February 23, 2024

ENGROSSED
HOUSE BILL No. 1414

DIGEST OF HB 1414 (Updated February 21, 2024 11:41 am - DI 104)

Citations Affected: IC 12-7; IC 12-15; IC 27-1; IC 27-7; IC 27-8.

Synopsis: Various health care matters. Requires the budget committee to review certain contracts with managed care organizations for the Medicaid program. Allows a managed care organization and a Medicaid provider to enter into a value based health care reimbursement agreement. Prohibits a managed care organization from imposing on a provider a reimbursement rate or payment methodology through a notice of contract change, a policy, or a provider manual change. Allows for case rate reimbursement for emergency services. Requires a managed care organization to contract with any willing provider if the provider: (1) meets licensure and certification requirements and enrollment criteria; and (2) agrees accept the terms and conditions of the managed care organization to provide services under the risk based managed care program; for Medicaid recipients who are eligible to participate in the Medicare program and receive nursing facility services or home and community based services (program). Requires the office of the secretary of family and social
(Continued next page)

Effective: July 1, 2024.

Karickhoff, Manning, Fleming
(SENATE SPONSOR — JOHNSON T)

January 11, 2024, read first time and referred to Committee on Public Health.
January 30, 2024, amended, reported — Do Pass.
February 1, 2024, read second time, amended, ordered engrossed.
February 2, 2024, engrossed.
February 5, 2024, read third time, passed. Yeas 98, nays 0.

SENATE ACTION

February 12, 2024, read first time and referred to Committee on Health and Provider Services.
February 22, 2024, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.

services to establish minimum reimbursement rates for covered services under the program. Requires a health plan to make current prior authorization requirements and restrictions accessible on the health plan's website. Prohibits the implementation of a new or amended prior authorization requirement or restriction unless certain conditions are met. Requires a health plan to release statistics concerning prior authorization and submit a report concerning the statistics to the department of insurance. Provides that a contracting entity may not grant a third party access to the provider network contract or to dental services or contractual discounts provided under the provider network contract unless certain conditions are satisfied. Provides that any provider that is a party to the network contract must be allowed to choose not to participate in the third party access. Prohibits a contracting entity from: (1) altering the rights or status under a provider network contract of a dental provider that chooses not to participate in third party access; or (2) rejecting a provider as a party to a provider network contract because the provider chose not to participate in third party access. Authorizes enforcement by the insurance commissioner. Provides that if a covered individual assigns the covered individual's rights to benefits for dental services to the provider of the dental services, the dental carrier shall pay the benefits assigned by the covered individual to the provider of the dental services. Prohibits the provider from billing the covered individual if the provider is in the dental carrier's network.

February 23, 2024

Second Regular Session of the 123rd General Assembly (2024)

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 2023 Regular Session of the General Assembly.

ENGROSSED
HOUSE BILL No. 1414

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

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

SECTION 1. IC 12-7-2-25.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 25.1. "Case rate", for purposes of IC 12-15, means a fixed rate per encounter used to reimburse for emergency services, regardless of the patient's level of acuity.**

SECTION 2. IC 12-7-2-196.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 196.7. (a) "Value based health care reimbursement agreement", for purposes of IC 12-15, has the meaning set forth in IC 27-1-37.6-15.**

SECTION 3. IC 12-15-1-24 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 24. (a) If the office enters into a comprehensive risk contract with a managed care organization that:**

(1) establishes a capitated rate for a new contract; or

(2) changes a capitated rate for an existing or a renewal of a contract;

with a managed care organization, the office shall provide the capitated rates to the budget committee for review.

(b) As part of the review required under subsection (a), the office shall present the following information to the budget committee:

(1) The capitation rate and the percentage of any change.

(2) The rationale for the capitation rate.

(3) The fiscal impact of the capitation rate on the Medicaid program.

SECTION 4. IC 12-15-12-12.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 12.2. (a) This section does not apply to a risk based managed care program described in section 12.5(a) of this chapter.**

(b) A managed care organization and a provider may enter into a value based health care reimbursement agreement in writing that provides for reimbursement, a reimbursement rate, or payment methodology for a Medicaid service that is greater than a minimum rate set by the office of the secretary for the service. However, a managed care organization may not do any of the following:

(1) Impose, either directly or indirectly, a reimbursement or payment methodology through:

(A) a notice of contract change;

(B) a policy; or

(C) a provider manual change;

to a provider.

(2) Condition a provider's participation, reimbursement, or any other term contained in any other contractual agreement between the parties based on the provider's acceptance of a different reimbursement or payment methodology under this section.

(3) Impact a supplemental payment that is applicable to an original reimbursement rate, reimbursement, or payment methodology.

(c) If a managed care organization and a provider enter into a value based health care reimbursement agreement under this section, the managed care organization shall notify the office of the secretary.

SECTION 5. IC 12-15-12-12.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 12.3. A managed care**

organization and a provider may mutually enter into an agreement in writing that provides for reimbursement to be made to the provider using a case rate. However:

(1) a managed care organization may not impose a case rate through a notice of contract change, a policy, or a provider manual change to a provider; and

(2) a case rate may not impact a supplemental payment applicable to the original payment rate or methodology.

SECTION 6. IC 12-15-12-12.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 12.5. (a) This section applies to a risk based managed care program that provides services to Medicaid recipients who are eligible to:**

(1) participate in the Medicare program (42 U.S.C. 1395 et seq.); and

(2) receive:

(A) nursing facility services; or

(B) home and community based services.

