PROPOSED AMENDMENT
HB 1604 # 3

DIGEST

Limitation on cost sharing. Requires an insurer, an administrator, and a pharmacy benefit manager to apply the annual limitation on cost sharing set forth in the federal Patient Protection and Affordable Care Act under 42 U.S.C. 18022(c)(1) to prescription drugs that: (1) are covered under a health plan; (2) are life-saving or intended to manage chronic pain; and (3) do not have an approved generic version. Provides that an insurer, an administrator, and a pharmacy benefit manager may not directly or indirectly set, alter, implement, or condition the terms of health insurance coverage based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug. Requires, before December 31 of each year, each insurer and administrator to certify to the insurance commissioner that the insurer or administrator has fully and completely complied with the cost sharing requirements during the previous calendar year.

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

"SECTION 1. IC 27-1-24.5-0.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: **Sec. 0.8. As used in this chapter, "cost sharing" means any copayment, coinsurance, deductible, or other similar charge that is:**

(1) required of a covered individual for a health care service covered by a health plan, including a prescription drug; and

(2) paid:

(A) by; or

(B) on behalf of;

the covered individual.

SECTION 2. IC 27-1-24.5-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: **Sec. 4.5. As used in this chapter, "health care service" means a service or good furnished for the purpose of preventing, alleviating, curing, or healing:**

(1) human illness;

(2) physical disability; or

(3) injury.

SECTION 3. IC 27-1-24.5-5, AS AMENDED BY P.L.207-2021, SECTION 52, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: Sec. 5. As used in this chapter, "health plan" means **a plan through which coverage is provided for health care services through insurance, prepayment, reimbursement, or otherwise. The term includes** the following:

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

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

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

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

SECTION 4. IC 27-1-24.5-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: **Sec. 6.5. As used in this chapter, "insurer" means an insurer subject to state law and rules regulating insurance or subject to the jurisdiction of the department that contracts, or offers to contract, to:**

(1) provide;

(2) deliver;

(3) arrange for;

(4) pay for; or

(5) reimburse;

any of the costs of health care services to a covered individual under a health plan.

SECTION 5. IC 27-1-24.5-11.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: **Sec. 11.5. As used in this chapter, "pharmacy benefit management services" means:**

(1) negotiating the price of prescription drugs, including negotiating and contracting for direct or indirect rebates, discounts, or other price concessions;

(2) managing any aspect of a prescription drug benefit, including:

(A) the processing and payment of claims for prescription

drugs;

(B) arranging alternative access to or funding for prescription drugs;

(C) the performance of drug utilization review;

(D) the processing of drug prior authorization requests;

(E) the adjudication of appeals or grievances related to the prescription drug benefit;

(F) contracting with network pharmacies;

(G) controlling the cost of covered prescription drugs;

(H) managing or providing data relating to the prescription drug benefit;

(I) the provision of services related to the prescription drug benefit; or

(J) creating or updating prescription drug formularies;

(3) the performance of any administrative, managerial, clinical, pricing, financial, reimbursement, data administration or reporting, or billing service; and

(4) any other services specified in a rule adopted by the department.

SECTION 6. IC 27-1-24.5-12, AS AMENDED BY P.L.32-2021, SECTION 77, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: Sec. 12. (a) As used in this chapter, "pharmacy benefit manager" means: ~~an entity that, on behalf of a health plan, state agency, insurer, managed care organization, or other third party payor:~~

(1) a person who, under a written agreement with an insurer, health plan, state agency, managed care organization, or other third party payor, directly or indirectly provides one (1) or more pharmacy benefit management services on behalf of the insurer, health plan, state agency, managed care organization, or other third party payor; and

(2) an agent, a contractor, an intermediary, an affiliate, a subsidiary, or a related entity of a person described in subdivision (1) who facilitates, provides, directs, or oversees the provision of the pharmacy benefit management services.

~~(1) contracts directly or indirectly with pharmacies to provide prescription drugs to individuals;~~

~~(2) administers a prescription drug benefit;~~

~~(3) processes or pays pharmacy claims;~~

~~(4) creates or updates prescription drug formularies;~~

~~(5) makes or assists in making prior authorization determinations~~

~~on prescription drugs;~~

~~(6) administers rebates on prescription drugs; or~~

~~(7) establishes a pharmacy network.~~

(b) The term does not include the following:

(1) A person licensed under IC 16.

(2) A health provider who is:

(A) described in IC 25-0.5-1; and

(B) licensed or registered under IC 25.

(3) A consultant who only provides advice concerning the selection or performance of a pharmacy benefit manager.

SECTION 7. IC 27-1-24.5-20, AS AMENDED BY P.L.158-2024, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: Sec. 20. (a) The commissioner shall do the following:

(1) Prescribe an application for use in applying for a license to operate as a pharmacy benefit manager.

(2) Adopt rules under IC 4-22-2 to establish the following:

(A) Pharmacy benefit manager licensing requirements.

(B) Licensing fees.

(C) A license application.

(D) Financial standards for pharmacy benefit managers.

(E) Reporting requirements described in sections 21 and 29 of this chapter.

(F) The time frame for the resolution of an appeal under section 22 of this chapter.

(b) The commissioner may do the following:

(1) Charge a license application fee and renewal fees established under subsection (a)(2) in an amount not to exceed five hundred dollars ($500) to be deposited in the department of insurance fund established by IC 27-1-3-28.

(2) Examine or audit the books and records of a pharmacy benefit manager one (1) time per year to determine if the pharmacy benefit manager is in compliance with this chapter.

