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. 480

AN ACT to amend the Indiana Code concerning insurance.

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

SECTION 1. IC 5-10-8-19, AS ADDED BY P.L.77-2018, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 19. A self-insurance program established under section 7(b) of this chapter to provide health care coverage shall comply with the prior authorization requirements that apply to a ~~health plan~~ **utilization review entity** under IC 27-1-37.5.

SECTION 2. IC 27-1-37.5-1, AS AMENDED BY P.L.190-2023, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 1. ~~(a) Except as provided in sections 10, 11, 12, 13, and 13.5 of this chapter, this chapter applies beginning September 1, 2018.~~

~~(b)~~ **(a)** This chapter does not apply to a step therapy protocol exception procedure under **IC 5-10-8-17,** IC 27-8-5-30, or IC 27-13-7-23.

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

(c) This chapter does not apply to health care services provided under the following state Medicaid waivers:

(1) Pathways for aging.

(2) Health and wellness.

(d) This chapter does not apply to the extent that it is preempted

by a federal statute or regulation relating to the Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

SECTION 3. IC 27-1-37.5-1.5, AS ADDED BY P.L.190-2023, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 1.5. As used in this chapter, "adverse determination" means a ~~denial of a request for benefits~~ **decision by a utilization review entity to deny, reduce, or terminate benefit coverage of a health care service furnished or proposed to be furnished to a covered individual** on the grounds that the health **care** service: ~~or item:~~

(1) is not medically necessary, appropriate, effective, or efficient;

(2) is not being provided in or at an appropriate health care setting or level of care; or

(3) is experimental or investigational.

SECTION 4. IC 27-1-37.5-1.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 1.6. As used in this chapter, "authorization" means a determination by a utilization review entity that:**

(1) a health care service:

(A) has been reviewed; and

(B) based on the information provided, satisfies the utilization review entity's requirements for medical necessity; and

(2) payment will be made for the health care service.

SECTION 5. IC 27-1-37.5-1.7, AS ADDED BY P.L.190-2023, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 1.7. As used in this chapter, "clinical peer" means ~~a practitioner or other health care provider who either:~~ **the following:**

(1) **Except as provided in subdivision (3), for a review of a request from a physician, a physician who:**

(A) holds a current and valid license ~~in any United States jurisdiction;~~ **under IC 25-22.5,** ~~(2)~~ has been granted reciprocity ~~in the state,~~ **under IC 25-1-21,** if reciprocity exists, or ~~(3)~~ holds a license that is part of a compact in which ~~the state~~ **Indiana** has entered;

(B) is certified in the same specialty as the physician under review, as recognized by:

(i) the American Board of Medical Specialties; or

(ii) the American Osteopathic Association; and

(C) if the review specifically concerns subspecialty care, is

certified in the same subspecialty as the physician under review, as recognized by:

(i) the American Board of Medical Specialties; or

(ii) the American Osteopathic Association.

(2) For a review of a request from an advanced practice registered nurse, an advanced practice registered nurse who:

(A) holds a current and valid license under IC 25-23-1 or has been granted reciprocity under IC 25-1-21, if reciprocity exists, or holds a license that is part of a compact in which Indiana has entered; and

(B) holds equivalent or similar:

(i) population focus; and

(ii) role specialty;

as the advanced practice registered nurse who is subject to the review.

(3) For a review of a request from a primary care physician (as defined in IC 25-22.5-5.5-1.5), a physician who:

(A) holds a current and valid license under IC 25-22.5, has been granted reciprocity under IC 25-1-21, if reciprocity exists, or holds a license that is part of a compact in which Indiana has entered;

(B) is certified in the same general practice of medicine under review, as recognized by:

(i) the American Board of Medical Specialties;

(ii) the American Board of Pediatrics; or

(iii) the American Osteopathic Association; and

(C) has been actively engaged in general practice for at least three (3) years.

(4) For a review of a request from a practitioner or health care provider other than those specified in subdivisions (1) through (3), a practitioner or health care provider who:

(A) holds a current and valid license in Indiana;

(B) has been granted reciprocity in Indiana, if reciprocity exists; or

(C) holds a license that is part of a compact in which Indiana has entered.