(b) This subsection applies to a contract entered into, amended, or renewed after June 30, 2024. A managed care organization shall contract with any willing provider that:

(1) meets licensure and certification requirements and enrollment criteria established by the office of the secretary; and

(2) agrees to accept the terms and conditions of a managed care organization to provide covered services under the risk based managed care program.

(c) A managed care organization shall reimburse a provider that contracts to provide services under the risk based managed care program in accordance with federal and state law.

(d) The office of the secretary shall establish a minimum reimbursement rate for a covered service provided by a provider for a Medicaid recipient participating in the Medicaid risk based managed care program described in subsection (a). A managed care organization shall reimburse a provider at least at the reimbursement rate established by the office of the secretary.

SECTION 7. IC 12-15-12-17, AS AMENDED BY P.L.152-2017, SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 17. (a) This section applies to post-stabilization care services provided to an individual enrolled in a Medicaid risk based managed care program.

(b) The managed care organization through which an individual is

enrolled in a risk based managed care program, is financially responsible for the following services provided to the enrollee:

(1) Post-stabilization care services that are preapproved by the managed care organization.

(2) Post-stabilization care services that are not preapproved by the managed care organization, but that are administered to maintain the enrollee's stabilized condition within one (1) hour of a request to the managed care organization for preapproval of further post-stabilization care services.

(3) Post-stabilization care services provided after an enrollee is stabilized that are not preapproved by the managed care organization, but that are administered to maintain, improve, or resolve the enrollee's stabilized condition if the managed care organization:

(A) does not respond to a request for preapproval within one (1) hour;

(B) cannot be contacted; or

(C) cannot reach an agreement with the enrollee's treating physician concerning the enrollee's care, and a physician representing the managed care organization is not available for consultation.

(c) If the conditions described in subsection (b)(3)(C) exist, the managed care organization shall give the enrollee's treating physician an opportunity to consult with a physician representing the managed care organization. The enrollee's treating physician may continue with care of the enrollee until a physician representing the managed care organization is reached or until one (1) of the following criteria is met:

(1) A physician:

(A) representing the managed care organization; and

(B) who has privileges at the treating hospital;

assumes responsibility for the enrollee's care.

(2) A physician representing the managed care organization assumes responsibility for the enrollee's care through transfer.

(3) A representative of the managed care organization and the treating physician reach an agreement concerning the enrollee's care.

(4) The enrollee is discharged from the treating hospital.

(d) This subsection applies to post-stabilization care services provided under subsection (b)(1), (b)(2), and (b)(3) to an individual enrolled in a Medicaid risk based managed care program by a provider who has not contracted with the individual's managed care organization to provide post-stabilization care services under subsection (b)(1),

(b)(2), and (b)(3) to the individual. Payment for post-stabilization care services provided under subsection (b)(1), (b)(2), and (b)(3) must be in an amount equal to one hundred percent (100%) of the current Medicaid fee for service reimbursement rates for such services **unless the managed care organization and the provider enter into a value based health care reimbursement agreement in accordance with section 12.2 of this chapter.**

(e) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (d), the managed care organization shall notify the office of the secretary.

~~(e)~~ **(f)** This section does not prohibit a managed care organization from entering into a subcontract with another managed care organization providing for the latter managed care organization to assume financial responsibility for making the payments required under this section.

~~(f)~~ **(g)** This section does not limit the ability of the office or the managed care organization to:

(1) review; and

(2) make a determination of;

the medical necessity of the post-stabilization care services provided to an enrollee for purposes of determining coverage for such services.

SECTION 8. IC 12-15-12-18, AS AMENDED BY P.L.152-2017, SECTION 17, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 18. (a) Except as provided in subsection (b), this section applies to:

(1) emergency services provided to an individual enrolled in a Medicaid risk based managed care program; and

(2) medically necessary screening services provided to an individual enrolled in a Medicaid risk based managed care program;

who presents to an emergency department with an emergency medical condition.

(b) This section does not apply to emergency services or screening services provided to an individual enrolled in a Medicaid risk based managed care program by a provider who has contracted with the individual's managed care organization to provide emergency services to the individual.

(c) Payment for emergency services and medically necessary screening services in the emergency department of a hospital licensed under IC 16-21 must be in an amount equal to one hundred percent (100%) of the current Medicaid fee for service reimbursement rates for

such services **unless the managed care organization and the provider enter into a value based health care reimbursement agreement in accordance with section 12.2 of this chapter.**

(d) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (c), the managed care organization shall notify the office of the secretary.

~~(d)~~ **(e)** Payment under subsection (c) is the responsibility of the enrollee's managed care organization. This subsection does not prohibit the managed care organization from entering into a subcontract with another managed care organization providing for the latter managed care organization to assume financial responsibility for making the payments required under this section.

~~(c)~~ **(f)** This section does not limit the ability of the managed care organization to:

(1) review; and

(2) make a determination of;

the medical necessity of the services provided in a hospital's emergency department for purposes of determining coverage for such services.

SECTION 9. IC 12-15-12-18.5, AS ADDED BY P.L.142-2022, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 18.5. (a) Except as provided in subsection (b), this section applies to an emergency medical services provider organization that meets the following requirements:

(1) Is certified by the Indiana emergency medical services commission to provide emergency medical services.

(2) Is a Medicaid provider.

(b) This section does not apply to an emergency medical services provider organization that has contracted with the recipient's managed care organization to provide emergency medical services described in this section at a negotiated rate that is different than the Medicare rate described in this section.

