SENATE MOTION

MR. PRESIDENT:

I move that Senate Bill 140 be amended to read as follows:

Page 1, delete lines 1 through 17, begin a new paragraph and insert:

"SECTION 1. IC 2-5-47-7, AS ADDED BY P.L.203-2023, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 7. The task force shall do the following:

(1) Review and make recommendations concerning the cost of health care in the state and in comparison to other states.

(2) Review and make recommendations concerning reductions in health care costs with the goal of ensuring that any reduction in health care prices ultimately reaches the health care payer.

(3) Review and make recommendations concerning reports submitted to the task force.

(4) Study and make recommendations concerning the availability of value-based care and other health care models that emphasize prevention and cost avoidance.

(5) Study and make recommendations concerning the market concentration of health care providers and contributing factors, including:

(A) whether:

(i) noncompete clauses in practitioner contracts contributes to a restraint of trade; and

(ii) prohibiting noncompete clauses would create greater competition in the health workforce;

(B) contract tiering with health carriers;

(C) all-or-nothing network plans; and

(D) disclosure of cost and price information to plan sponsors.

(6) Study and make recommendations concerning whether medical consumers would benefit from prohibiting

anti-competitive practices or otherwise encouraging increased competition among providers.

(7) Study and make recommendations concerning whether medical consumers overall would benefit from reestablishing the former Indiana comprehensive health insurance association policies (IC 27-8-10).

~~(8) Review and make recommendations concerning required reporting for pharmacy benefit managers to the department of insurance, including the report required under IC 27-1-24.5-21.~~

~~(9)~~ **(8)** Study and make recommendations concerning whether there is sufficient competition in the commercial insurance market and whether health care consumers would benefit from policies designed to increase competition among commercial carriers, including the promotion of:

(A) direct contracting;

(B) narrow networks; and

(C) insurance brokers.

~~(10)~~ **(9)** Study and make recommendations concerning whether there is sufficient innovation in the design of health insurance plans, including whether health care consumers would benefit from policies that:

(A) better distinguish wellness and prevention from comprehensive and catastrophic coverage;

(B) promote price discounts based on individual underwriting; and

(C) empower the health care consumer with a focus on prevention and shoppable services.

~~(11)~~ **(10)** Any other topic the task force deems relevant to the oversight of health care costs in Indiana.

SECTION 2. IC 5-10-8-20, AS AMENDED BY P.L.9-2022, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 20. (a) As used in this section, "covered individual" means an individual entitled to coverage under a state employee plan.

(b) As used in this section, "drug" means a prescription drug.

(c) As used in this section, "pharmacy" refers to a pharmacist or pharmacy that has entered into an agreement with a state employee plan to provide drugs to individuals covered under a state employee plan.

(d) As used in this section, "state employee plan" refers to the following that provide coverage for drugs:

(1) A self-insurance program established under section 7(b) of this chapter to provide group health coverage.

(2) A contract with a prepaid health care delivery plan that is entered into or renewed under section 7(c) of this chapter.

The term includes a person that administers drug benefits on behalf of

a state employee plan.

(e) A pharmacy or pharmacist shall have the right to provide a covered individual with information concerning the amount of the covered individual's cost share for a prescription drug. ~~Neither a pharmacy nor a pharmacist shall be proscribed by a pharmacy benefit manager from discussing this information or from selling to the covered individual a more affordable alternative if an affordable alternative is available.~~

~~(f) A pharmacy benefit manager that covers prescription drugs may not include a provision that requires a covered individual to make payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:~~

~~(1) the contracted copayment amount; or~~

~~(2) the amount of total approved charges by the pharmacy benefit manager at the point of sale.~~

~~This subsection does not prohibit the adjudication of claims in accordance with the state employee plan administered by a pharmacy benefit manager. The covered individual is not liable for any additional charges or entitled to any credits as a result of the adjudicated claim.~~

~~(g)~~ **(f)** The state employee plan ~~or a pharmacy benefit manager~~ may not require a pharmacy or pharmacist to collect a higher copayment for a prescription drug from a covered individual than the state employee plan or pharmacy benefit manager allows the pharmacy or pharmacist to retain.