SECTION 6. IC 27-1-37.5-1.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 1.8. As used in this chapter, "clinical criteria" means:**

(1) written policies;

(2) written screen procedures;

(3) drug formularies or lists of covered drugs;

(4) determination rules;

(5) determination abstracts;

(6) clinical protocols;

(7) practice guidelines;

(8) medical protocols; and

(9) any other criteria or rationale;

used by the utilization review entity to determine the medical necessity of a health care service.

SECTION 7. IC 27-1-37.5-1.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 1.9. (a) As used in this chapter, "cosmetic surgery" means any procedure that:**

(1) is directed at improving the patient's appearance; and

(2) does not meaningfully:

(A) promote the proper function of the body; or

(B) prevent or treat illness or disease.

(b) The term does not include the following:

(1) A procedure that is necessary to ameliorate a deformity arising from or directly related to a:

(A) congenital abnormality;

(B) personal injury resulting from an accident or trauma; or

(C) disfiguring disease.

(2) A procedure related to the treatment of breast cancer.

SECTION 8. IC 27-1-37.5-2, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 2. As used in this chapter, "covered individual" means an individual who is covered under a health plan. **The term includes a covered individual's legally authorized representative.**

SECTION 9. IC 27-1-37.5-3.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 3.7. As used in this chapter, "emergency health care service" means a health care service that is provided in an emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses average knowledge of health and medicine to:**

(1) place an individual's health in serious jeopardy;

(2) result in serious impairment to the individual's bodily

function; or

(3) result in serious dysfunction of any bodily organ or part of the individual.

SECTION 10. IC 27-1-37.5-3.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 3.8. As used in this chapter, "episode of care" means the medical care ordered to be provided for a specific medical procedure, condition, or illness.**

SECTION 11. IC 27-1-37.5-3.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 3.9. (a) As used in this chapter, except as provided in subsection (b), "health care provider" means an individual who holds a license issued by a board described in IC 25-0.5-11.**

(b) The term does not include the following:

(1) A dentist licensed under IC 25-14.

(2) An optometrist licensed under IC 25-24.

(3) A veterinarian licensed under IC 25-38.1.

SECTION 12. IC 27-1-37.5-4, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 4. (a) As used in this chapter, "health care service" means a health care ~~related service or product rendered or sold~~ **procedure, treatment, or service provided** by:

(1) a health care facility (as defined in IC 16-18-2-161(a));

(2) an ambulatory outpatient surgical center (as defined in IC 16-18-2-14); or

(3) a health care provider within the scope of **practice of** the health care provider's license or legal authorization.

~~including hospital, medical, surgical, mental health, and substance abuse services or products.~~ **The term includes the provision of pharmaceutical products or services or durable medical equipment.**

(b) The term does not include the following:

(1) Dental services.

(2) Vision services.

(3) ~~Long term rehabilitation treatment.~~ **Cosmetic surgery.**

~~(4) Pharmaceutical services or products.~~

SECTION 13. IC 27-1-37.5-5.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 5.4. As used in this chapter, "medically necessary" means a health care service that a prudent health care provider would provide to a patient for the purpose of**

preventing, diagnosing, or treating an illness, injury, disease, or symptoms in a manner that is:

(1) in accordance with generally accepted standards of medical practice;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for:

(A) the economic benefit of the health plan or purchaser; or

(B) the convenience of the health plan, patient, treating physician, or other health care provider.

SECTION 14. IC 27-1-37.5-7, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 7. As used in this chapter, "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.~~ **the process by which a utilization review entity determines the medical necessity of an otherwise covered health care service before the health care service is rendered. The term includes a utilization review entity's requirement that a covered individual or health care provider notify the utilization review entity prior to providing a health care service.**

SECTION 15. IC 27-1-37.5-8 IS REPEALED [EFFECTIVE JULY 1, 2025]. ~~Sec. 8. As used in this chapter, "urgent care situation" means a situation in which a covered individual's treating physician has determined that the covered individual's condition is likely to result in:~~

~~(1) adverse health consequences or serious jeopardy to the covered individual's life, health, or safety; or~~