(c) ~~Beginning July 1, 2023,~~ A managed care organization shall reimburse an emergency medical services provider organization for Medicaid covered services provided to a Medicaid recipient, including:

(1) advanced life support services;

(2) basic life support services; and

(3) nonemergency medical transportation services;

that are within the emergency medical services provider organization's scope of practice at a rate that is comparable to the federal Medicare reimbursement rate for the service provided by the emergency medical services provider organization **unless the managed care organization**

and the provider enter into a value based health care reimbursement agreement in accordance with section 12.2 of this chapter. ~~However, the reimbursement rate specified in this subsection may not be implemented by the office of the secretary before July 1, 2023.~~

SECTION 10. IC 12-15-44.5-5, AS AMENDED BY P.L.201-2023, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 5. (a) A managed care organization that contracts with the office to provide health coverage, dental coverage, or vision coverage to an individual who participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall reimburse providers at a rate that is not less than the rate established by the secretary; and

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan.

However, a managed care organization and a provider may enter into a value based health care reimbursement agreement in accordance with IC 12-15-12-12.2.

(b) A managed care organization that contracts with the office to provide health coverage under the plan must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.

SECTION 11. IC 27-1-37.5-18 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 18. (a) A health plan shall make any current prior authorization requirements and restrictions, including written clinical criteria, readily accessible on the health plan's website to covered individuals, health care providers, and the general public. The prior authorization requirements and restrictions must be described in detail and easily understandable language.**

(b) A health plan may not implement a new prior authorization requirement or restriction or amend an existing requirement or restriction unless:

(1) the health plan's website has been updated to reflect the new or amended requirement or restriction; and

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

(c) A health plan shall make statistics available regarding prior

authorization approvals and denials on the health plan's website in a readily accessible format, including statistics for the following categories:

(1) Physician 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 health plan shall:

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

(2) submit the report to the department.

SECTION 12. IC 27-1-37.6-15, AS ADDED BY P.L.203-2023, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 15. (a) As used in this chapter, "value based health care reimbursement agreement" may include the following:

(1) An accountable care organization that has a contract with a health plan in which the health plan:

(A) does not assume risk for prior authorization to a provider organization; or

(B) delegates risk to a provider organization to manage prior authorization.

(2) Bundled payments.

(3) A capitated rate reimbursement arrangement.

(4) A pay for performance arrangement.

(5) Any other health care reimbursement arrangement in which the health care provider accepts at most ten percent (10%) of the downside risk.

(b) The term does not include any of the following:

(1) Narrow networks.

(2) Fixed fee schedules.

(3) A supplemental payment for the original rate or payment methodology.

SECTION 13. IC 27-7-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]:

Chapter 18. Third Party Access to Dental Provider Networks

Sec. 1. As used in this chapter, "contracting entity" means a dental carrier, a third party administrator, or another person that enters into a provider network contract with providers for the

delivery of dental services in the ordinary course of business.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to:

(1) dental services; or

(2) coverage of dental services;

through a provider network contract.

Sec. 3. As used in this chapter, "dental carrier" means any of the following:

(1) An insurer that issues a policy of accident and sickness insurance that covers dental services.

(2) A health maintenance organization that provides, or provides coverage for, dental services.

(3) An entity that:

(A) provides dental services; or

(B) arranges for dental services to be provided;

but is not itself a provider.

Sec. 4. (a) As used in this chapter, "dental service" means any service provided by a dentist within the scope of the dentist's licensure under IC 25-14.

(b) The term does not include a service delivered by a provider that is billed as a medical expense.

Sec. 5. As used in this chapter, "health insurer" means:

(1) an insurer that issues policies of accident and sickness insurance (as defined in IC 27-8-5-1); or

(2) a health maintenance organization (as defined in IC 27-13-1-19).

Sec. 6. As used in this chapter, "person" means an individual, a corporation, a limited liability company, a partnership, or any other legal entity.

Sec. 7. (a) As used in this chapter, "provider" means:

(1) a dentist licensed under IC 25-14; or

(2) a dental office through which one (1) or more dentists licensed under IC 25-14 provide dental services.

(b) The term does not include a physician organization or physician hospital organization that leases or rents the network of the physician organization or physician hospital organization network to a third party.

Sec. 8. As used in this chapter, "provider network contract" means a contract between a contracting entity and one (1) or more providers:

(1) that establishes a network through which the providers:

(A) provide dental services to covered individuals; and

(B) are compensated for providing the dental services; and

(2) that specifies the rights and responsibilities of the contracting entity and the providers concerning the network.

Sec. 9. (a) As used in this chapter, "third party" means a person that enters into a contract with a contracting entity or another third party to gain access to:

(1) a provider network contract;

(2) dental services provided pursuant to a provider network contract; or

(3) contractual discounts provided pursuant to a provider network contract.

(b) The term does not include an employer or another group or entity for which the contracting entity provides administrative services.

Sec. 10. (a) This section applies if a contracting entity seeks to grant a third party access to:

(1) a provider network contract;

(2) dental services provided pursuant to a provider network contract; or

(3) contractual discounts provided pursuant to a provider network contract.

(b) Except as provided in subsection (c) and section 16 of this chapter, in order for a contracting entity to grant a third party access as described in subsection (a), the following conditions must be satisfied:

(1) When a provider network contract is entered into or renewed, or when there are material modifications to a provider network contract relevant to granting access to a third party as described in subsection (a):

(A) any provider that is a party to the provider network contract must be allowed to choose not to participate in the third party access as described in subsection (a); or

(B) if third party access is to be provided through the acquisition of the provider network by a health insurer, any provider that is a party to the provider network contract must be allowed to enter into a contract directly with the health insurer that acquired the provider network.