(3) Adopt rules under IC 4-22-2 to:

(A) implement this chapter; and

(B) specify requirements for the following:

(i) Prohibited market conduct practices.

(ii) Data reporting in connection with violations of state law.

(iii) Maximum allowable cost list compliance and enforcement requirements, including the requirements of

sections 22 and 23 of this chapter.

(iv) Prohibitions and limits on pharmacy benefit manager practices that require licensure under IC 25-22.5.

(v) Pharmacy benefit manager affiliate information sharing.

(vi) Lists of health plans administered by a pharmacy benefit manager in Indiana.

(vii) Pharmacy benefit management services included under section 11.5(4) of this chapter.

(c) Financial information and proprietary information submitted by a pharmacy benefit manager to the department is confidential.

SECTION 8. IC 27-1-24.5-27.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: **Sec. 27.7. (a) This section applies to a health plan that is issued, delivered, amended, or renewed after December 31, 2025.**

(b) A pharmacy benefit manager shall apply the annual limitation on cost sharing set forth in the federal Patient Protection and Affordable Care Act under 42 U.S.C. 18022(c)(1) to prescription drugs that:

(1) are covered under a health plan administered by the pharmacy benefit manager;

(2) are life-saving or intended to manage chronic pain; and

(3) do not have an approved generic version.

(c) Except as provided in subsection (d), when calculating a covered individual's contribution to an applicable cost sharing requirement, a pharmacy benefit manager must include any cost sharing amounts paid:

(1) by the covered individual; or

(2) on behalf of the covered individual by another person.

(d) If application of subsection (c) would result in a covered individual becoming ineligible for a health savings account under Section 223 of the Internal Revenue Code, the requirement under subsection (c) applies with respect to the deductible of a high deductible health plan after the covered individual satisfies the minimum deductible under Section 223 of the Internal Revenue Code. However, subsection (c) applies to items or services that are preventative care under Section 223(c)(2)(C) of the Internal Revenue Code regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code is satisfied.

(e) A pharmacy benefit manager may not directly or indirectly:

(1) set;

(2) alter;

(3) implement; or

(4) condition;

the terms of health plan coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.".

Page 3, after line 16, begin a new paragraph and insert:

"SECTION 10. IC 27-1-51 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]:

Chapter 51. Cost Sharing for Health Insurance Coverage

Sec. 1. This chapter applies to a policy of health insurance coverage that is issued, delivered, amended, or renewed after December 31, 2025.

Sec. 2. As used in this chapter, "administrator" means a person who, directly or indirectly and on behalf of an insurer:

(1) underwrites; or

(2) collects charges or premiums from or adjusts or settles claims on:

(A) residents of Indiana; or

(B) residents of another state from offices in Indiana;

in connection with health insurance coverage offered or provided by an insurer.

Sec. 3. As used in this chapter, "cost sharing" means any copayment, coinsurance, deductible, or other similar charge that is:

(1) required of a covered individual for a health care service covered by a policy of health insurance coverage, including a prescription drug; and

(2) paid:

(A) by; or

(B) on behalf of;

the covered individual.

Sec. 4. As used in this chapter, "covered individual" means an individual who is entitled to health insurance coverage.

Sec. 5. As used in this chapter, "health care service" means a service or good furnished for the purpose of preventing, alleviating, curing, or healing:

(1) human illness;

(2) physical disability; or

(3) injury.

Sec. 6. (a) As used in this chapter, "health insurance coverage" means:

(1) an individual or group policy of accident and sickness insurance (as defined in IC 27-8-5-1);

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

(3) any other health plan that is issued on an individual or group basis;

that is subject to state law and rules regulating insurance or subject to the jurisdiction of the department. The term includes coverage of a dependent of the covered individual under a policy or contract described in subdivisions (1) through (3).

(b) The term does not include a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.).

Sec. 7. As used in this chapter, "insurer" means an insurer that provides health insurance coverage to a covered individual.

Sec. 8. As used in this chapter, "person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government, or governmental subdivision or agency.

Sec. 9. An insurer and an administrator shall apply the annual limitation on cost sharing set forth in the federal Patient Protection and Affordable Care Act under 42 U.S.C. 18022(c)(1) to prescription drugs that:

(1) are covered under a policy or contract of health insurance coverage offered or issued by the insurer;

(2) are life-saving or intended to manage chronic pain; and

(3) do not have an approved generic version.

Sec. 10. (a) Except as provided in subsection (b), when calculating a covered individual's contribution to an applicable cost sharing requirement, an insurer and administrator must include any cost sharing amounts paid:

(1) by the covered individual; and

(2) on behalf of the covered individual by another person.

(b) If application of subsection (a) would result in a covered individual becoming ineligible for a health savings account under Section 223 of the Internal Revenue Code, the requirement under subsection (a) applies with respect to the deductible of a high deductible health plan after the covered individual satisfies the minimum deductible under Section 223 of the Internal Revenue Code. However, subsection (a) applies to items or services that are preventative care under Section 223(c)(2)(C) of the Internal Revenue Code regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code is satisfied.

Sec. 11. An insurer and an administrator may not directly or indirectly:

(1) set;

(2) alter;

(3) implement; or

(4) condition;

the terms of health insurance coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.

Sec. 12. Before December 31 of each year, each insurer and administrator shall certify to the commissioner that the insurer or administrator has fully and completely complied with the requirements of this chapter during the previous calendar year. The certification must be signed by the chief executive officer or chief financial officer of the insurer or administrator.

Sec. 13. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.".

Renumber all SECTIONS consecutively.

(Reference is to HB 1604 as printed February 11, 2025.)