SECTION 3. IC 12-15-29-0.5 IS REPEALED [EFFECTIVE JULY 1, 2025]. ~~Sec. 0.5. As used in this chapter, "insurer" includes a pharmacy benefit manager.~~

SECTION 4. IC 16-47-1-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 4. (a) The department, with the approval of the budget agency, shall establish, implement, and maintain an aggregate prescription drug purchasing program through which terms are negotiated related to the purchase of prescription drugs by:

(1) an entity described in section 5(a) or 5(b) of this chapter; or

(2) an individual who is covered under a health benefit plan that includes a prescription drug benefit.

(b) The budget agency may contract with ~~a pharmacy benefit manager or other~~ **another** person to conduct the negotiations of the program established under subsection (a).

(c) The terms and conditions of the program are subject to the approval of the budget agency.

SECTION 5. IC 25-1-8.5-2, AS ADDED BY P.L.95-2024, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 2. (a) As used in this chapter, "health care entity" means any of the following:

(1) Any organization or business that provides diagnostic,

medical, surgical, dental treatment, or rehabilitative care.

(2) An insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1), except for the following types of coverage:

(A) Accident only, credit, dental, vision, long term care, or disability income insurance.

(B) Coverage issued as a supplement to liability insurance.

(C) Automobile medical payment insurance.

(D) A specified disease policy.

(E) A policy that provides indemnity benefits not based on any expense incurred requirements, including a plan that provides coverage for:

(i) hospital confinement, critical illness, or intensive care; or

(ii) gaps for deductibles or copayments.

(F) Worker's compensation or similar insurance.

(G) A student health plan.

(H) A supplemental plan that always pays in addition to other coverage.

(3) A health maintenance organization (as defined in IC 27-13-1-19).

~~(4) A pharmacy benefit manager (as defined in IC 27-1-24.5-12).~~

~~(5)~~ **(4)** An administrator (as defined in IC 27-1-25-1).

~~(6)~~ **(5)** A private equity partnership, regardless of where the private equity partnership is located, seeking to enter into a merger or acquisition with an entity described in subdivisions (1) through ~~(5).~~ **(4).**

(b) The term does not include the Medicaid program or the Medicare program.

SECTION 6. IC 27-1-24.5 IS REPEALED [EFFECTIVE JULY 1, 2025]. (Pharmacy Benefit Managers).".

Page 2, delete lines 1 through 23.

Page 4, line 14, delete "insurer," and insert "**insurer**".

Page 4, line 15, delete "pharmacy benefit manager,".

Page 4, line 19, delete "insurer," and insert "**insurer**".

Page 4, line 20, delete "pharmacy benefit manager,".

Page 4, line 29, delete "insurer, a pharmacy benefit manager," and insert "**insurer**".

Page 4, delete lines 31 through 32.

Page 4, line 33, delete "14." and insert "**13.**".

Page 4, line 42, delete "15." and insert "**14.**".

Page 5, line 8, delete "16. (a) An insurer, a pharmacy benefit manager," and insert "**15. (a) An insurer**".

Page 5, line 22, delete "insurer, a pharmacy benefit manager," and insert "**insurer**".

Page 5, line 26, delete "insurer, pharmacy benefit manager," and insert "**insurer**".

Page 5, line 37, delete "17." and insert "**16.**".

Page 5, line 38, delete "insurer, a pharmacy benefit manager," and insert "**insurer**".

Page 6, line 4, delete "insurer, pharmacy benefit manager," and insert "**insurer**".

Page 6, line 37, delete "insurer, pharmacy benefit" and insert "**insurer**".

Page 6, line 38, delete "manager,".

Page 7, line 22, delete "insurer, pharmacy benefit" and insert "**insurer**".

Page 7, line 23, delete "manager,".

Page 8, line 3, delete "insurer, a pharmacy benefit manager," and insert "**insurer**".

Page 8, line 7, delete "18." and insert "**17.**".

Page 8, line 12, delete "17" and insert "**16**".

Page 8, line 14, delete "insurer, a pharmacy benefit manager," and insert "**insurer**".

Page 8, line 38, delete "pharmacy benefit manager's,".

Page 9, line 22, delete "insurer," and insert "**insurer**".

Page 9, line 23, delete "pharmacy benefit manager,".

Page 9, line 25, delete "this insurer, pharmacy benefit manager," and insert "**the insurer**".

