February 20, 2023

HOUSE BILL No. 1004

DIGEST OF HB 1004 (Updated February 20, 2023 12:07 pm - DI 104)

Citations Affected: IC 6-3.1; IC 12-15; IC 16-18; IC 16-21; IC 16-51; IC 27-1; IC 27-8; IC 27-13.

Synopsis: Health care matters. Allows a credit against an employer's state tax liability if the employer has adopted a health reimbursement arrangement. Requires certain employers that claim and are allowed the credit to report certain information to the department of insurance. Provides a credit against state tax liability to certain physicians who have an ownership interest in a physician practice and meet other eligibility criteria. Establishes the health care cost oversight board and sets forth duties of the board. Requires provider facilities and practitioners to include the address of the service facility location in order to obtain reimbursement for a commercial claim for health care services. Provides that specified health insurance payers are not required to accept a claim for a health care service if the claim does not contain the service facility location. Beginning in 2024, requires the department of insurance (department) to calculate a national mean price and mean price for each Indiana nonprofit hospital system as a percentage of Medicare or using another nationally recognized metric. Requires each Indiana nonprofit hospital system to submit specified information to the department. Requires the department to, beginning in 2026, take corrective action or assess a penalty against an Indiana nonprofit hospital system if the Indiana nonprofit hospital system exceeds specified percentages of the national means calculated by the department. Requires the department to annually report to the governor and the legislative council concerning the calculations and any corrective action or penalties assessed to an Indiana nonprofit hospital system. Allows for the provisional credentialing of physicians who establish or join an independent primary care practice.

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

Schaibley, Lehman, Pierce K, McGuire

January 12, 2023, read first time and referred to Committee on Public Health.
February 20, 2023, amended, reported — Do Pass. Referred to Committee on Ways and Means pursuant to Rule 127.

February 20, 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.

HOUSE BILL No. 1004

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 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 in a particular state fiscal year may not exceed the greater of:

(1) the amount of penalties deposited in the state general fund under IC 27-1-47.5 during the preceding state fiscal year; or

(2) ten million dollars ($10,000,000).

(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 may adopt rules under IC 4-22-2 to implement this chapter.

SECTION 2. IC 6-3.1-40 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 40. Physician Practice Ownership Tax Credit

Sec. 1. This chapter applies to taxable years beginning after December 31, 2024.

Sec. 2. As used in this chapter, "physician" means an individual who is licensed to practice medicine in Indiana under IC 25-22.5.

Sec. 3. As used in this chapter, "primary care physician" refers to a physician practicing in one (1) or more of the following:

(1) Family medicine.

(2) General pediatric medicine.

(3) Internal medicine.

(4) The general practice of medicine.

Sec. 4. As used in this chapter, "state income tax liability" means the taxpayer's total tax liability that is incurred under IC 6-3-1 through IC 6-3-7 (the adjusted gross income 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. 5. As used in this chapter, "taxpayer" means an individual who:

(1) is a physician practicing as a primary care physician;

(2) has an ownership interest in a corporation, limited liability company, partnership, or other legal entity organized to provide health care services as a physician owned entity;

(3) is not employed by a health system (as defined in IC 16-18-2-168.5); and

(4) has any state income tax liability.

Sec. 6. If a taxpayer has an ownership interest in a physician owned medical practice described in section 5(2) of this chapter that:

(1) is established as a legal entity under Indiana law after December 31, 2024;

(2) opens and begins to provide health care services to patients in a particular taxable year beginning after December 31, 2024; and

(3) has billed for health care services described in subdivision (2) for at least six (6) months of that taxable year;

the taxpayer may, subject to section 7 of this chapter, claim a credit against the taxpayer's state income tax liability. Subject to section 8 of this chapter, the amount of the credit allowed under this chapter for a particular taxable year is twenty thousand dollars ($20,000).

Sec. 7. A taxpayer may claim a tax credit under this chapter for the taxable year described in section 6 of this chapter and the two (2) immediately following taxable years.

