March 17, 2023

# ENGROSSED
# HOUSE BILL No. 1003

DIGEST OF HB 1003 (Updated March 15, 2023 12:41 pm - DI 55)

**Citations Affected:** IC 5-10; IC 6-3.1; IC 27-1.

**Synopsis:** Health matters. Allows a credit against the state tax liability of an employer with fewer than 50 employees if the employer has adopted a health reimbursement arrangement in lieu of a traditional employer provided health insurance plan and if the employer's contribution toward the health reimbursement arrangement meets a certain standard. Requires employers that are allowed the credit to report certain information to the department of insurance. Provides that the total amount of credits granted to employers may not exceed $10,000,000 in a taxable year. Provides that the credit may be carried over for 10 years, but may not be carried back. Provides that a health care provider that enters into: (1) a value-based health care reimbursement agreement; and (2) an electronic medical record access agreement; with a health plan may qualify to participate in the health plan's program to reduce or eliminate prior authorization requirements. Requires a health plan that establishes a program to reduce or eliminate prior authorization requirements to provide certain information to health care providers concerning the program.

**Effective:** July 1, 2023; January 1, 2024.


## Snow, Lehman, Carbaugh, Fleming

(SENATE SPONSOR — BALDWIN)



January 12, 2023, read first time and referred to Committee on Insurance.
February 16, 2023, amended, reported — Do Pass. Referred to Committee on Ways and Means pursuant to Rule 127.
February 21, 2023, amended, reported — Do Pass.
February 23, 2023, read second time, ordered engrossed.
February 24, 2023, engrossed.
February 27, 2023, read third time, passed. Yeas 85, nays 10.

SENATE ACTION

March 1, 2023, read first time and referred to Committee on Insurance and Financial Institutions.
March 16, 2023, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.

March 17, 2023

First Regular Session of the 123rd General Assembly (2023)

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 2022 Regular Session of the General Assembly.

# ENGROSSED
# HOUSE BILL No. 1003

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

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

SECTION 1. IC 5-10-8-7, AS AMENDED BY P.L.119-2022, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 7. (a) The state, excluding state educational institutions, may not purchase or maintain a policy of group insurance, except:

(1) life insurance for the state's employees;

(2) long term care insurance under a long term care insurance policy (as defined in IC 27-8-12-5), for the state's employees; or

(3) an insurance policy that provides coverage that supplements coverage provided under a United States military health care plan.

(b) With the consent of the governor, the state personnel department may establish self-insurance programs to provide group insurance other than life or long term care insurance for state employees and retired state employees. The state personnel department may contract with a private agency, business firm, limited liability company, or corporation for administrative services. A commission may not be paid for the placement of the contract. The department may require, as part of a

contract for administrative services, that the provider of the administrative services offer to an employee terminating state employment the option to purchase, without evidence of insurability, an individual policy of insurance.

(c) Notwithstanding subsection (a), with the consent of the governor, the state personnel department may contract for health services for state employees through one (1) or more prepaid health care delivery plans.

(d) The state personnel department shall adopt rules under IC 4-22-2 to establish long term and short term disability plans for state employees (except employees who hold elected offices (as defined by IC 3-5-2-17)). The plans adopted under this subsection may include any provisions the department considers necessary and proper and must:

(1) require participation in the plan by employees with six (6) months of continuous, full-time service;

(2) require an employee to make a contribution to the plan in the form of a payroll deduction;

(3) require that an employee's benefits under the short term disability plan be subject to a thirty (30) day elimination period and that benefits under the long term plan be subject to a six (6) month elimination period;

(4) prohibit the termination of an employee who is eligible for benefits under the plan;

(5) except as provided in section 25 of this chapter, provide, after a seven (7) day elimination period, eighty percent (80%) of base biweekly wages for an employee disabled by injuries resulting from tortious acts, as distinguished from passive negligence, that occur within the employee's scope of state employment;

(6) provide that an employee's benefits under the plan may be reduced, dollar for dollar, if the employee derives income from:

(A) Social Security;

(B) the public employees' retirement fund;

(C) the Indiana state teachers' retirement fund;

(D) pension disability;

(E) worker's compensation;

(F) benefits provided from another employer's group plan; or

(G) remuneration for employment entered into after the disability was incurred.