Page 9, line 29, delete "insurer, pharmacy benefit manager," and insert "**insurer**".

Page 9, line 34, delete "pharmacy benefit manager's,".

Page 9, line 38, delete "pharmacy benefit manager's,".

Page 10, line 4, delete "insurer, a pharmacy benefit manager," and insert "**insurer**".

Page 10, line 10, delete "insurer, pharmacy benefit manager," and insert "**insurer**".

Page 10, line 11, delete "16" and insert "**15**".

Page 10, line 16, delete "19." and insert "**18.**".

Page 10, line 25, delete "17(a)(2)(E)" and insert "**16(a)(2)(E)**".

Page 10, line 28, delete "insurer, a pharmacy benefit manager," and insert "**insurer**".

Page 10, delete lines 33 through 42.

Page 11, line 1, delete "21." and insert "**19.**".

Page 11, line 5, delete "22." and insert "**20.**".

Page 11, after line 6, begin a new paragraph and insert:

"SECTION 8. IC 27-1-24.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 24.7. Pharmacy Benefit Managers Unlawful

Sec. 1. As used in this chapter, "covered individual" means an individual who is entitled to coverage under a health plan.

Sec. 2. As used in this chapter, "health plan" means 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.

Sec. 3. As used in this chapter, "operate" means, with respect to a pharmacy benefit manager, to provide services, including services described in section 4(a)(1) through 4(a)(7) of this chapter, on behalf of a health plan, state agency, insurer, managed care organization, or other third party payor.

Sec. 4. (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) 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.

Sec. 5. As used in this chapter, "pharmacy benefit manager affiliate" means a pharmacy or pharmacist that directly or indirectly, through one (1) or more intermediaries:

(1) owns or controls;

(2) is owned or controlled by; or

(3) is under common ownership or control with;

a pharmacy benefit manager.

Sec. 6. As used in this chapter, "third party" means a person other than a:

(1) pharmacy benefit manager; or

(2) covered individual.

Sec. 7. A pharmacy benefit manager may not operate in Indiana.

Sec. 8. A person may not own or control a pharmacy benefit manager, directly or through a pharmacy benefit manager affiliate, that operates in Indiana.

Sec. 9. (a) A health plan, state agency, insurer, managed care organization, or other third party payor that does business in Indiana may not contract for or otherwise receive services from a pharmacy benefit manager, including services described in section 4(a)(1) through 4(a)(7) of this chapter, unless:

(1) the health plan, state agency, insurer, managed care organization, or other third party payor that does business in Indiana also does business outside Indiana; and

(2) the health plan, state agency, insurer, managed care organization, or other third party payor only contracts for or otherwise receives services outside of Indiana.

(b) Nothing in this section prohibits a health plan, state agency, insurer, managed care organization, or other third party payor that does business in Indiana from providing the services described in section 4(a)(1) through 4(a)(7) on its own behalf.

Sec. 10. The commissioner may impose a civil penalty for a violation of section 7, 8, or 9 of this chapter as follows:

(1) A civil penalty of not more than one hundred thousand dollars ($100,000) for a first offense.

(2) A civil penalty of not more than two hundred fifty thousand dollars ($250,000) for a second or subsequent offense.

Sec. 11. (a) A director, an officer, an employee, or an agent of:

(1) a pharmacy benefit manager; or

(2) a health plan, state agency, insurer, managed care organization, or other third party payor;

who knowingly or intentionally violates section 7, 8, or 9 of this chapter, commits pharmacy benefit deception, a Level 6 felony.

(b) If the commissioner has reason to believe that a director, an officer, an employee, or an agent of person described in subsection (a) has knowingly or intentionally violated section 7, 8, or 9 of this chapter, the commissioner shall report the violation to the prosecutor of the county in which the violation occurred.

SECTION 9. IC 27-1-37-7, AS AMENDED BY P.L.198-2021, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 7. (a) This section applies to health provider contracts entered into or renewed after June 30, 2020.

(b) A health provider contract, including a contract with ~~a pharmacy benefit manager or~~ a health facility, may not contain a provision that prohibits the disclosure of health care service claims data to:

(1) employers providing the coverage; or

(2) beginning July 1, 2021, another person for use in the all payer claims data base established by IC 27-1-44.5.