~~(2) due to the covered individual's psychological state, serious jeopardy to the life, health, or safety of another individual;~~

~~unless treatment of the covered individual's condition for which prior authorization is sought occurs earlier than the period generally considered by the medical profession to be reasonable to treat routine or non-life threatening conditions.~~

SECTION 16. IC 27-1-37.5-8.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 8.1. As used in this chapter, "urgent health care service" means a health care service in which the application of the time period for making a nonexpedited prior**

authorization, in the opinion of a physician with knowledge of the covered individual's medical condition, could:

(1) seriously jeopardize:

(A) the life or health of the covered individual; or

(B) the covered individual's ability to regain maximum function; or

(2) subject the covered individual to severe pain that cannot be adequately managed without the health care service.

The term includes a mental and behavioral health care service.

SECTION 17. IC 27-1-37.5-8.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 8.3. As used in this chapter, "utilization review entity" means an individual or entity that performs prior authorization for one (1) or more of the following:**

(1) An employer who employs a covered individual.

(2) A health plan.

(3) A preferred provider organization.

(4) Any other individual or entity that:

(A) provides;

(B) offers to provide; or

(C) administers;

hospital, outpatient, medical, prescription drug, or other health benefits to a covered individual.

SECTION 18. IC 27-1-37.5-9 IS REPEALED [EFFECTIVE JULY 1, 2025]. ~~Sec. 9. (a) A health plan shall make available to participating providers on the health plan's Internet web site or portal the applicable CPT code for the specific health care services for which prior authorization is required.~~

~~(b) A health plan shall make available to participating providers, on the health plan's Internet web site or portal, a list of the health plan's prior authorization requirements, including specific information that a provider must submit to establish a complete request for prior authorization. This subsection does not prevent a health plan from requiring specific additional information upon review of the request for prior authorization.~~

~~(c) A health plan shall, not less than forty-five (45) days before the prior authorization requirement becomes effective, disclose to a participating provider any new prior authorization requirement.~~

~~(d) A disclosure made under subsection (c) must:~~

~~(1) be sent via electronic or United States mail and conspicuously labeled "Notice of Changes to Prior Authorization Requirements"; and~~

~~(2) specifically identify the location on the health plan's Internet web site or portal of the new prior authorization requirement.~~

~~However, a health plan is considered to have met the requirements of this subsection if the health plan conspicuously posts the information required by this subsection, including the effective date of the new prior authorization requirement, on the health plan's Internet web site.~~

~~(c) A participating provider shall, not more than seven (7) days after the change is made, notify the health plan of a change in the participating provider's electronic or United States mail address.~~

SECTION 19. IC 27-1-37.5-10, AS ADDED BY P.L.208-2018, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 10. (a) This section ~~applies to a request for prior authorization delivered to a health plan after December 31, 2019.~~ **does not apply to prior authorization for a prescription drug.**

(b) A ~~health plan~~ **utilization review entity** shall accept a request for prior authorization delivered to the ~~health plan~~ **utilization review entity** by a covered individual's health care provider through a secure electronic transmission **or an application programming interface.** A health care provider shall submit a request for prior authorization through a secure electronic transmission **or an application programming interface.** A ~~health plan~~ **utilization review entity** shall provide for:

(1) a secure electronic transmission **or an application programming interface;** and

(2) acknowledgment of receipt, by use of a transaction number or another reference code;

of a request for prior authorization and any supporting information.

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

(1) **a** secure electronic transmission **or an application programming interface** of prior authorization requests would cause financial hardship for the health care provider;

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

(3) the health care provider has an insufficient number of covered

individuals as patients or customers, as determined by the commissioner, to warrant the financial expense that compliance with subsection (b) would require.