(2) The provider network contract must specifically authorize the contracting entity to enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were

the contracting entity.

(3) If the contracting entity seeking to grant a third party access as described in subsection (a) is a dental carrier, a provider that is a party to the provider network contract must have chosen to participate in third party access at the time the provider network contract was entered into or renewed.

(4) If the contracting entity seeking to grant a third party access as described in subsection (a) is a health insurer, the provider network contract must contain a third party access provision specifically granting third party access to the provider network.

(5) If the contracting entity seeking to grant a third party access as described in subsection (a) is a dental carrier, the provider network contract must state that the provider has a right to choose not to participate in the third party access.

(6) The third party being granted access as described in subsection (a) must agree to comply with all of the terms of the provider network contract.

(7) The contracting entity seeking to grant third party access as described in subsection (a) must identify to each provider that is a party to the provider network contract, in writing or electronic form, all third parties in existence as of the date on which the provider network contract is entered into or renewed.

(8) The contracting entity granting third party access as described in subsection (a) must identify, in a list on its website that is updated at least once every ninety (90) days, all third parties to which third party access has been granted.

(9) If third party access as described in subsection (a) is to be granted through the sale or leasing of the network established by the provider network contract, the contracting entity must notify all providers that are parties to the provider network contract of the leasing or sale of the network at least thirty (30) days before the sale or lease of the network takes effect.

(10) The contracting entity seeking to grant third party access to contractual discounts as described in subsection (a)(3) must require each third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken. However, this subdivision does not apply to electronic transactions mandated by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(c) A contracting entity may grant a third party access as described in subsection (a) even if the conditions set forth in subsection (b)(1) are not satisfied if the contracting entity is not a health insurer or a dental carrier.

(d) Except as provided in subsection (c) and section 16 of this chapter, a provider that is a party to a provider network contract is not required to provide dental services pursuant to third party access granted as described in subsection (a) unless all of the applicable conditions set forth in subsection (b) are satisfied.

Sec. 11. A contracting entity that is a party to a provider network contract with a provider that chooses under section 10(b)(1)(A) of this chapter not to participate in third party access shall not alter the provider's rights or status under the provider network contract because of the provider's choice not to participate in third party access.

Sec. 12. A contracting entity that is a party to a provider network contract shall notify a third party granted third party access as described in section 10(a) of this chapter of the termination of the provider network contract not more than thirty (30) days after the date of the termination.

Sec. 13. The right of a third party to contractual discounts described in section 10(a)(3) of this chapter ceases as of the termination date of the provider network contract.

Sec. 14. A contracting entity that is a party to a provider network contract shall make a copy of the provider network contract relied on in the adjudication of a claim available to a participating provider not more than thirty (30) days after the date of the participating provider's request.

Sec. 15. When entering into a provider network contract with providers, a contracting entity shall not reject a provider as a party to the provider network contract because the provider chooses or has chosen under section 10(b)(1)(A) of this chapter not to participate in third party access.

Sec. 16. (a) Section 10 of this chapter does not apply to access as described in section 10(a) of this chapter if granted by a contracting entity to:

(1) a dental carrier or other entity operating in accordance with the same brand licensee program as the contracting entity; or

(2) an entity that is an affiliate of the contracting entity.

(b) For the purposes of this section, a contracting entity shall make a list of the contracting entity's affiliates available to

providers on the contracting entity's website.

(c) Section 10 of this chapter does not apply to a provider network contract established for the purpose of providing dental services to beneficiaries of health programs sponsored by the state, including Medicaid (IC 12-15) and the children's health insurance program (IC 12-17.6).

Sec. 17. The provisions of this chapter cannot be waived by contract. A contract provision that:

(1) conflicts with this chapter; or

(2) purports to waive any requirements of this chapter;

is null and void.

Sec. 18. (a) If a person violates this chapter, the insurance commissioner may enter an order requiring the person to cease and desist from violating this chapter.

(b) If a person violates a cease and desist order issued under subsection (a), the insurance commissioner, after notice and hearing under IC 4-21.5, may:

(1) impose a civil penalty upon the person of not more than ten thousand dollars ($10,000) for each day of violation;

(2) suspend or revoke the person's certificate of authority, if the person holds a certificate of authority under this title; or

(3) both impose a civil penalty upon the person under subdivision (1) and suspend or revoke the person's certificate of authority under subdivision (2).

SECTION 14. IC 27-8-11-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 14. (a) As used in this section, "covered individual" means an individual who is entitled to the coverage of dental services by a dental carrier.**

(b) As used in this section, "dental carrier" means any of the following:

(1) An insurer that issues a policy of accident and sickness insurance that covers dental services.

(2) A health maintenance organization that provides, or provides coverage for, dental services.

(3) A preferred provider plan subject to this chapter under which dental services are provided.

(c) As used in this section, "dental services" means health care services provided by:

(1) a dentist licensed under IC 25-14;

(2) an individual using a dental residency permit issued under IC 25-14-1-5;

(3) an individual who holds:

(A) a dental faculty license under IC 25-14-1-5.5; or

(B) an instructor's license under IC 25-14-1-27.5;

(4) a dental hygienist licensed under IC 25-13; or

(5) a dental assistant (as defined in IC 25-14-1-1.5(4));

within the scope of the individual's license or work description in IC 25-13 or IC 25-14, as appropriate. However, the term does not include a service delivered by a provider if the service is billed as a medical expense.