However, any disclosure of claims data must comply with health privacy laws, including the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(c) A violation of this section constitutes an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

SECTION 10. IC 27-1-37-8, AS ADDED BY P.L.198-2021, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 8. (a) This section applies to a health provider contract entered into, amended, or renewed after June 30, 2021.

(b) A health provider contract ~~including a contract with a pharmacy benefit manager,~~ may not contain a provision that does any of the following:

(1) Limits the ability of either the health carrier or the health provider facility to disclose the allowed amount and fees of services to any insured (as defined in IC 27-8-5.8-3) or enrollee (as defined in IC 27-13-1-12), or to the treating health provider facility or physician of the insured or enrollee.

(2) Limits the ability of either the health carrier or the health provider facility to disclose out-of-pocket costs to an insured (as defined in IC 27-8-5.8-3) or an enrollee (as defined in IC 27-13-1-12).

(c) Any provision of a health provider contract that includes a provision described in subsection (b) in violation of this section is severable and the provision in violation is null and void. The remaining provisions of the health provider contract, excluding the provision in violation of this section, remain in effect and are enforceable.

(d) The attorney general may issue a civil investigative demand to obtain information from a party of, or pertaining to, a health provider contract and compliance of this section.

SECTION 11. IC 27-1-44.5-2, AS AMENDED BY P.L.190-2023, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 2. As used in this chapter, "health payer" includes the following:

(1) Medicare.

(2) Medicaid or a managed care organization (as defined in IC 12-7-2-126.9) that has contracted with Medicaid to provide services to a Medicaid recipient.

(3) An insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1), except for the following types of coverage:

(A) Accident only, credit, dental, vision, long term care, or disability income insurance.

(B) Coverage issued as a supplement to liability insurance.

(C) Automobile medical payment insurance.

(D) A specified disease policy.

(E) A policy that provides indemnity benefits not based on any

expense incurred requirements, including a plan that provides coverage for:

(i) hospital confinement, critical illness, or intensive care; or

(ii) gaps for deductibles or copayments.

(F) Worker's compensation or similar insurance.

(G) A student health plan.

(H) A supplemental plan that always pays in addition to other coverage.

(4) A health maintenance organization (as defined in IC 27-13-1-19).

~~(5) A pharmacy benefit manager (as defined in IC 27-1-24.5-12).~~

~~(6)~~ **(5)** An administrator (as defined in IC 27-1-25-1).

~~(7)~~ **(6)** A multiple employer welfare arrangement (as defined in IC 27-1-34-1).

~~(8)~~ **(7)** An employee benefit plan that is subject to the federal Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), including a third party administrator of an employee benefit plan.

~~(9)~~ **(8)** A state employee health plan (as defined in IC 5-10-8-6.7(a)).

~~(10)~~ **(9)** Any other person identified by the commissioner for participation in the data base described in this chapter.

SECTION 12. IC 27-2-25.5-3, AS ADDED BY P.L.152-2024, SECTION 15, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 3. (a) This section applies to a contract entered into, issued, amended, or renewed after ~~June 30, 2024.~~ **June 30, 2025.**

(b) A contract:

(1) between a:

(A) third party administrator; and

(B) plan sponsor; **or**

(2) between a:

(A) prepaid health care delivery plan under IC 5-10-8-7(c) to provide group health coverage for state employees; and

(B) plan sponsor; ~~or~~

~~(3) between:~~

~~(A) a pharmacy benefit manager (as defined in IC 27-1-24.5-12); and~~

~~(B) either a:~~

~~(i) plan sponsor; or~~

~~(ii) third party administrator for the administration of a self-funded health benefit plan on behalf of the plan sponsor;~~

must provide that the plan sponsor owns the claims data relating to the contract. However, a plan sponsor's ownership of the claims data under this section may not be construed to require the ~~pharmacy benefit manager or~~ third party administrator to disclose a trade secret (as

defined in IC 24-2-3-2).

(c) Any claims data provided under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

SECTION 13. IC 27-4-1-4, AS AMENDED BY P.L.158-2024, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 4. (a) The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement:

(A) misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(B) making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(E) making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender the policyholder's insurance.