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

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

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

SECTION 20. IC 27-1-37.5-11 IS REPEALED [EFFECTIVE JULY 1, 2025]. ~~Sec. 11. (a) This section applies to a prior authorization request delivered to a health plan after December 31, 2019.~~

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

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

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

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

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

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

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

~~(3) if the request is for an urgent care situation, the health care provider shall respond to the request for additional information~~

~~not more than forty-eight (48) hours after the health care provider receives the response under subdivision (1).~~

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

SECTION 21. IC 27-1-37.5-12, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 12. (a) This section applies to a claim for a health care service rendered by a ~~participating~~ **health care** provider:

(1) for which:

(A) prior authorization is requested after ~~December 31, 2019;~~ **June 30, 2025;** and

(B) a ~~health plan~~ **utilization review entity** gives prior authorization; and

(2) that is rendered in accordance with

~~(A)~~ the ~~prior~~ authorization. ~~and~~

~~(B) all terms and conditions of the participating provider's agreement or contract with the health plan.~~

(b) The ~~health plan~~ **utilization review entity** shall not deny the claim described in subsection (a) unless:

~~(1) the:~~

~~(A) request for prior authorization; or~~

~~(B) claim;~~

~~contains fraudulent or materially incorrect information; or~~

(1) the health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from the utilization review entity;

(2) the health care service was no longer a covered benefit on the date the health care service was provided;

(3) the health care provider was no longer contracted with the patient's health plan on the date the health care service was provided;

(4) the health care provider failed to meet the utilization review entity's timely filing requirements;

(5) the utilization review entity does not have liability for the claim; or

~~(2)~~ **(6)** the ~~covered individual is~~ **patient was** not covered under the health plan on the date on which the health care service ~~is~~ **was** rendered.

(c) If:

(1) the claim described in subsection (a) contains an unintentional and inaccurate inconsistency with the request for prior authorization; and

(2) the inconsistency results in denial of the claim;

the health care provider may resubmit the claim with accurate, corrected information.

SECTION 22. IC 27-1-37.5-13, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 13. (a) This section applies to a claim filed after ~~December 31, 2018,~~ **June 30, 2025,** for a medically necessary health care service rendered by a ~~participating~~ **health care** provider, the necessity of which:

(1) is not anticipated at the time ~~prior authorization is obtained for~~ **of scheduling** another health care service **that:**

(A) was authorized by the utilization review entity; or

(B) is not subject to a prior authorization requirement; and

(2) is determined at the time the other health care service is rendered.

(b) A utilization review entity may not:

(1) require retrospective review of; or

(2) deny a claim based solely on lack of prior authorization for;

an unanticipated health care service described in subsection (a).

(c) A health care provider that renders an unanticipated health care service described in subsection (a) shall submit to the utilization review entity documentation explaining why the unanticipated health care service was medically necessary.

~~(b) The health plan shall not deny a claim described in subsection (a) based solely on lack of prior authorization for the unanticipated health care service.~~

~~(c) The health plan:~~

~~(1) shall not deny payment for a health care service that is rendered in accordance with:~~

~~(A) a prior authorization; and~~

~~(B) all terms and conditions of the participating provider's agreement or contract with the health plan; and~~

~~(2) may:~~

~~(A) require retrospective review of; and~~

~~(B) withhold payment for;~~

~~an unanticipated health care service described in subsection (a).~~

SECTION 23. IC 27-1-37.5-13.7 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 13.7. (a) This section does not apply to the following:**

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

(2) The Medicaid program.

(b) A utilization review entity may not require prior authorization for the first twelve (12):

(1) physical therapy; or

(2) chiropractic;

visits of each new episode of care.

SECTION 24. IC 27-1-37.5-14, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 14. A provision that:

(1) is contained in a policy or contract that is entered into, amended, or renewed after June 30, ~~2018;~~ **2025;** and

(2) contradicts this chapter;

is void.

SECTION 25. IC 27-1-37.5-15, AS ADDED BY P.L.77-2018, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 15. A violation of this chapter by a ~~health plan~~ **utilization review entity** is an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

SECTION 26. IC 27-1-37.5-16, AS AMENDED BY P.L.265-2019, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 16. (a) Except as provided in subsection (b), the department shall establish, post, and maintain on the department's ~~Internet web site~~ **website** a standardized prior authorization form for use by health care providers and ~~health plans~~ **utilization review entities** for purposes of any notice or authorization required by a ~~health plan~~ **utilization review entity** with respect to payment for a health care service rendered to a covered individual.