(The department of state revenue and the department of workforce development shall cooperate with the state personnel department to confirm that an employee has disclosed complete and accurate

information necessary to administer this subdivision.);

(7) provide that an employee will not receive benefits under the plan for a disability resulting from causes specified in the rules; and

(8) provide that, if an employee refuses to:

(A) accept work assignments appropriate to the employee's medical condition;

(B) submit information necessary for claim administration; or

(C) submit to examinations by designated physicians;

the employee forfeits benefits under the plan.

(e) This section does not affect insurance for retirees under IC 5-10.3 or IC 5-10.4.

(f) The state may pay part of the cost of self-insurance or prepaid health care delivery plans for its employees.

(g) A state agency may not provide any insurance benefits to its employees that are not generally available to other state employees, unless specifically authorized by law.

(h) The state may pay a part of the cost of group medical and life coverage for its employees.

(i) To carry out the purposes of this section, a trust fund may be established. The trust fund established under this subsection is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be transferred, assigned, or otherwise removed from the trust fund established under this subsection by the state board of finance, the budget agency, or any other state agency. Money in a trust fund established under this subsection does not revert to the state general fund at the end of any state fiscal year. The trust fund established under this subsection consists of appropriations, revenues, or transfers to the trust fund under IC 4-12-1. Contributions to the trust fund are irrevocable. The trust fund must be limited to providing prefunding of annual required contributions and to cover OPEB liability for covered individuals. Funds may be used only for these purposes and not to increase benefits or reduce premiums. The trust fund shall be established to comply with and be administered in a manner that satisfies the Internal Revenue Code requirements concerning a trust fund for prefunding annual required contributions and for covering OPEB liability for covered individuals. All assets in the trust fund established under this subsection:

(1) are dedicated exclusively to providing benefits to covered individuals and their beneficiaries according to the terms of the health plan; and

(2) are exempt from levy, sale, garnishment, attachment, or other

legal process.

The trust fund established under this subsection shall be administered by the state personnel department. The expenses of administering the trust fund shall be paid from money in the trust fund. Notwithstanding IC 5-13, the treasurer of state shall invest the money in the trust fund not currently needed to meet the obligations of the trust fund in the same manner as money may be invested by the public employees' retirement fund under IC 5-10.3-5. However, the trustee may not invest the money in the trust in equity securities. The trustee shall also comply with the prudent investor rule set forth in IC 30-4-3.5. The trustee may contract with investment management professionals, investment advisors, and legal counsel to assist in the investment of the trust and may pay the state expenses incurred under those contracts from the trust. Interest that accrues from these investments shall be deposited in the trust fund.

(j) Nothing in this section prohibits the state personnel department from directly contracting with health care providers for health care services for state employees.

**(k) The state personnel department shall ensure that the private entity it contracts with under subsection (b) for administration of the self-insurance programs for state employees and retired state employees complies with IC 27-1-37.6 concerning a program to reduce or eliminate prior authorization requirements.**

SECTION 2. IC 6-3.1-38 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2024]:

**Chapter 38. Health Reimbursement Arrangement Credit**

**Sec. 1. This chapter applies only to taxable years beginning after December 31, 2023.**

**Sec. 2. As used in this chapter, "qualified taxpayer" means an employer that is a corporation, a limited liability company, a partnership, or another entity that:**

**(1) has any state tax liability; and**

**(2) has adopted a health reimbursement arrangement (as described in Section 9831(d) of the Internal Revenue Code) in lieu of a traditional employer provided health insurance plan.**

**Sec. 3. As used in this chapter, "state tax liability" means a qualified taxpayer's total tax liability that is incurred under:**

**(1) IC 6-3-1 through IC 6-3-7 (the adjusted gross income tax);**

**(2) IC 6-5.5 (the financial institutions tax); and**

**(3) IC 27-1-18-2 (the insurance premiums tax) or IC 6-8-15 (the nonprofit agricultural organization health coverage tax);**

**as computed after the application of the credits that, under IC 6-3.1-1-2, are to be applied before the credit provided by this chapter.**