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Entering into any agreement to commit, or individually or by a concerted action committing any act of boycott, coercion, or

intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive. Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

(6) Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Making or permitting any of the following:

(A) Unfair discrimination between individuals of the same class and equal expectation of life in the rates or assessments charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract. However, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(B) Unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, assessments, or rates charged or made for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. However, in determining the class, consideration may be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(C) Excessive or inadequate charges for premiums, policy fees, assessments, or rates, or making or permitting any unfair discrimination between persons of the same class involving essentially the same hazards, in the amount of premiums,

policy fees, assessments, or rates charged or made for:

(i) policies or contracts of reinsurance or joint reinsurance, or abstract and title insurance;

(ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance; or

(iii) policies or contracts of any other kind or kinds of insurance whatsoever.

However, nothing contained in clause (C) shall be construed to apply to any of the kinds of insurance referred to in clauses (A) and (B) nor to reinsurance in relation to such kinds of insurance. Nothing in clause (A), (B), or (C) shall be construed as making or permitting any excessive, inadequate, or unfairly discriminatory charge or rate or any charge or rate determined by the department or commissioner to meet the requirements of any other insurance rate regulatory law of this state.

(8) Except as otherwise expressly provided by IC 27-1-47 or another law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends, savings, or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract or policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, limited liability company, or partnership, or any dividends, savings, or profits accrued thereon, or anything of value whatsoever not specified in the contract. Nothing in this subdivision and subdivision (7) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(A) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, so long as any such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the company and its policyholders.

(B) In the case of life insurance policies issued on the

industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first year or of any subsequent year of insurance thereunder, which may be made retroactive only for such policy year.

(D) Paying by an insurer or insurance producer thereof duly licensed as such under the laws of this state of money, commission, or brokerage, or giving or allowing by an insurer or such licensed insurance producer thereof anything of value, for or on account of the solicitation or negotiation of policies or other contracts of any kind or kinds, to a broker, an insurance producer, or a solicitor duly licensed under the laws of this state, but such broker, insurance producer, or solicitor receiving such consideration shall not pay, give, or allow credit for such consideration as received in whole or in part, directly or indirectly, to the insured by way of rebate.

(9) Requiring, as a condition precedent to loaning money upon the security of a mortgage upon real property, that the owner of the property to whom the money is to be loaned negotiate any policy of insurance covering such real property through a particular insurance producer or broker or brokers. However, this subdivision shall not prevent the exercise by any lender of the lender's right to approve or disapprove of the insurance company selected by the borrower to underwrite the insurance.

(10) Entering into any contract, combination in the form of a trust or otherwise, or conspiracy in restraint of commerce in the business of insurance.

(11) Monopolizing or attempting to monopolize or combining or conspiring with any other person or persons to monopolize any part of commerce in the business of insurance. However, participation as a member, director, or officer in the activities of any nonprofit organization of insurance producers or other workers in the insurance business shall not be interpreted, in itself, to constitute a combination in restraint of trade or as combining to create a monopoly as provided in this subdivision and subdivision (10). The enumeration in this chapter of specific unfair methods of competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or department or of any court of review under section 8 of this chapter.

(12) Requiring as a condition precedent to the sale of real or

personal property under any contract of sale, conditional sales contract, or other similar instrument or upon the security of a chattel mortgage, that the buyer of such property negotiate any policy of insurance covering such property through a particular insurance company, insurance producer, or broker or brokers. However, this subdivision shall not prevent the exercise by any seller of such property or the one making a loan thereon of the right to approve or disapprove of the insurance company selected by the buyer to underwrite the insurance.

(13) Issuing, offering, or participating in a plan to issue or offer, any policy or certificate of insurance of any kind or character as an inducement to the purchase of any property, real, personal, or mixed, or services of any kind, where a charge to the insured is not made for and on account of such policy or certificate of insurance. However, this subdivision shall not apply to any of the following:

(A) Insurance issued to credit unions or members of credit unions in connection with the purchase of shares in such credit unions.

(B) Insurance employed as a means of guaranteeing the performance of goods and designed to benefit the purchasers or users of such goods.

(C) Title insurance.

(D) Insurance written in connection with an indebtedness and intended as a means of repaying such indebtedness in the event of the death or disability of the insured.

(E) Insurance provided by or through motorists service clubs or associations.