Sec. 8. (a) If the amount of the credit allowed under section 6 of this chapter for a taxpayer in a taxable year exceeds the taxpayer's state income tax liability for that taxable year, the taxpayer may carry the excess credit over for a period not to exceed the taxpayer's following ten (10) taxable years. The amount of the credit carryover from a taxable year must be reduced to the extent that the carryover is used by the taxpayer to obtain a credit under this chapter for any subsequent taxable year. A taxpayer is not entitled to a carryback or a refund of any unused credit amount.

(b) A taxpayer may not assign any part of a credit to which the taxpayer is entitled under this chapter.

Sec. 9. To obtain a credit under this chapter, a taxpayer must claim the credit on the taxpayer's annual state income tax return in the manner prescribed by the department. The taxpayer shall

submit to the department all information that the department determines is necessary to verify the taxpayer's eligibility for the credit provided by this chapter.

Sec. 10. (a) If the department determines within five (5) years of a taxpayer's receipt of a tax credit under this chapter that the taxpayer:

(1) has sold, transferred, granted, or otherwise relinquished the taxpayer's ownership interest in an entity described in section 5(2) of this chapter; and

(2) is employed by a health system or another non-physician owned medical practice;

the department shall impose an assessment upon the taxpayer equal to the amount of tax credits provided to the taxpayer under this chapter.

(b) The department shall deposit assessments collected under this section in the state general fund.

SECTION 3. IC 12-15-11-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 10. (a) A physician licensed under IC 25-22.5 who was credentialed with an insurer to provide services within the previous twelve (12) months shall be considered provisionally credentialed by the insurer if the physician:**

(1) is in good standing with the insurer; and

(2) establishes or joins an independent primary care practice.

(b) The office or a managed care organization or contractor of the office shall complete the credentialing process for an individual who is provisionally credentialed under subsection (a).

SECTION 4. IC 16-18-2-37.5, AS AMENDED BY P.L.3-2008, SECTION 103, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 37.5. **(a) "Board", for purposes of IC 16-21-18, has the meaning set forth in IC 16-21-18-1.**

~~(a)~~ **(b)** "Board", for purposes of IC 16-22-8, has the meaning set forth in IC 16-22-8-2.1.

~~(b)~~ **(c)** "Board", for purposes of IC 16-41-42.2, has the meaning set forth in IC 16-41-42.2-1.

SECTION 5. IC 16-18-2-163.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 163.6. "Health care services", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-2.**

SECTION 6. IC 16-18-2-167.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 167.8. "Health maintenance**

organization", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-3.

SECTION 7. IC 16-18-2-190.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 190.7. "Insurer", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-4.**

SECTION 8. IC 16-18-2-288, AS AMENDED BY P.L.96-2014, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 288. (a) "Practitioner", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-5.

(b) "Practitioner", for purposes of IC 16-41-14, has the meaning set forth in IC 16-41-14-4.

(c) "Practitioner", for purposes of IC 16-42-21, has the meaning set forth in IC 16-42-21-3.

(d) "Practitioner", for purposes of IC 16-42-22 and IC 16-42-25, has the meaning set forth in IC 16-42-22-4.5.

(e) "Practitioner", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-5.

SECTION 9. IC 16-18-2-295.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 295.5. "Provider facility", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-6.**

SECTION 10. IC 16-18-2-327.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 327.7. "Service facility location", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-7.**

SECTION 11. IC 16-21-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 18. Health Care Cost Oversight Board

Sec. 1. As used in this chapter, "board" refers to the health care cost oversight board established by section 2 of this chapter.

Sec. 2. The health care cost oversight board is established.

Sec. 3. (a) The health care cost oversight board consists of the following members:

(1) The secretary of family and social services appointed under IC 12-8-1.5-2 or the secretary's designee.

(2) The state health commissioner or the commissioner's designee.

(3) The commissioner of the department of insurance appointed under IC 27-1-1-2 or the commissioner's designee.

(4) Four (4) members of the general assembly as follows:

(A) One (1) member of the senate appointed by the president pro tempore.

(B) One (1) member of the senate appointed by the minority leader of the senate.

(C) One (1) member of the house of representatives appointed by the speaker of the house.

(D) One (1) member of the house of representatives appointed by the minority leader of the house of representatives.

