SB 196

Healthy Indiana plan health care accounts. Repeals the health care account and cost sharing requirements of an individual for the healthy Indiana plan.

HB 1273

Prescription drug rebates and pricing. Provides that, for individual health insurance coverage, the defined cost sharing for a prescription drug be calculated at the point of sale and based on a price that is reduced by an amount equal to at least 85% of all rebates received by the insurer in connection with the dispensing or administration of the prescription drug. Requires that, for group health insurance coverage, an insurer: (1) pass through to a plan sponsor 100% of all rebates received or estimated to be received by the insurer concerning the dispensing or administration of prescription drugs to the covered individuals of the plan sponsor; (2) provide a plan sponsor, at the time of contracting, the option of calculating defined cost sharing for covered individuals of the plan sponsor at the point of sale based on a price that is reduced by some or all of the rebates received or estimated to be received by the insurer concerning the dispensing or administration of the prescription drug; and (3) disclose specified information to the plan sponsor. Allows the department of insurance to enforce the provisions and impose a civil penalty.

HB 1445

Audit of Medicaid program prescription drug costs. Amends the requirements for a physician to provide office based opioid treatment. Provides that the attorney general may issue a request for proposal to audit the prescription drug programs within the state employee health plan and the Medicaid program. Provides that the attorney general may evaluate and determine whether to include specified metrics in the request for proposal. Provides that the audit look back period must be the previous five state fiscal years. Provides that the results of the audits must be provided to the interim study committee on public health, behavioral health, and human services before September 1, 2024. Provides that a practitioner is not

required to obtain information about a patient from the Indiana scheduled prescription electronic collection and tracking program (INSPECT) data base or through the patient's integrated health record before prescribing certain medications if the patient is enrolled in a hospice program.

HB 1181

Medicaid matters. Allows a provider that has entered into a contract with a managed care organization, after exhausting any internal procedures of the managed care organization for provider grievances and appeals, to request an administrative appeal within the office of Medicaid policy and planning of the managed care organization's action in denying or reducing reimbursement for claims for covered services provided to an applicant, pending applicant, conditionally eligible individual, or member. Establishes a procedure for an administrative appeal, including a hearing before an administrative law judge that could be followed by agency review and then by judicial review. Prohibits a provision in a contract between a provider and a managed care organization that would negate or restrict the right of a provider to an administrative appeal and provides that such a contract provision is void and unenforceable. Repeals a provision under which Medicaid law is controlling when Medicaid law conflicts with insurance law. Provides that if the office of the secretary of family and social services (office) or a contractor of the office fails to pay or denies a clean claim for any eligible Medicaid service within certain time limits due to the office or contractor incorrectly processing the clean claim because of errors attributable to the internal system of an insurer or managed care organization, the office or contractor may not assert that the provider failed to meet the timely filing requirements for the claim. Adds members to the Medicaid advisory committee (committee). Allows a member of the committee whose position was eliminated to continue to serve until the member's term expires. Establishes co-chairs for the committee. Requires the office to prepare a report that describes every type of report that must be prepared by a Medicaid contractor or managed care entity and submitted to the office or the office of Medicaid policy and planning. Specifies the information that must be contained in the report. Requires the office to submit the report to the committee and the general assembly. Requires the advisory committee to hold public hearings on the report. Makes technical changes.

SB 433

Medicaid services for northwest Indiana. Requires the office of Medicaid policy and planning (office) to establish a program for northwest Indiana Medicaid recipients to enhance access to medical services closer to the recipient’s residence with a priority on trauma care and pediatric services. Requires the office to submit a state plan amendment implementing enhanced access. Requires the office to review and analyze certain Medicaid reimbursement rates, statistics, and information concerning the Illinois Medicaid program in comparison to Indiana. Appropriates $20 million to northwest Indiana hospitals in state fiscal year 2024 for disproportionate share eligible hospitals that apply for funds to offset federal law changes in the disproportionate share program

HB 1272

Hospital pricing information and penalties. Requires a hospital to post certain pricing information on the hospital’s website. Sets forth civil penalties for the Indiana department of health to assess a hospital or ambulatory outpatient surgical center that fails to post the pricing information.

State Regulation of Outpatient Facility Fees

Indiana hospital eliminates physician

noncompetes

HB 1459

Cooperative agreements of home health agencies. Adds language concerning statements and findings of the general assembly concerning home health agency cooperative agreements. Specifies that a home health agency may contract directly or indirectly through a network of home health agencies. Removes the expiration of the home health agency cooperative agreement statute.

SB 310

Medicaid buy-in program – amends specialty disability add-on to Medicaid to remove asset test. Removes consideration of income and countable resources in determining an individual's eligibility for participation in the Medicaid buy-in program (program). Requires the office of the secretary of family and social services (office of the secretary) to apply for a state plan amendment or waiver to implement this provision. Prohibits the office of the secretary from considering resources and whether the individual participated in a specified program in determining the individual's eligibility or continuous eligibility for the program. Allows a recipient's participation in an employment network recognized by the federal Social Security Administration to qualify as participating with an approved provider of employment services. Changes minimum and maximum premiums that a recipient must pay. Requires that the premium scale be promulgated by administrative rule. Allows the office of the secretary to annually review the premium amount that a recipient must pay in the program. (Current law requires annual review of the premium amount.) Specifies changes in circumstances that must result in an adjustment of the premium. Specifies that a recipient in the program is eligible for the same services as offered in the Medicaid program. States that an individual's participation in the program does not preclude the individual from participating in a Medicaid waiver program. Specifies that a recipient of the program may simultaneously participate in a Medicaid waiver program and requires the office of the secretary to individually determine eligibility for both programs based on the individual's medical need requirements.