(F) Insurance that is provided to the purchaser or holder of an air transportation ticket and that:

(i) insures against death or nonfatal injury that occurs during the flight to which the ticket relates;

(ii) insures against personal injury or property damage that occurs during travel to or from the airport in a common carrier immediately before or after the flight;

(iii) insures against baggage loss during the flight to which the ticket relates; or

(iv) insures against a flight cancellation to which the ticket relates.

(14) Refusing, because of the for-profit status of a hospital or medical facility, to make payments otherwise required to be made under a contract or policy of insurance for charges incurred by an insured in such a for-profit hospital or other for-profit medical facility licensed by the Indiana department of health.

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of

coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(16) Committing or performing, with such frequency as to indicate a general practice, unfair claim settlement practices (as defined in section 4.5 of this chapter).

(17) Between policy renewal dates, unilaterally canceling an individual's coverage under an individual or group health insurance policy solely because of the individual's medical or physical condition.

(18) Using a policy form or rider that would permit a cancellation of coverage as described in subdivision (17).

(19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1 concerning motor vehicle insurance rates.

(20) Violating IC 27-8-21-2 concerning advertisements referring to interest rate guarantees.

(21) Violating IC 27-8-24.3 concerning insurance and health plan coverage for victims of abuse.

(22) Violating IC 27-8-26 concerning genetic screening or testing.

(23) Violating IC 27-1-15.6-3(b) concerning licensure of insurance producers.

(24) Violating IC 27-1-38 concerning depository institutions.

(25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning the resolution of an appealed grievance decision.

(26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).

(27) Violating IC 27-2-21 concerning use of credit information.

(28) Violating IC 27-4-9-3 concerning recommendations to consumers.

(29) Engaging in dishonest or predatory insurance practices in marketing or sales of insurance to members of the United States Armed Forces as:

(A) described in the federal Military Personnel Financial Services Protection Act, P.L.109-290; or

(B) defined in rules adopted under subsection (b).

(30) Violating IC 27-8-19.8-20.1 concerning stranger originated life insurance.

(31) Violating IC 27-2-22 concerning retained asset accounts.

(32) Violating IC 27-8-5-29 concerning health plans offered through a health benefit exchange (as defined in IC 27-19-2-8).

(33) Violating a requirement of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal

Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), that is enforceable by the state.

(34) After June 30, 2015, violating IC 27-2-23 concerning unclaimed life insurance, annuity, or retained asset account benefits.

(35) Willfully violating IC 27-1-12-46 concerning a life insurance policy or certificate described in IC 27-1-12-46(a).

(36) Violating IC 27-1-37-7 concerning prohibiting the disclosure of health care service claims data.

(37) Violating IC 27-4-10-10 concerning virtual claims payments.

(38) Violating ~~IC 27-1-24.5~~ **IC 27-1-24.7** concerning pharmacy benefit managers.

(39) Violating IC 27-7-17-16 or IC 27-7-17-17 concerning the marketing of travel insurance policies.

(40) Violating IC 27-1-49 concerning individual prescription drug rebates.

(41) Violating IC 27-1-50 concerning group prescription drug rebates.

(b) Except with respect to federal insurance programs under Subchapter III of Chapter 19 of Title 38 of the United States Code, the commissioner may, consistent with the federal Military Personnel Financial Services Protection Act (10 U.S.C. 992 note), adopt rules under IC 4-22-2 to:

(1) define; and

(2) while the members are on a United States military installation or elsewhere in Indiana, protect members of the United States Armed Forces from;

dishonest or predatory insurance practices.

SECTION 14. IC 27-8-5.8-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 4. (a) This section applies to an insurer that:

(1) issues an accident and sickness insurance policy that provides coverage for prescription drugs or devices; and

(2) issues a card or other technology for claims processing.

This section also applies to a third party administrator for self-insured plans ~~a pharmacy benefit manager,~~ or a health benefit plan administered by the state if the administrator, manager, or plan issues a card or other technology described in subdivision (2).

(b) The card or other technology issued by an insurer or another entity referred to in subsection (a) must contain uniform prescription drug information that complies with the requirements established under subsection (c).

(c) Prescription drug information cards or other technology must meet either of the following criteria:

(1) Be in a format and contain information fields approved by the National Council for Prescription Drug Programs (NCPDP) as

contained in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide in effect on the October 1 most immediately preceding the issuance of the card.