A member appointed under this subdivision shall serve as a nonvoting member of the board.

(5) Subject to subsection (c), the following members appointed by the governor:

(A) Three (3) individuals representing Indiana consumers of health care.

(B) Two (2) representatives of employers domiciled in Indiana and are as follows:

(i) One (1) representative of an employer that employs less than one hundred fifty (150) employees in Indiana.

(ii) One (1) representative of an employer that employs at least five hundred (500) employees in Indiana.

In making these appointments, the governor may consider a recommendation of the Indiana Chamber of Commerce or the Indiana Manufacturers Association.

(C) One (1) representative of a nonprofit acute care hospital system licensed under IC 16-21 that has at least three (3) acute care hospital members. In making this appointment, the governor may consider a recommendation of the Indiana Hospital Association.

(D) One (1) representative of an acute care hospital licensed under IC 16-21, IC 16-22, or IC 16-23 and that operates an independent hospital. In making this appointment, the governor may consider a recommendation of the Indiana Hospital Association.

(E) One (1) physician licensed under IC 25-22.5 that is not employed by a hospital, an insurer, or a health maintenance organization. In making this appointment, the governor may consider a recommendation of the Indiana State Medical Association.

(F) One (1) representative of:

(i) an insurer that offers policies of accident and sickness

insurance (as defined in IC 27-8-5-1); or

(ii) a health maintenance organization that offers contracts for health care services;

in Indiana. In making this appointment, the governor may consider a recommendation of the Insurance Institute of Indiana.

(G) One (1) representative of a pharmaceutical manufacturer domiciled in Indiana. In making this appointment, the governor may consider a recommendation of the Indiana Pharmaceutical Research & Manufacturers Association.

(H) One (1) representative of a pharmacy benefit manager licensed under IC 27-1-24.5 that does business in Indiana. In making this appointment, the governor may consider a recommendation of the Indiana Pharmaceutical Care Management Association.

(I) One (1) economist or actuary with expertise in health care.

(J) One (1) individual with accounting experience in health care.

(b) The governor shall designate a member appointed under subsection (a)(5)(A) or (a)(5)(B) as the chairperson of the board.

(c) A member appointed under subsection (a)(5)(A), (a)(5)(B), (a)(5)(I), or (a)(5)(J) may not be employed by any of the following:

(1) The health care industry.

(2) The health insurance industry.

(3) The pharmaceutical industry.

(d) Each member of the board who is not a state employee is not entitled to a salary, compensation, or reimbursement for expenses incurred as a member of the board. Each member of the commission who is a state employee is entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the board member's duties, as provided in the state travel policies and procedures established by the department of administration and approved by the state budget agency.

(e) The affirmative votes of a majority of the members appointed to the board are required for the board to take action on any measure.

(f) Except as provided in subsection (h), a member shall serve a term of two (2) years.

(g) If a vacancy exists on the board, the appointing authority who appointed the former member whose position has become

vacant shall appoint an individual to fill the vacancy.

(h) Notwithstanding subsection (f), the initial appointments for the board under subsection (a)(5) are as follows:

(1) The members appointed under subsection (a)(5)(A) shall serve the initial term as follows:

(A) Two (2) members shall serve a term of one (1) year.

(B) One (1) member shall serve a term of two (2) years.

(2) The members appointed under subsection (a)(5)(B) shall serve the initial term as follows:

(A) One (1) member shall serve a term of one (1) year.

(B) One (1) member shall serve a term of two (2) years.

(3) The members appointed under subsection (a)(5)(C), (a)(5)(E), (a)(5)(G), and (a)(5)(I) shall serve a term of one (1) year.

(4) The members appointed under subsection (a)(5)(D), (a)(5)(F), (a)(5)(H), and (a)(5)(J) shall serve a term of two (2) years.

This subsection expires June 30, 2027.

Sec. 4. The board shall meet at least three (3) times per calendar year and at the call of the chairperson.

Sec. 5. The office of the secretary of family and social services shall staff the board.

Sec. 6. The board has the following duties:

(1) Monitoring health care delivery models used in Indiana.

(2) Obtaining and reviewing data and other information from the following:

(A) The Medicaid program.