**Sec. 4. Subject to section 7 of this chapter, a qualified taxpayer may claim a credit against the qualified taxpayer's state tax liability for a qualified contribution for a qualified taxpayer with less than fifty (50) employees, up to four hundred dollars ($400) in the first year per covered employee if the amount provided toward the health reimbursement arrangement is equal to or greater than either the level of benefits provided in the previous benefit year, or if the amount the employer contributes toward the health reimbursement arrangement equals the same amount contributed per covered individual toward the employer provided health insurance plan during the previous benefit year. The credit under this section decreases to two hundred dollars ($200) per covered employee in the second year.**

**Sec. 5. Qualified taxpayers that claim the credit under this chapter are required to report to the department of insurance every three (3) years following the allowance of a credit under this chapter in a manner prescribed by the department of insurance. The report must state whether or not the qualified taxpayer continued to offer the health reimbursement arrangement or reverted to a traditional employer sponsored plan. If the qualified taxpayer continued to offer the health reimbursement arrangement, the report must include information regarding the amount of the benefit.**

**Sec. 6. To receive the credit provided by this chapter, a qualified taxpayer must claim the credit on the qualified taxpayer's state tax return or returns in the manner prescribed by the department.**

**Sec. 7. (a) The amount of tax credits granted under this chapter may not exceed ten million dollars ($10,000,000) in any taxable year.**

**(b) The department shall record the time of filing of each return claiming a credit under section 6 of this chapter and shall approve the claims if they otherwise qualify for a tax credit under this chapter, in the chronological order in which the claims are filed in the state fiscal year.**

**(c) The department may not approve a claim for a tax credit after the date on which the total credits approved under this section equal the maximum amount allowable in a particular state fiscal year.**

**Sec. 8. (a) The amount of the credit provided by this chapter**

**that a qualified taxpayer uses during a particular taxable year may not exceed the state tax liability of the qualified taxpayer.**

**(b) If the amount of a credit determined under this chapter for a particular qualified taxpayer and a particular taxable year exceeds the qualified taxpayer's state tax liability for that taxable year, then the qualified taxpayer may carry the excess over to the immediately succeeding taxable years. The credit carryover may not be used for any taxable year that begins more than ten (10) years after the date on which the donation from which the credit results is made. The amount of the credit carryover from a taxable year shall be reduced to the extent that the carryover is used by the qualified taxpayer to obtain a credit under this chapter for any subsequent taxable year.**

**(c) A qualified taxpayer is not entitled to a carryback or refund of any unused credit.**

**Sec. 9. The department shall adopt rules under IC 4-22-2 to implement this chapter.**

SECTION 3. IC 27-1-37.6 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

**Chapter 37.6. Program to Reduce or Eliminate Prior Authorization Requirements for Health Care Providers**

**Sec. 1. As used in this chapter, "bundled payments" means a reimbursement structure in which different health care providers who are treating a patient for the same or related conditions are paid an overall sum for treating a patient's condition rather than being paid for each individual treatment, test, or procedure.**

**Sec. 2. As used in this chapter, "capitated rate reimbursement arrangement" means a fixed amount of money per patient per unit of time paid in advance to the health care provider for the delivery of health care services.**

**Sec. 3. As used in this chapter, "downside risk" means the risk borne by health care providers in a situation in which, if the total cost of care exceeds projected or budgeted costs, the health care providers will be responsible for a defined percentage of the amount by which the total cost of care exceeds the projected or budgeted costs.**

**Sec. 4. As used in this chapter, "electronic medical record":**

**(1) means a digital collection of medical information about a person that is stored on a computer, electronic platform, or cloud that is automated or permitted to be accessed; and**

**(2) includes information about a patient's health history, such**

**as:**

**(A) diagnoses;**

**(B) medicines;**

**(C) tests;**

**(D) allergies; and**

**(E) treatment plans.**

**Sec. 5. As used in this chapter, "electronic medical records access agreement" means an agreement between a health plan and health care provider that:**

**(1) authorizes the health plan to access the provider's electronic medical records; or**

**(2) allows the transfer of automated medical records information between a health care provider and health plan.**

**Sec. 6. As used in this chapter, "fixed fee schedule" means a total listing of fees used by a health plan to reimburse health care providers or facilities whether:**