(2) Contain the following information:

(A) The health benefit plan's name.

(B) The insured's name, group number, and identification number.

(C) A telephone number to inquire about pharmacy related issues.

(D) The issuer's international identification number or ANSI BIN number, labeled as RxBIN.

(E) The processor control number, labeled as RxPCN.

(F) The insured's pharmacy benefits group number if different than the medical group number, labeled as RxGRP.

Only those fields listed in clauses (A) through (F) that are required for proper adjudication of the claim must appear on the card. If the card is used to adjudicate non-pharmacy claims, then the designation "Rx" listed in clauses (D) through (F) is not required to be used by the issuer.

(d) An insurer or an insurer's agents, contractors, or administrators ~~including pharmacy benefits managers~~ may not be required to issue a prescription drug information card or other technology to a person more than one (1) time during a twelve (12) month period.

(e) The prescription drug information cards or other technology issued under this section may be used for health insurance coverage other than the coverage to which this chapter applies.

SECTION 15. IC 27-8-11-12, AS AMENDED BY P.L.9-2022, SECTION 52, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 12. (a) As used in this section, "drug" means a prescription drug.

(b) As used in this section, "insurer" refers to an insurer that provides coverage for drugs. The term includes a person that administers drug benefits on behalf of an insurer.

(c) As used in this section, "pharmacy" refers to a pharmacist or pharmacy that has entered into an agreement with an insurer under section 3 of this chapter.

(d) A pharmacy or pharmacist shall have the right to provide an insured with information concerning the amount of the insured's cost share for a prescription drug. Neither a pharmacy nor a pharmacist shall be proscribed by an insurer from discussing this information or from selling to the insured a more affordable alternative if an affordable alternative is available.

(e) An insurer that covers prescription drugs may not include a provision that requires an insured to make payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(1) the contracted copayment amount; or

(2) the amount of total approved charges by the insurer at the point of sale.

This subsection does not prohibit the adjudication of claims in accordance with an accident and sickness insurance policy issued or administered by an insurer. The insured is not liable for any additional charges or entitled to any credits as a result of the adjudicated claim.

(f) The insurer ~~or a pharmacy benefit manager~~ may not require a pharmacy or pharmacist to collect a higher copayment for a prescription drug from an insured than the insurer ~~or pharmacy benefit manager~~ allows the pharmacy or pharmacist to retain.

SECTION 16. IC 27-13-15-6, AS AMENDED BY P.L.9-2022, SECTION 53, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 6. (a) As used in this section, "drug" means a prescription drug.

(b) As used in this section, "health maintenance organization" refers to a health maintenance organization that provides coverage for drugs. The term includes the following:

(1) A limited service health maintenance organization.

(2) A person that administers drug benefits on behalf of a health maintenance organization or a limited service health maintenance organization.

(c) As used in this section, "pharmacy" refers to a pharmacist or pharmacy that is a participating provider.

(d) A pharmacy or pharmacist shall have the right to provide an enrollee with information concerning the amount of the enrollee's cost share for a prescription drug. Neither a pharmacy nor a pharmacist shall be proscribed by a health maintenance organization from discussing this information or from selling to the enrollee a more affordable alternative if an affordable alternative is available.

(e) A health maintenance organization that covers prescription drugs may not include a provision that requires an enrollee to make payment for a prescription drug at the point of sale in an amount that exceeds the lesser of:

(1) the contracted copayment amount; or

(2) the amount of total approved charges by the health maintenance organization at the point of sale.

This subsection does not prohibit the adjudication of claims in accordance with an individual contract or group contract issued or administered by a health maintenance organization. The enrollee is not liable for any additional charges or entitled to any credits as a result of the adjudicated claim.

(f) The health maintenance organization ~~or a pharmacy benefit manager~~ may not require a pharmacy or pharmacist to collect a higher copayment for a prescription drug from an enrollee than the health maintenance organization ~~or pharmacy benefit manager~~ allows the pharmacy or pharmacist to retain.

SECTION 17. IC 35-52-27-9.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 9.7. IC 27-1-24.7-11 defines a crime concerning pharmacy benefit managers.**".

Renumber all SECTIONS consecutively.

(Reference is to SB 140 as printed February 14, 2025.)

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Senator FREEMAN