(b) After December 31, 2020, a Medicaid managed care organization (as defined in IC 12-7-2-126.9) shall use a standardized prior authorization form prescribed by the office of the secretary of family and social services.

SECTION 27. IC 27-1-37.5-17, AS ADDED BY P.L.190-2023, SECTION 18, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 17. (a) As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation, second opinion, or other clinical information that is directly applicable to the requested **health care** service that may be required.

(b) If a ~~health plan~~ **utilization review entity** makes an adverse determination on a prior authorization request by a covered individual's health care provider, the ~~health plan~~ **utilization review entity** must offer the covered individual's health care provider the option to request a peer to peer review by a clinical peer concerning the adverse determination.

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

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

(1) the ~~health plan's~~ **utilization review entity's** clinical peer and the covered individual's health care provider or the health care provider's designee shall make every effort to provide the peer to peer review not later than ~~seven (7) business days~~ **forty-eight (48) hours (excluding weekends and state and federal legal holidays)** ~~from the date of receipt by the health plan~~ **after the utilization review entity receives** ~~of~~ the request by the covered individual's health care provider for a peer to peer review if the ~~health plan~~ **utilization review entity** has received the necessary information for the peer to peer review; and

(2) the ~~health plan~~ **utilization review entity** must have the peer to peer review conducted between the clinical peer and the covered individual's health care provider or the provider's designee.

SECTION 28. IC 27-1-37.5-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 19. (a) A utilization review entity shall make any current prior authorization requirements and restrictions, including written clinical criteria, readily accessible on the utilization review entity's website to covered individuals, health care providers, and the general public. The prior authorization requirements and restrictions must be described in detail and in easily understandable language.**

(b) A utilization review entity may not implement a new prior authorization requirement or restriction or amend an existing requirement or restriction unless:

(1) the utilization review entity's website has been updated to reflect the new or amended requirement or restriction; and

(2) the utilization review entity provides written notice to covered individuals and health care providers at least sixty (60) days before the requirement or restriction is implemented.

(c) A utilization review entity shall make statistics available regarding prior authorization approvals and denials on the utilization review entity's website in a readily accessible format, including statistics for the following categories:

(1) Health care provider specialty.

(2) Medication or diagnostic test or procedure.

(3) Indication offered.

(4) Reason for denial.

(5) If a decision was appealed.

(6) If a decision was approved or denied on appeal.

(7) The time between submission and the response.

(d) Not later than December 31 of each year, a utilization review entity shall:

(1) prepare a report of the statistics compiled under subsection (c); and

(2) submit the report to the department.

SECTION 29. IC 27-1-37.5-20 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 20. (a) A utilization review entity must ensure that:**

(1) all:

(A) adverse determinations based on medical necessity are made; and

(B) appeals are reviewed and decided;

by a clinical peer; and

(2) when making an adverse determination based on medical necessity or reviewing and deciding an appeal, the clinical peer is under the clinical direction of a medical director of the utilization review entity who is:

(A) responsible for the provision of health care services provided to covered individuals; and

(B) a physician licensed in Indiana under IC 25-22.5.

(b) An appeal may not be reviewed or decided by a clinical peer who:

(1) has a financial interest in the outcome of the appeal; or

(2) was involved in making the adverse determination that is the subject of the appeal.

SECTION 30. IC 27-1-37.5-21 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 21. A clinical peer who:**

(1) makes an adverse determination; or

(2) reviews and decides an appeal;

owes a duty to the covered individual to exercise the applicable standard of care.

SECTION 31. IC 27-1-37.5-23 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 23. (a) The time frames set forth in this section do not include weekends and state and federal legal holidays.**

(b) A utilization review entity shall respond to a request for prior authorization as follows:

(1) If the request for prior authorization is for an urgent health care service, the utilization review entity shall respond with an authorization or adverse determination not later than twenty-four (24) hours after receiving the request.

(2) If the request for prior authorization is:

(A) for a health care service other than the health care services described in subdivision (1); or

(B) for a prescription drug;

the utilization review entity shall respond with an authorization or adverse determination not later than forty-eight (48) hours after receiving the request.