(d) As used in this section, "network" means all providers that have entered into a contract with a dental carrier under which the providers agree to charge no more than a certain amount for certain dental services provided to covered individuals who are entitled to the coverage of dental services by the dental carrier.

(e) As used in this section, "provider" means:

(1) a dentist licensed under IC 25-14; or

(2) a dental office through which one (1) or more dentists licensed under IC 25-14 provide dental services.

(f) If a covered individual assigns the rights of the covered individual to benefits for dental services to the provider of the dental services, the covered individual's dental carrier shall pay the benefits assigned by the covered individual to the provider of the dental services.

(g) A dental carrier shall make a payment under this section:

(1) directly to the provider of the dental services; and

(2) according to the same criteria and payment schedule under which the dental carrier would have been required to make the payment to the covered individual if the insured had not assigned the insured's rights to the benefits.

(h) An assignment of benefits under this section does not affect or limit the dental carrier's obligation to pay the benefits.

(i) A dental carrier's payment of benefits in compliance with this section discharges the dental carrier's obligation to pay the benefits to the insured.

(j) If:

(1) a covered individual is entitled to coverage from a dental carrier;

(2) the covered individual is provided dental services by a provider;

(3) the covered individual assigns the covered individual's rights to benefits from the dental carrier to the provider of the dental services; and

(4) the provider of the dental services is a member of the network of the dental carrier;

the provider shall accept compensation from the dental carrier in the amount specified in the network contract as payment in full for the dental services provided to the covered individual and shall not bill the covered individual for the dental services, except for copayments, coinsurance and any deductible amount that remains after the dental carrier's payment for the dental services.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1414, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-7-2-196.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 196.7. (a) "Value based health care reimbursement agreement", for purposes of IC 12-15, may include the following:**

(1) An accountable care organization that has a contract with a managed care organization in which the managed care organization:

(A) does not assume risk for prior authorization to a provider organization; or

(B) delegates risk to a provider organization to manage prior authorization.

(2) Bundled payments.

(3) Case rate.

(4) A capitated rate reimbursement arrangement.

(5) A pay for performance arrangement.

(6) Any other health care reimbursement arrangement in which the health care provider accepts at most ten percent (10%) of the downside risk.

(b) The term does not include any of the following:

(1) Narrow networks.

(2) Fixed fee schedules.

(3) A supplemental payment for the original rate or payment methodology.".

Page 1, line 17, delete "mutually" and insert "**enter into a value based health care reimbursement agreement in writing providing for**".

Page 2, line 1, delete "agree in writing to".

Page 2, line 2, delete "less" and insert "**different**".

Page 2, line 3, after "service." insert "**However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.**".

Page 2, between lines 3 and 4, begin a new paragraph and insert:

"**(c) If a managed care organization and a provider enter into a value based health care reimbursement agreement under**

subsection (b), the managed care organization shall notify the office of the secretary.

SECTION 3. IC 12-15-12-12.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 12.5. (a) This section applies to a risk based managed care program that provides services to Medicaid recipients who are eligible to:**

(1) participate in the Medicare program (42 U.S.C. 1395 et seq.); and

(2) receive:

(A) nursing facility services; or

(B) home and community based services.

(b) This subsection applies to a contract entered into, amended, or renewed after June 30, 2024. A managed care organization may not deny any provider willing and qualified to meet the terms and conditions of an agreement to provide services under the risk based managed care program the right to enter into an agreement.".

Page 3, line 14, delete "both mutually" and insert "**enter into a value based health care reimbursement agreement in writing providing for**".

Page 3, line 15, delete "agree in writing to".

Page 3, line 15, after "methodology." insert "**However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.**".

Page 3, between lines 15 and 16, begin a new paragraph and insert:

"**(e) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (d), the managed care organization shall notify the office of the secretary.**"

Page 3, line 16, strike "(e)" and insert "**(f)**".

Page 3, line 20, strike "(f)" and insert "**(g)**".

Page 4, line 5, delete "both mutually agree in writing to" and insert "**enter into a value based health care reimbursement agreement in writing providing for**".

Page 4, line 6, after "methodology." insert "**However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.**".

Page 4, between lines 6 and 7, begin a new paragraph and insert:

"**(d) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (c), the managed care organization shall notify the office of the secretary.**".

Page 4, line 7, strike "(d)" and insert "**(e)**".

Page 4, line 13, strike "(e)" and insert "**(f)**".

Page 4, line 42, delete "both mutually agree in writing to" and insert "**enter into a value based health care reimbursement agreement in writing providing for**".

Page 5, line 1, after "methodology." insert "**However, a managed care organization may not impose a different rate or payment methodology through a notice of contract change to a provider.**".

Page 5, between lines 3 and 4, begin a new paragraph and insert:

"**(d) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (c), the managed care organization shall notify the office of the secretary.**".

Page 5, line 13, delete "both mutually agree in writing" and insert "**enter into a value based health care reimbursement agreement in writing providing for**".

Page 5, line 14, delete "to".

Page 5, between lines 16 and 17, begin a new line blocked left and insert:

"**A managed care organization may not impose a different rate or payment methodology through under subdivision (2) a notice of contract change to a provider.**".