(B) A hospital licensed under IC 16-21, IC 16-22, or IC 16-23.

(C) National mean price data.

(D) A health carrier (as defined in IC 27-2-26-1).

(E) Information described in IC 27-1-24.5-21 and submitted to the board by a pharmacy benefit manager.

(3) Preparing an annual report as set forth in section 9 of this chapter.

(4) Determining whether any decrease in Indiana mean price by an Indiana nonprofit hospital system is resulting in the health care consumer spending less money on health care.

Sec. 7. (a) A hospital described in section 6(2)(B) of this chapter shall submit the following information to the board not later than March 1 of each year:

(1) The hospital's Indiana specific:

(A) income statement;

(B) balance sheet; and

(C) cash flow statement;

for the previous calendar year and that is prepared according to generally accepted accounting principles.

(2) Information concerning:

(A) the hospital's pricing of health services in comparison to the amounts of reimbursement for the health services under the Medicare program;

(B) the rationale for any pricing of health services by the hospital that is higher than the corresponding reimbursement for the health services under the Medicare program; and

(C) any increase in the hospital's pricing of health services that occurred in the previous year.

(b) A health carrier (as defined in IC 27-2-26-1) shall submit the following to the board not later than March 1 of each year:

(1) The following financial statements for the preceding calendar years, using statutory accounting principles, at the corporate level and at the Indiana market level:

(A) Income statements.

(B) Balance sheets.

(C) Cash flow statements.

(2) Information concerning the following:

(A) The health carrier's Indiana based profits, if the health carrier is publicly traded.

(B) The premiums (as defined in IC 27-1-2-3(w)) charged by the health carrier.

(C) The health carrier's strategy to lower health care costs.

(D) Any increase in the health carrier's premiums, on average statewide, that occurred in the previous year for each health carrier.

(E) Annual audited financial reports, if required under IC 27-1-3.5-6 and if the health carrier is publicly traded.

(c) A pharmacy benefit manager (as defined in IC 27-1-24.5-12) shall submit the information described in section 6(2)(E) of this chapter to the board not later than March 1 of each year.

(d) Any records or documents disclosed to, received by, or generated by the board are exempt from the requirements of IC 5-14-3.

Sec. 8. A board meeting is subject to IC 5-14-1.5.

Sec. 9. (a) Beginning August 1, 2024, and annually thereafter,

the board shall prepare and submit a report based on the board's actions. The board shall submit the report to the governor and to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6.

(b) The report must include the following:

(1) Information concerning national and statewide health care costs, prices, growth, and use in Indiana for the previous calendar year.

(2) Factors that contributed to any health care cost growth in Indiana and the relationship with the increase and:

(A) health care provider costs;

(B) health insurance premium rates;

(C) medical loss ratios of health carriers;

(D) profits of health care providers and health carriers;

(E) pharmaceutical costs paid by hospitals;

(F) supplies costs paid by hospitals; and

(G) salaries, wages, and benefits paid by hospitals.

(3) Growth of health carrier premium rates and the percentage of a health carrier's premium rate growth attributable to the following:

(A) Hospital services.

(B) Physician services.

(C) Medical devices.

(D) Durable medical equipment.

(E) Pharmaceuticals.

(F) The health carrier's medical loss ratio.

(G) Health carrier profits.

(H) Pharmacy benefit managers.

(4) The impact of health care payment and delivery reform efforts on health care costs, including the following:

(A) Limited and tiered networks.

(B) Increased price transparency.

(C) Increased use of electronic medical records.

(D) Use of health technology.

(E) Alternative payment methodologies, including value based purchasing and direct employer models.

(5) Behavioral health costs, cost trends, price, and use.

(6) The information required to be submitted to the board under section 7 of this chapter.

(7) Any recommendations on the following:

(A) The enhancement of transparency of hospital prices

and any basis for any increase in hospital prices.

(B) The enhancement of transparency of prescription drug prices and the basis for any increase in prescription drug prices.

(C) The enhancement of transparency of health plan premiums and the basis for any increase in health plan premiums.

(D) The enhancement of transparency of pharmacy benefit managers and the basis for any increase in payments to pharmacy benefit managers.