(c) If a utilization review entity issues an adverse determination in a response under subsection (b), the response must include the following information:

(1) Specific reasons for the adverse determination.

(2) Suggested alternatives to the requested health care service.

(d) A health care provider shall respond not later than forty-eight (48) hours after receiving an adverse determination under subsection (b) if the health care provider:

(1) needs to correct a typographical, clerical, or spelling error; or

(2) accepts an alternative suggested by the utilization review entity.

(e) Not later than forty-eight (48) hours after receiving a health care provider's response under subsection (d), the utilization review entity shall:

(1) render a prior authorization or adverse determination based on the information provided in the health care provider's response; and

(2) notify the health care provider of the authorization or adverse determination.

(f) A health care provider may appeal an adverse determination received under subsection (b) or (e). The health care provider shall

notify the utilization review entity of an appeal not later than forty-eight (48) hours after receiving notice of the adverse determination.

(g) A utilization review entity shall respond to an appeal under subsection (f) not later than forty-eight (48) hours after receiving notice of the appeal.

SECTION 32. IC 27-1-37.5-24 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 24. (a) A utilization review entity shall allow a covered individual and a covered individual's health care provider at least twenty-four (24) hours (excluding weekends and state and federal legal holidays) after an emergency admission or provision of emergency health care services for the covered individual or health care provider to notify the utilization review entity of the emergency admission or provision of the emergency health care service.**

(b) A utilization review entity shall cover emergency health care services necessary to screen and stabilize a covered individual. If a health care provider certifies in writing to a utilization review entity not later than seventy-two (72) hours (excluding weekends and state and federal legal holidays) after a covered individual's emergency admission that the covered individual's condition required the emergency health care service, the certification will create a presumption that the emergency health care service was medically necessary. The presumption may be rebutted only if the utilization review entity can establish, with clear and convincing evidence, that the emergency health care service was not medically necessary.

(c) The medical necessity of an emergency health care service may not be based on whether the service was provided by a participating or nonparticipating provider. Any restriction on the coverage of an emergency health care service provided by a nonparticipating provider may not be greater than the restriction that applies when the service is provided by a participating provider.

SECTION 33. IC 27-1-37.5-25 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 25. A utilization review entity may not revoke, limit, condition, or restrict an authorization if the health care provider begins providing the health care service not later than forty-five (45) days (excluding weekends and state and federal legal holidays) after the date the health care provider**

received the authorization.

SECTION 34. IC 27-1-37.5-26 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 26. (a) The authorization periods in this section do not apply if:**

(1) the health care provider has not begun providing the health care service within forty-five (45) days (excluding weekends and state and federal legal holidays) after receiving the authorization as set forth in section 25 of this chapter; and

(2) the utilization review entity revokes, limits, conditions, or restricts the authorization.

(b) An authorization for a health care service shall be valid for at least one (1) year after the date the health care provider receives the authorization.

(c) The authorization period under subsection (b) is effective regardless of any changes in dosage for a prescription drug prescribed by the health care provider.

SECTION 35. IC 27-1-37.5-27 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 27. (a) A utilization review entity shall honor an authorization that was granted to a covered individual by a previous utilization review entity for at least the initial ninety (90) days of the covered individual's coverage under a new health plan if:**

(1) the utilization review entity receives information documenting the authorization from the covered individual or the covered individual's health care provider; and

(2) the authorization is for a health care service that is covered under the new health plan.

(b) During the time period described in subsection (a), a utilization review entity may perform its own review of the prior authorization request.

(c) If there is a change in:

(1) coverage of; or

(2) approval criteria for;

a previously authorized health care service, the change in coverage or approval criteria may not affect a covered individual who received authorization before the effective date of the change for the remainder of the plan year.

(d) A utilization review entity shall continue to honor an authorization that the utilization review entity granted to a covered individual when the covered individual changes products under the

same health insurance company.

SECTION 36. IC 27-1-37.5-28 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 28. If a utilization review entity fails to comply with the deadlines or other requirements under this chapter, the health care service subject to prior authorization shall be automatically deemed authorized by the utilization review entity.**

SECTION 37. 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 38. 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.

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: _____ Time: _____

SEA 480 — Concur