Page 5, after line 21, begin a new paragraph and insert:

"**(c) If a managed care organization and a provider enter into a value based health care reimbursement agreement under subsection (a)(2), the managed care organization shall notify the office of the secretary.**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1414 as introduced.)

BARRETT

Committee Vote: yeas 10, nays 0.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1414 be amended to read as follows:

Page 2, between lines 7 and 8, begin a new paragraph and insert:

"SECTION 2. IC 12-15-1-24 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 24. (a) If the office enters into a comprehensive risk contract with a managed care organization that:**

(1) establishes a capitated rate for a new contract; or

(2) changes a capitated rate for an existing or a renewal of a contract;

with a managed care organization, the office shall provide the capitated rates to the budget committee for review.

(b) As part of the review required under subsection (a), the office shall present the following information to the budget committee:

(1) The capitation rate and the percentage of any change.

(2) The rationale for the capitation rate.

(3) The fiscal impact of the capitation rate on the Medicaid program.".

Renumber all SECTIONS consecutively.

(Reference is to HB 1414 as printed January 30, 2024.)

KARICKHOFF

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1414, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 12-7-2-25.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 25.1. "Case rate", for purposes of IC 12-15, means a fixed rate per encounter used to reimburse for emergency services, regardless of the patient's level of acuity.**".

Page 1, line 4, delete "may" and insert "**has the meaning set forth**

in IC 27-1-37.6-15.".

Page 1, delete lines 5 through 17.

Page 2, delete lines 1 through 7.

Page 2, delete lines 24 through 42, begin a new paragraph and insert:

"SECTION 4. IC 12-15-12-12.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 12.2. (a) This section does not apply to a risk based managed care program described in section 12.5(a) of this chapter.**

(b) A managed care organization and a provider may enter into a value based health care reimbursement agreement in writing that provides for reimbursement, a reimbursement rate, or payment methodology for a Medicaid service that is greater than a minimum rate set by the office of the secretary for the service. However, a managed care organization may not do any of the following:

(1) Impose, either directly or indirectly, a reimbursement or payment methodology through:

(A) a notice of contract change;

(B) a policy; or

(C) a provider manual change;

to a provider.

(2) Condition a provider's participation, reimbursement, or any other term contained in any other contractual agreement between the parties based on the provider's acceptance of a different reimbursement or payment methodology under this section.

(3) Impact a supplemental payment that is applicable to an original reimbursement rate, reimbursement, or payment methodology.

(c) If a managed care organization and a provider enter into a value based health care reimbursement agreement under this section, the managed care organization shall notify the office of the secretary.

SECTION 5. IC 12-15-12-12.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 12.3. A managed care organization and a provider may mutually enter into an agreement in writing that provides for reimbursement to be made to the provider using a case rate. However:**

(1) a managed care organization may not impose a case rate

through a notice of contract change, a policy, or a provider manual change to a provider; and

(2) a case rate may not impact a supplemental payment applicable to the original payment rate or methodology.".

Page 3, delete lines 1 through 8.

Page 3, line 20, delete "may" and insert "**shall contract with any willing provider that:**

(1) meets licensure and certification requirements and enrollment criteria established by the office of the secretary; and

(2) agrees to accept the terms and conditions of a managed care organization to provide covered services under the risk based managed care program.

(c) A managed care organization shall reimburse a provider that contracts to provide services under the risk based managed care program in accordance with federal and state law.

(d) The office of the secretary shall establish a minimum reimbursement rate for a covered service provided by a provider for a Medicaid recipient participating in the Medicaid risk based managed care program described in subsection (a). A managed care organization shall reimburse a provider at least at the reimbursement rate established by the office of the secretary.".

Page 3, delete lines 21 through 23.

Page 4, line 35, delete "in writing providing" and insert "**in accordance with section 12.2 of this chapter.**".

Page 4, delete lines 36 through 38.

Page 5, line 34, delete "in writing providing for a different rate or payment" and insert "**in accordance with section 12.2 of this chapter.**".

Page 5, delete lines 35 through 37.

Page 6, line 36, delete "in writing providing for a different rate" and insert "**in accordance with section 12.2 of this chapter.**".

Page 6, delete lines 37 through 38.

Page 6, line 39, delete "a notice of contract change to a provider.".

Page 6, delete line 42.

Page 7, delete lines 1 through 3.

Page 7, line 12, after "secretary" insert ";".

Page 7, line 12, delete "unless the managed care".

Page 7, delete lines 13 through 14.

Page 7, line 15, delete "different rate or payment methodology;".

Page 7, line 18, delete "A" and insert "**However, a**".

Page 7, line 18, delete "may not impose a different rate or" and

insert "**and a provider may enter into a value based health care reimbursement agreement in accordance with IC 12-15-12-12.2.**".

Page 7, delete lines 19 through 20.

Page 7, delete lines 26 through 29, begin a new paragraph and insert:

"SECTION 9. IC 27-1-37.5-18 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 18. (a) A health plan shall make any current prior authorization requirements and restrictions, including written clinical criteria, readily accessible on the health plan's website to covered individuals, health care providers, and the general public. The prior authorization requirements and restrictions must be described in detail and easily understandable language.**

(b) A health plan may not implement a new prior authorization requirement or restriction or amend an existing requirement or restriction unless:

(1) the health plan's website has been updated to reflect the new or amended requirement or restriction; and

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

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

(1) Physician 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 health plan shall:

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

(2) submit the report to the department.