(E) Payments under the Medicaid program and other governmental programs for which health care services are provided.

(F) The improvement, efficiency, and cost effective delivery of health care services in Indiana.

(G) An accountability system to ensure health care cost savings are ultimately realized by health care consumers.

SECTION 12. IC 16-51 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

ARTICLE 51. HEALTH CARE REQUIREMENTS

Chapter 1. Health Care Billing

Sec. 1. This chapter is effective beginning January 1, 2025.

Sec. 2. (a) As used in this chapter, "health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization.

(b) The term includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

Sec. 3. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

Sec. 4. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-11-1(e).

Sec. 5. As used in this chapter, "practitioner" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 6. As used in this chapter, "provider facility" means any of the following:

(1) A hospital, including a critical access hospital.

(2) A comprehensive care health facility.

(3) An end state renal disease provider.

(4) A home health agency.

(5) A hospice organization.

(6) An outpatient physical therapy, occupational therapy, or speech pathology service provider.

(7) A comprehensive outpatient rehabilitation facility.

(8) A community mental health center.

(9) A federally qualified health center.

(10) A histocompatibility laboratory.

(11) An Indian health service facility.

(12) An organ procurement organization.

(13) A religious nonmedical health care institution.

(14) A rural health clinic.

Sec. 7. As used in this chapter, "service facility location" means the address where the services of a provider facility or practitioner were provided. The term consists of the exact address and place of service codes as required by CMS form 1500 and CMS form 1450, or the equivalent electronic version of each form, including:

(1) an office;

(2) an on campus location of a hospital; and

(3) an off campus location of a hospital.

Sec. 8. (a) A provider facility or practitioner shall include the address of the service facility location as required by CMS form 1500 and CMS form 1450, or the equivalent electronic version of each form, in order to obtain reimbursement for a commercial claim for health care services from:

(1) an insurer;

(2) a health maintenance organization;

(3) an employer; or

(4) another person responsible for the payment of the cost of health care services.

(b) A person described in subsection (a) is not required to accept a bill for health care services that does not contain the service facility location.

Sec. 9. A patient is not liable for any additional payment that is the result of a practitioner or provider facility filing an incorrect form or not including the correct service facility location as required under this chapter.

SECTION 13. IC 27-1-47.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 47.5. Oversight of Health Care Costs

Sec. 1. As used in this chapter, "governmental hospital" means an acute care hospital licensed under IC 16-21-2 that is governed

by:

(1) IC 16-22-2;

(2) IC 16-22-8; or

(3) IC 16-23.

Sec. 2. As used in this chapter, "independent hospital" means a private nonprofit acute care hospital licensed under IC 16-21-2 that meets the following criteria:

(1) Is either:

(A) not directly or indirectly owned or controlled by an entity that is headquartered outside of the county where the hospital is located; or

(B) owned or controlled by an entity that is located in a contiguous county and operates not more than two (2) hospitals.

(2) Except as provided in subdivision (1)(B), does not directly or indirectly own another acute care hospital.

Sec. 3. (a) As used in this chapter, "Indiana nonprofit hospital system" means a hospital that is organized as a nonprofit corporation or a charitable trust under Indiana law or the laws of any other state or country and that is:

(1) eligible for tax exempt bond financing; or

(2) exempt from state or local taxes.

(b) The term does not apply to the following:

(1) A nonprofit hospital that is owned by a county.

(2) A critical access hospital that meets the criteria under 42 CFR 485.601 et seq.

(3) An independent hospital.

(4) A governmental hospital.

Sec. 4. (a) Before August 1, 2024, and before August every subsequent year, the department shall determine the method or means in which to calculate, and calculate, the following:

(1) Either:

(A) the national mean hospital facility price for commercially insured individuals as a percentage of Medicare for all nonprofit hospital:

(i) inpatient facility; and

(ii) outpatient facility;

services; or

(B) a nationally recognized metric to measure the national mean hospital facility price for commercially insured patients for all nonprofit hospital:

(i) inpatient facility; and

(ii) outpatient facility;

services.