**(1) the fixed fee schedule is based on or equal to Medicare reimbursement for the same health care service; or**

**(2) the health plan provides the fixed fee schedule to the health care provider.**

**Sec. 7. As used in this chapter, "health care provider" means an individual or entity that is:**

**(1) licensed, certified, registered, or regulated by an entity described in IC 25-0.5-11;**

**(2) authorized to provide health care services; and**

**(3) contracted to provide health care services to members of a health plan.**

**Sec. 8. (a) As used in this chapter, "health care service" means a medical or surgical service for the diagnosis, prevention, treatment, cure, or relief of illness, injury, or disease that is measured at the diagnosis and procedure level for an individual health care provider.**

**(b) The term does not include the following:**

**(1) Dental services.**

**(2) Vision services.**

**(3) Long term rehabilitation treatment.**

**(4) Pharmaceutical or pharmacist services or products.**

**Sec. 9. (a) As used in this chapter, "health plan" means any of the following:**

**(1) 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).**

**(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).**

**(3) A self-insurance program established under IC 5-10-8-7(b) to provide health care coverage.**

**(b) The term includes the following:**

**(1) The insurer that issues a policy of accident and sickness insurance described in subsection (a)(1).**

**(2) The health maintenance organization referred to in subsection (a)(2).**

**(3) The entity with which the state contracts for the administration of the self-insurance program established under IC 5-10-8-7(b) to provide health care coverage.**

**(c) The term does not include a Medicaid managed care organization, as defined in IC 12-7-2-126.9.**

**Sec. 10. As used in this chapter, "narrow network" means a network:**

**(1) significantly limited to select health care providers that offer a range of health care services to health plan members; and**

**(2) for which any other health care provider that is not included in the network is an out of network health care provider.**

**Sec. 11. As used in this chapter, "pay for performance arrangement" means a reimbursement model that reimburses health care providers for meeting predefined targets as defined in the agreement for quality indicators or efficacy parameters to increase the quality or efficacy of care.**

**Sec. 12. As used in this chapter, "prior authorization" means a practice implemented by a health plan through which coverage of a health care service is dependent on the covered individual or health care provider obtaining approval from the health plan before the health care service is rendered. The term includes prospective or utilization review procedures conducted before a health care service is rendered.**

**Sec. 13. As used in this chapter, "provider organization" means an entity that serves beneficiaries on a risk basis through a network of employed or affiliated providers.**

**Sec. 14. For the purposes of this chapter, a health care service that is assigned a unique CPT code or combination of CPT codes to be used for the care of a patient with a specific diagnosis is the "same health care service" as another health care service that is**

**assigned the same unique CPT code or combination of CPT codes to be used for the care of a patient with the same specific diagnosis.**

**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.**

**Sec. 16. A health care provider that enters into:**

**(1) a value based health care reimbursement agreement; and**

**(2) an electronic medical record access agreement;**

**with a health plan may qualify to participate in a program established by the health plan to reduce or eliminate prior authorization requirements.**

**Sec. 17. (a) A health plan shall notify a health care provider of any requirements that a health care provider must meet to participate in a program under section 16 of this chapter.**

**(b) If a health plan determines that a health care provider is qualified to participate in a program established under section 16 of this chapter, the health plan shall send a notice to the health care provider that contains the following information:**

**(1) A statement that the health care provider qualifies to participate in the program.**

**(2) A list of each type of health care service that is subject to the elimination or reduction of prior authorization requirements under the program.**

**Sec. 18. This chapter does not preclude a health plan from requiring a health care provider to provide additional information to the health plan about health care services rendered to the health plan's members.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1003, 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 5, delete lines 3 through 39, begin a new paragraph and insert:

"**Sec. 4. A qualified taxpayer with less than fifty (50) employees is entitled to a credit against the qualified taxpayer's state tax liability for a qualified contribution up to four hundred dollars ($400) in the first year per covered life if the amount provided toward the health reimbursement arrangement is equal to or greater than the level of benefits provided in the previous benefit year, or if the amount the employer contributes toward the health reimbursement arrangement equals the same amount contributed per covered life toward the employer provided health insurance plan during the previous benefit year. The credit under this section decreases to two hundred dollars ($200) per covered life in the second year.**".