SECTION 10. IC 27-1-37.6-15, AS ADDED BY P.L.203-2023, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 15. (a) As used in this chapter, "value based health care reimbursement agreement" may include the following:

(1) An accountable care organization that has a contract with a

health plan in which the health plan:

(A) does not assume risk for prior authorization to a provider organization; or

(B) delegates risk to a provider organization to manage prior authorization.

(2) Bundled payments.

(3) A capitated rate reimbursement arrangement.

(4) A pay for performance arrangement.

(5) Any other health care reimbursement arrangement in which the health care provider accepts at most ten percent (10%) of the downside risk.

(b) The term does not include any of the following:

(1) Narrow networks.

(2) Fixed fee schedules.

(3) A supplemental payment for the original rate or payment methodology.

SECTION 11. IC 27-7-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]:

Chapter 18. Third Party Access to Dental Provider Networks

Sec. 1. As used in this chapter, "contracting entity" means a dental carrier, a third party administrator, or another person that enters into a provider network contract with providers for the delivery of dental services in the ordinary course of business.

Sec. 2. As used in this chapter, "covered individual" means an individual who is entitled to:

(1) dental services; or

(2) coverage of dental services;

through a provider network contract.

Sec. 3. As used in this chapter, "dental carrier" means any of the following:

(1) An insurer that issues a policy of accident and sickness insurance that covers dental services.

(2) A health maintenance organization that provides, or provides coverage for, dental services.

(3) An entity that:

(A) provides dental services; or

(B) arranges for dental services to be provided;

but is not itself a provider.

Sec. 4. (a) As used in this chapter, "dental service" means any service provided by a dentist within the scope of the dentist's licensure under IC 25-14.

(b) The term does not include a service delivered by a provider that is billed as a medical expense.

Sec. 5. As used in this chapter, "health insurer" means:

(1) an insurer that issues policies of accident and sickness insurance (as defined in IC 27-8-5-1); or

(2) a health maintenance organization (as defined in IC 27-13-1-19).

Sec. 6. As used in this chapter, "person" means an individual, a corporation, a limited liability company, a partnership, or any other legal entity.

Sec. 7. (a) As used in this chapter, "provider" means:

(1) a dentist licensed under IC 25-14; or

(2) a dental office through which one (1) or more dentists licensed under IC 25-14 provide dental services.

(b) The term does not include a physician organization or physician hospital organization that leases or rents the network of the physician organization or physician hospital organization network to a third party.

Sec. 8. As used in this chapter, "provider network contract" means a contract between a contracting entity and one (1) or more providers:

(1) that establishes a network through which the providers:

(A) provide dental services to covered individuals; and

(B) are compensated for providing the dental services; and

(2) that specifies the rights and responsibilities of the contracting entity and the providers concerning the network.

Sec. 9. (a) As used in this chapter, "third party" means a person that enters into a contract with a contracting entity or another third party to gain access to:

(1) a provider network contract;

(2) dental services provided pursuant to a provider network contract; or

(3) contractual discounts provided pursuant to a provider network contract.

(b) The term does not include an employer or another group or entity for which the contracting entity provides administrative services.

Sec. 10. (a) This section applies if a contracting entity seeks to grant a third party access to:

(1) a provider network contract;

(2) dental services provided pursuant to a provider network contract; or

(3) contractual discounts provided pursuant to a provider network contract.

(b) Except as provided in subsection (c) and section 16 of this chapter, in order for a contracting entity to grant a third party access as described in subsection (a), the following conditions must be satisfied:

(1) When a provider network contract is entered into or renewed, or when there are material modifications to a provider network contract relevant to granting access to a third party as described in subsection (a):

(A) any provider that is a party to the provider network contract must be allowed to choose not to participate in the third party access as described in subsection (a); or

(B) if third party access is to be provided through the acquisition of the provider network by a health insurer, any provider that is a party to the provider network contract must be allowed to enter into a contract directly with the health insurer that acquired the provider network.

(2) The provider network contract must specifically authorize the contracting entity to enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

(3) If the contracting entity seeking to grant a third party access as described in subsection (a) is a dental carrier, a provider that is a party to the provider network contract must have chosen to participate in third party access at the time the provider network contract was entered into or renewed.

(4) If the contracting entity seeking to grant a third party access as described in subsection (a) is a health insurer, the provider network contract must contain a third party access provision specifically granting third party access to the provider network.

(5) If the contracting entity seeking to grant a third party access as described in subsection (a) is a dental carrier, the provider network contract must state that the provider has a right to choose not to participate in the third party access.

(6) The third party being granted access as described in subsection (a) must agree to comply with all of the terms of the provider network contract.

(7) The contracting entity seeking to grant third party access

as described in subsection (a) must identify to each provider that is a party to the provider network contract, in writing or electronic form, all third parties in existence as of the date on which the provider network contract is entered into or renewed.

(8) The contracting entity granting third party access as described in subsection (a) must identify, in a list on its website that is updated at least once every ninety (90) days, all third parties to which third party access has been granted.

(9) If third party access as described in subsection (a) is to be granted through the sale or leasing of the network established by the provider network contract, the contracting entity must notify all providers that are parties to the provider network contract of the leasing or sale of the network at least thirty (30) days before the sale or lease of the network takes effect.

(10) The contracting entity seeking to grant third party access to contractual discounts as described in subsection (a)(3) must require each third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken. However, this subdivision does not apply to electronic transactions mandated by the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(c) A contracting entity may grant a third party access as described in subsection (a) even if the conditions set forth in subsection (b)(1) are not satisfied if the contracting entity is not a health insurer or a dental carrier.