(2) Either:

(A) the Indiana mean price for commercially insured individuals as a percentage of Medicare for each Indiana nonprofit hospital system:

(i) inpatient facility; and

(ii) outpatient facility;

services; or

(B) a nationally recognized metric to measure the Indiana mean hospital facility price for commercially insured patients for each Indiana nonprofit hospital system's:

(i) inpatient facility; and

(ii) outpatient facility;

services.

(b) The department may contract with a consultant in the performance of the duties specified in this section.

(c) If the department determines to use a metric calculation described in subsection (a)(1)(B) or (a)(2)(B), the department shall report to the budget committee to review the metric before the department may use the metric.

Sec. 5. (a) Before March 1, 2024, and before March 1 of each subsequent year, an Indiana nonprofit hospital system shall submit the following:

(1) Information the department determines is necessary to make the assessments required in this chapter.

(2) Standard charge information required to be made public by the federal Centers for Medicare and Medicaid Services for price transparency for each hospital facility within the Indiana nonprofit hospital system.

(b) Information required under this section shall be submitted to the department in a manner prescribed by the department.

(c) Any records or documents disclosed to, received by, or generated by the department for purposes of this chapter are exempt from the requirements of IC 5-14-3.

Sec. 6. (a) Before November 1, 2025, and before November 1 of each subsequent year, the department shall compare the pricing information of an Indiana nonprofit hospital system using the calculation described in section 4(a)(2) of this chapter to the national pricing level using the calculation described in section 4(a)(1) of this chapter. Before November 1, 2026, and before November 1 of each subsequent year, the department shall assess

corrective action or penalties under subsection (c) for each Indiana nonprofit hospital system that the department determines is pricing in excess of the national pricing level calculated under section 4 of this chapter.

(b) The department shall review the data and resources submitted concerning health care costs in Indiana specific to each Indiana nonprofit hospital system.

(c) Beginning with determinations under subsection (a) made on or after November 1, 2026, the department shall annually make the calculations described in section 4 of this chapter for each Indiana nonprofit hospital system and do the following;

(1) If the department determines that the pricing of an Indiana nonprofit hospital system exceeds either:

(A) the national mean pricing level expressed as a percentage of Medicare pricing by fewer than twenty-five (25) percentage points; or

(B) the national mean pricing level determined using another metric by an amount equivalent to the amount described in clause (A);

the department shall issue a notice for corrective action to the Indiana nonprofit hospital system for a time period not to exceed six (6) months to decrease the Indiana nonprofit hospital system's prices. If the Indiana nonprofit hospital system does not meet the corrective action, the department shall assess the Indiana nonprofit hospital system a penalty equal to one percent (1%) of the Indiana nonprofit hospital system's commercial net patient revenue in that calendar year.

(2) If the department determines that the pricing of an Indiana nonprofit hospital system exceeds either:

(A) the national mean pricing level expressed as a percentage of Medicare pricing by at least twenty-five (25) percentage points; or

(B) the national mean pricing level determined using another metric by an amount equivalent to the amount described in clause (A);

the department shall assess the Indiana nonprofit hospital system a penalty equal to one percent (1%) of the Indiana nonprofit hospital system's commercial net patient revenue in that calendar year.

(3) If the department determines that the pricing of an Indiana nonprofit hospital system is less than or equal to

either:

(A) the national mean pricing level expressed as a percentage of Medicare pricing; or

(B) the national mean pricing level determined using another metric;

the department shall not take any action.

(d) A department's determination under this section is subject to administrative review.

(e) A penalty collected under this section shall be deposited into the state general fund for use of the health reimbursement arrangement credit established under IC 6-3.1-38.

Sec. 7. (a) For purposes of this section, in calculating the twenty-five percent (25%) in subsection (b), the calculation may not include coverage of individuals participating in the federal Medicare program or the Medicaid program.

(b) The department shall assess a health carrier (as defined in IC 27-1-37-1.5) that has at least twenty-five percent (25%) of the share of premiums in Indiana an assessment that is equal to the health carrier's share of the one percent (1%) of commercial revenue for each Indiana nonprofit hospital system that is assessed a penalty under section 6(c) of this chapter.

