for utilizing the network, if the insurer, pharmacy benefit manager, or other administrator complies with this section and section 14 of this chapter.

(c) A pharmacist shall have the right to provide an insured with information regarding lower cost alternatives to assist the insured in making informed decisions.

Sec. 17. (a) Any insured, pharmacy, or pharmacist impacted by an alleged violation of this chapter may file a complaint with the commissioner.

(b) The commissioner shall:

(1) review and investigate all complaints filed under this section; and

(2) issue, in writing, a determination to the insured, pharmacy, or pharmacist as to whether a violation occurred.

(c) An insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits shall:

(1) respond to; and

(2) comply with;

any requests made by the commissioner under this section.

Sec. 18. (a) This section applies to a state employee health plan (as defined in IC 5-10-8-6.7). If a pharmacy benefit manager is used with regard to a state employee health plan, the state personnel department shall either:

(1) create a pharmacy benefit manager within the state personnel department; or

(2) contract with an insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits.

(b) All data collected by a contractor while administering a contract under subsection (a)(2) is the property of the state.

Sec. 19. (a) As used in this section, "plan sponsor" means an employer or organization that:

(1) has more than one hundred (100) employees or members; and

(2) offers health insurance coverage to its employees or members through a self-funded health benefit plan.

(b) A third party administrator may not:

(1) require, as a condition of a plan sponsor entering into a contract with the third party administrator, that the plan sponsor enter into a contract with a particular pharmacy benefit manager; or

(2) charge a different fee for services provided by the third party administrator to a plan sponsor based on the plan sponsor's selection of a particular pharmacy benefit manager.

Sec. 20. In addition to any other remedies, penalties, or damages available under common law or statute, the commissioner may order reimbursement to any person who has incurred a monetary loss as a result of a violation of this chapter.

Sec. 21. This chapter applies to the extent that it is not in conflict

with federal law.

SECTION 2. [EFFECTIVE UPON PASSAGE] **(a) The legislative council is urged to assign to the appropriate study committee during the 2025 legislative interim the task of studying the topic of contracts for pharmacy benefit coverage under:**

(1) the Medicaid program under IC 12-15; and

(2) a state employee health plan (as defined in IC 5-10-8-6.7).

(b) If the topic is assigned to a study committee under subsection (a), the study committee shall issue a final report to the legislative council containing the study committee's findings and recommendations, including any recommended legislation concerning the topic, not later than November 1, 2025.

(c) This SECTION expires December 31, 2025.

SECTION 3. **An emergency is declared for this act.**

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: _____ Time: _____