Page 6, delete lines 32 through 42, begin a new paragraph and insert:

"SECTION 3. IC 27-1-37.6 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

**Chapter 37.6. Program to Reduce or Eliminate Prior Authorization Requirements for Health Care Providers**

**Sec. 1. As used in this chapter, "bundled payments" means a reimbursement structure in which different health care providers who are treating a patient for the same or related conditions are paid an overall sum for treating a patient's condition rather than being paid for each individual treatment, test, or procedure.**

**Sec. 2. As used in this chapter, "capitated rate reimbursement arrangement" means a fixed amount of money per patient per unit of time paid in advance to the health care provider for the delivery of health care services.**

**Sec. 3. As used in this chapter, "downside risk" means that health care providers share in the savings and potential losses, which health care providers are responsible for a defined percentage of excess costs if the total cost of care is greater than the projected budgeted costs.**

**Sec. 4. As used in this chapter, "electronic medical record" means a:**

**(1) digital collection of medical information about a person**

**that is stored on a computer, electronic platform, or cloud that is automated or permitted to be accessed; and**

**(2) includes information about a patient's health history, such as:**

**(A) diagnoses;**

**(B) medicines;**

**(C) tests;**

**(D) allergies; and**

**(E) treatment plans.**

**Sec. 5. As used in this chapter, "electronic medical records access agreement" means an agreement between a health plan and health care provider that:**

**(1) authorizes the health plan to access the provider's electronic medical records; or**

**(2) allows the transfer of automated medical records information between a health care provider and health plan.**

**Sec. 6. As used in this chapter, "fixed fee schedule" means a total listing of fees used by a health plan to reimburse health care providers or facilities whether:**

**(1) the fixed fee schedule is based on or equal to Medicare reimbursement for the same health care service; or**

**(2) the health plan provides the fixed fee schedule to the health care provider.**

**Sec. 7. As used in this chapter, "health care provider" means an individual or entity that is:**

**(1) licensed, certified, registered, or regulated by an entity described in IC 25-0.5-11;**

**(2) authorized to provide health care services; and**

**(3) contracted to provide health care services to members of a health plan.**

**Sec. 8. (a) As used in this chapter, "health care service" means a medical or surgical service for the diagnosis, prevention, treatment, cure, or relief of illness, injury, or disease that is measured at the diagnosis and procedure level for an individual health care provider.**

**(b) The term does not include the following:**

**(1) Dental services.**

**(2) Vision services.**

**(3) Long term rehabilitation treatment.**

**(4) Pharmaceutical or pharmacist services or products.**

**Sec. 9. (a) As used in this chapter, "health plan" means any of the following:**

**(1) 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).**

**(2) A contract with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).**

**(3) A self-insurance program established under IC 5-10-8-7(b) to provide health care coverage.**

**(b) The term includes the following:**

**(1) The insurer that issues a policy of accident and sickness insurance described in subsection (a)(1).**

**(2) The health maintenance organization referred to in subsection (a)(2).**

**(3) The entity with which the state contracts for the administration of the self-insurance program established under IC 5-10-8-7(b) to provide health care coverage.**

**Sec. 10. As used in this chapter, "narrow network" means a network:**

**(1) significantly limited to select health care providers that offer a range of health care services to health plan members; and**

**(2) for which any other health care provider that is not included in the network is an out of network health care provider.**

**Sec. 11. As used in this chapter, "pay for performance arrangement" means a reimbursement model that reimburses health care providers for meeting pre-defined targets as defined in the agreement for quality indicators or efficacy parameters to increase the quality or efficacy of care.**

**Sec. 12. As used in this chapter, "prior authorization" means a practice implemented by a health plan through which coverage of a health care service is dependent on the covered individual or health care provider obtaining approval from the health plan before the health care service is rendered. The term includes prospective or utilization review procedures conducted before a health care service is rendered.**

**Sec. 13. As used in this chapter, "provider organization" means an entity that serves beneficiaries on a risk basis through a network of employed or affiliated providers.**

**Sec. 14. As used in this chapter, "same health care service" means a health care service that is assigned a unique CPT code or combination of CPT codes to be used for the care of a patient with**