(c) A penalty collected under this section shall be deposited into the state general fund for use of the health reimbursement arrangement credit established under IC 6-3.1-38.

(d) A department's determination under this section is subject to administrative review.

Sec. 8. Before November 1 of each year, the department shall prepare and submit a report to the governor and the legislative council in an electronic format under IC 5-14-6 including the following:

(1) The calculations determined for each Indiana nonprofit hospital under section 4 of this chapter.

(2) Any corrective action or penalties assessed to an Indiana nonprofit hospital or insurance carrier under this chapter.

Sec. 9. The department may adopt rules under IC 4-22-2, including emergency rules under IC 4-22-2-37.1, necessary to implement this chapter.

SECTION 14. IC 27-8-11-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 7.5. (a) A physician licensed under IC 25-22.5 who was credentialed to provide services under Medicaid within the previous twelve (12) months shall be**

considered provisionally credentialed if the physician:

(1) is in good standing with the office or a managed care organization or contractor of the office; and

(2) establishes or joins an independent primary care practice.

(b) The insurer shall complete the credentialing process for an individual who is provisionally credentialed under subsection (a).

SECTION 15. IC 27-13-43-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 3.5. (a) A physician licensed under IC 25-22.5 who was credentialed with a health maintenance organization to provide services within the previous twelve (12) months shall be considered provisionally credentialed if the physician:**

(1) is in good standing with the health maintenance organization; and

(2) establishes or joins an independent primary care practice.

(b) The health maintenance organization shall complete the credentialing process for an individual who is provisionally credentialed under subsection (a).

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1004, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

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

"SECTION 1. IC 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 in a particular state fiscal year may not exceed the greater of:

(1) the amount of penalties deposited in the state general fund under IC 27-1-47.5 during the preceding state fiscal year; or

(2) ten million dollars ($10,000,000).

(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 may adopt rules under IC 4-22-2 to implement this chapter.".

Page 1, between lines 8 and 9, begin a new paragraph and insert:

"**Sec. 3. As used in this chapter, "primary care physician" refers to a physician practicing in one (1) or more of the following:**

(1) Family medicine.

(2) General pediatric medicine.

(3) Internal medicine.

(4) The general practice of medicine.".

Page 1, line 9, delete "3." and insert "**4.**".

Page 1, delete line 15, begin a new paragraph and insert:

"**Sec. 5. As used in this chapter, "taxpayer" means an individual who:**

(1) is a physician practicing as a primary care physician;

(2) has an ownership interest in a corporation, limited liability company, partnership, or other legal entity organized to provide health care services as a physician owned entity;

(3) is not employed by a health system (as defined in IC 16-18-2-168.5); and

(4) has any state income tax liability.".

Page 2, delete lines 1 through 7.

Page 2, line 8, delete "5." and insert "**6.**".

Page 2, line 9, delete "4(1)" and insert "**5(2)**".

Page 2, line 18, delete "6" and insert "**7**".

Page 2, line 20, delete "7" and insert "**8**".

Page 2, line 21, delete "ten" and insert "**twenty**".

Page 2, line 22, delete "($10,000)." and insert "**($20,000).**".

Page 2, line 23, delete "6." and insert "**7.**".

Page 2, line 24, delete "5" and insert "**6**".

Page 2, line 26, delete "7." and insert "**8.**".

Page 2, line 26, delete "5" and insert "**6**".

Page 2, line 37, delete "8." and insert "**9.**".

Page 2, after line 42, begin a new paragraph and insert:

"**Sec. 10. (a) If the department determines within five (5) years of a taxpayer's receipt of a tax credit under this chapter that the taxpayer:**

(1) has sold, transferred, granted, or otherwise relinquished the taxpayer's ownership interest in an entity described in section 5(2) of this chapter; and

(2) is employed by a health system or another non-physician owned medical practice;

the department shall impose an assessment upon the taxpayer equal to the amount of tax credits provided to the taxpayer under this chapter.

(b) The department shall deposit assessments collected under this section in the state general fund.