(d) Except as provided in subsection (c) and section 16 of this chapter, a provider that is a party to a provider network contract is not required to provide dental services pursuant to third party access granted as described in subsection (a) unless all of the applicable conditions set forth in subsection (b) are satisfied.

Sec. 11. A contracting entity that is a party to a provider network contract with a provider that chooses under section 10(b)(1)(A) of this chapter not to participate in third party access shall not alter the provider's rights or status under the provider network contract because of the provider's choice not to participate in third party access.

Sec. 12. A contracting entity that is a party to a provider network contract shall notify a third party granted third party access as described in section 10(a) of this chapter of the termination of the provider network contract not more than thirty

(30) days after the date of the termination.

Sec. 13. The right of a third party to contractual discounts described in section 10(a)(3) of this chapter ceases as of the termination date of the provider network contract.

Sec. 14. A contracting entity that is a party to a provider network contract shall make a copy of the provider network contract relied on in the adjudication of a claim available to a participating provider not more than thirty (30) days after the date of the participating provider's request.

Sec. 15. When entering into a provider network contract with providers, a contracting entity shall not reject a provider as a party to the provider network contract because the provider chooses or has chosen under section 10(b)(1)(A) of this chapter not to participate in third party access.

Sec. 16. (a) Section 10 of this chapter does not apply to access as described in section 10(a) of this chapter if granted by a contracting entity to:

(1) a dental carrier or other entity operating in accordance with the same brand licensee program as the contracting entity; or

(2) an entity that is an affiliate of the contracting entity.

(b) For the purposes of this section, a contracting entity shall make a list of the contracting entity's affiliates available to providers on the contracting entity's website.

(c) Section 10 of this chapter does not apply to a provider network contract established for the purpose of providing dental services to beneficiaries of health programs sponsored by the state, including Medicaid (IC 12-15) and the children's health insurance program (IC 12-17.6).

Sec. 17. The provisions of this chapter cannot be waived by contract. A contract provision that:

(1) conflicts with this chapter; or

(2) purports to waive any requirements of this chapter;

is null and void.

Sec. 18. (a) If a person violates this chapter, the insurance commissioner may enter an order requiring the person to cease and desist from violating this chapter.

(b) If a person violates a cease and desist order issued under subsection (a), the insurance commissioner, after notice and hearing under IC 4-21.5, may:

(1) impose a civil penalty upon the person of not more than ten thousand dollars ($10,000) for each day of violation;

(2) suspend or revoke the person's certificate of authority, if the person holds a certificate of authority under this title; or

(3) both impose a civil penalty upon the person under subdivision (1) and suspend or revoke the person's certificate of authority under subdivision (2).

SECTION 12. IC 27-8-11-14 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 14. (a) As used in this section, "covered individual" means an individual who is entitled to the coverage of dental services by a dental carrier.**

(b) As used in this section, "dental carrier" means any of the following:

(1) An insurer that issues a policy of accident and sickness insurance that covers dental services.

(2) A health maintenance organization that provides, or provides coverage for, dental services.

(3) A preferred provider plan subject to this chapter under which dental services are provided.

(c) As used in this section, "dental services" means health care services provided by:

(1) a dentist licensed under IC 25-14;

(2) an individual using a dental residency permit issued under IC 25-14-1-5;

(3) an individual who holds:

(A) a dental faculty license under IC 25-14-1-5.5; or

(B) an instructor's license under IC 25-14-1-27.5;

(4) a dental hygienist licensed under IC 25-13; or

(5) a dental assistant (as defined in IC 25-14-1-1.5(4));

within the scope of the individual's license or work description in IC 25-13 or IC 25-14, as appropriate. However, the term does not include a service delivered by a provider if the service is billed as a medical expense.

(d) As used in this section, "network" means all providers that have entered into a contract with a dental carrier under which the providers agree to charge no more than a certain amount for certain dental services provided to covered individuals who are entitled to the coverage of dental services by the dental carrier.

(e) As used in this section, "provider" means:

(1) a dentist licensed under IC 25-14; or

(2) a dental office through which one (1) or more dentists licensed under IC 25-14 provide dental services.

(f) If a covered individual assigns the rights of the covered

individual to benefits for dental services to the provider of the dental services, the covered individual's dental carrier shall pay the benefits assigned by the covered individual to the provider of the dental services.

(g) A dental carrier shall make a payment under this section:

(1) directly to the provider of the dental services; and

(2) according to the same criteria and payment schedule under which the dental carrier would have been required to make the payment to the covered individual if the insured had not assigned the insured's rights to the benefits.

(h) An assignment of benefits under this section does not affect or limit the dental carrier's obligation to pay the benefits.

(i) A dental carrier's payment of benefits in compliance with this section discharges the dental carrier's obligation to pay the benefits to the insured.

(j) If:

(1) a covered individual is entitled to coverage from a dental carrier;

(2) the covered individual is provided dental services by a provider;

(3) the covered individual assigns the covered individual's rights to benefits from the dental carrier to the provider of the dental services; and

(4) the provider of the dental services is a member of the network of the dental carrier;

the provider shall accept compensation from the dental carrier in the amount specified in the network contract as payment in full for the dental services provided to the covered individual and shall not bill the covered individual for the dental services, except for copayments, coinsurance and any deductible amount that remains after the dental carrier's payment for the dental services.".

Renumber all SECTIONS consecutively.

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

(Reference is to HB 1414 as reprinted February 2, 2024.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 10, Nays 0.