**a specific diagnosis.**

**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.**

**Sec. 16. A health care provider that enters into:**

**(1) a value based health care reimbursement agreement; and**

**(2) an electronic medical record access agreement;**

**with a health plan may qualify to participate in a program established by the health plan to reduce or eliminate prior authorization requirements.**

**Sec. 17. (a) A health plan shall notify a health care provider of any requirements that a health care provider must meet to participate in a program under section 16 of this chapter.**

**(b) If a health plan determines that a health care provider is qualified to participate in a program established under section 16 of this chapter, the health plan shall send a notice to the health care provider that contains the following information:**

**(1) A statement that the health care provider qualifies to participate in the program.**

**(2) A list of each type of health care service that is subject to the elimination or reduction of prior authorization requirements under the program.**

**Sec. 18. This chapter does not preclude a health plan from requiring a health care provider to provide additional information to the health plan about health care services rendered to the health plan's members.**".

Delete pages 7 through 16.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1003 as introduced.)

CARBAUGH

Committee Vote: yeas 9, nays 4.

---

COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, to which was referred House Bill 1003, 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 4, line 22, delete "exemptions from" and insert "**a program to reduce or eliminate prior authorization requirements.**".

Page 4, delete line 23.

Page 4, line 34, after "arrangement" insert "**(as described in Section 9831(d) of the Internal Revenue Code)**".

Page 5, delete lines 3 through 14, begin a new paragraph and insert:

"**Sec. 4. Subject to section 7 of this chapter, a qualified taxpayer may claim a credit against the qualified taxpayer's state tax liability for a qualified contribution for a qualified taxpayer with less than fifty (50) employees, up to four hundred dollars ($400) in the first year per covered employee if the amount provided toward the health reimbursement arrangement is equal to or greater than either the level of benefits provided in the previous benefit year, or if the amount the employer contributes toward the health reimbursement arrangement equals the same amount contributed per covered individual toward the employer provided health insurance plan during the previous benefit year. The credit under this section decreases to two hundred dollars ($200) per covered employee in the second year.**".

Page 5, line 28, after "7." insert "**(a)**".

Page 5, between lines 30 and 31, begin a new paragraph and insert:

"**(b) The department shall record the time of filing of each return claiming a credit under section 6 of this chapter and shall approve the claims if they otherwise qualify for a tax credit under this chapter, in the chronological order in which the claims are filed in the state fiscal year.**

**(c) The department may not approve a claim for a tax credit**

**after the date on which the total credits approved under this section equal the maximum amount allowable in a particular state fiscal year.**".

Page 6, line 26, after "record"" insert "**:**".

Page 6, delete line 27.

Page 6, line 28, after "(1)" insert "**means a**".

Page 8, line 13, delete "pre-defined" and insert "**predefined**".

and when so amended that said bill do pass.

(Reference is to HB 1003 as printed February 16, 2023.)

THOMPSON

Committee Vote: yeas 18, nays 3.

---

COMMITTEE REPORT

Madam President: The Senate Committee on Insurance and Financial Institutions, to which was referred House Bill No. 1003, 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 6, delete lines 32 through 36, begin a new paragraph and insert:

"**Sec. 3. As used in this chapter, "downside risk" means the risk borne by health care providers in a situation in which, if the total cost of care exceeds projected or budgeted costs, the health care providers will be responsible for a defined percentage of the amount by which the total cost of care exceeds the projected or budgeted costs.**".

Page 8, between lines 12 through 13, begin a new paragraph and insert:

"**(c) The term does not include a Medicaid managed care organization, as defined in IC 12-7-2-126.9.**".

Page 8, delete lines 36 through 39, begin a new paragraph and insert:

"**Sec. 14. For the purposes of this chapter, a health care service that is assigned a unique CPT code or combination of CPT codes to be used for the care of a patient with a specific diagnosis is the "same health care service" as another health care service that is assigned the same unique CPT code or combination of CPT codes**

**to be used for the care of a patient with the same specific diagnosis.**".

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

(Reference is to HB 1003 as printed February 21, 2023.)

BALDWIN, Chairperson

Committee Vote: Yeas 7, Nays 0.