SECTION 3. IC 12-15-11-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 10. (a) A physician licensed under IC 25-22.5 who was credentialed with an insurer to provide services within the previous twelve (12) months shall be considered provisionally credentialed by the insurer if the physician:**

(1) is in good standing with the insurer; and

(2) establishes or joins an independent primary care practice.

(b) The office or a managed care organization or contractor of the office shall complete the credentialing process for an individual who is provisionally credentialed under subsection (a).

SECTION 4. IC 16-18-2-37.5, AS AMENDED BY P.L.3-2008, SECTION 103, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 37.5. **(a) "Board", for purposes of IC 16-21-18, has the meaning set forth in IC 16-21-18-1.**

~~(a)~~ **(b)** "Board", for purposes of IC 16-22-8, has the meaning set forth in IC 16-22-8-2.1.

~~(b)~~ **(c)** "Board", for purposes of IC 16-41-42.2, has the meaning set forth in IC 16-41-42.2-1.

SECTION 5. IC 16-18-2-163.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 163.6. "Health care services", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-2.**

SECTION 6. IC 16-18-2-167.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 167.8. "Health maintenance organization", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-3.**

SECTION 7. IC 16-18-2-190.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 190.7. "Insurer", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-4.**

SECTION 8. IC 16-18-2-288, AS AMENDED BY P.L.96-2014, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 288. (a) "Practitioner", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-5.

(b) "Practitioner", for purposes of IC 16-41-14, has the meaning set

forth in IC 16-41-14-4.

(c) "Practitioner", for purposes of IC 16-42-21, has the meaning set forth in IC 16-42-21-3.

(d) "Practitioner", for purposes of IC 16-42-22 and IC 16-42-25, has the meaning set forth in IC 16-42-22-4.5.

(e) "Practitioner", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-5.

SECTION 9. IC 16-18-2-295.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 295.5. "Provider facility", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-6.**

SECTION 10. IC 16-18-2-327.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 327.7. "Service facility location", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-7.**

SECTION 11. IC 16-21-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 18. Health Care Cost Oversight Board

Sec. 1. As used in this chapter, "board" refers to the health care cost oversight board established by section 2 of this chapter.

Sec. 2. The health care cost oversight board is established.

Sec. 3. (a) The health care cost oversight board consists of the following members:

(1) The secretary of family and social services appointed under IC 12-8-1.5-2 or the secretary's designee.

(2) The state health commissioner or the commissioner's designee.

(3) The commissioner of the department of insurance appointed under IC 27-1-1-2 or the commissioner's designee.

(4) Four (4) members of the general assembly as follows:

(A) One (1) member of the senate appointed by the president pro tempore.

(B) One (1) member of the senate appointed by the minority leader of the senate.

(C) One (1) member of the house of representatives appointed by the speaker of the house.

(D) One (1) member of the house of representatives appointed by the minority leader of the house of representatives.

A member appointed under this subdivision shall serve as a

nonvoting member of the board.

(5) Subject to subsection (c), the following members appointed by the governor:

(A) Three (3) individuals representing Indiana consumers of health care.

(B) Two (2) representatives of employers domiciled in Indiana and are as follows:

(i) One (1) representative of an employer that employs less than one hundred fifty (150) employees in Indiana.

(ii) One (1) representative of an employer that employs at least five hundred (500) employees in Indiana.

In making these appointments, the governor may consider a recommendation of the Indiana Chamber of Commerce or the Indiana Manufacturers Association.

(C) One (1) representative of a nonprofit acute care hospital system licensed under IC 16-21 that has at least three (3) acute care hospital members. In making this appointment, the governor may consider a recommendation of the Indiana Hospital Association.

(D) One (1) representative of an acute care hospital licensed under IC 16-21, IC 16-22, or IC 16-23 and that operates an independent hospital. In making this appointment, the governor may consider a recommendation of the Indiana Hospital Association.

(E) One (1) physician licensed under IC 25-22.5 that is not employed by a hospital, an insurer, or a health maintenance organization. In making this appointment, the governor may consider a recommendation of the Indiana State Medical Association.

(F) One (1) representative of:

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

(ii) a health maintenance organization that offers contracts for health care services;

in Indiana. In making this appointment, the governor may consider a recommendation of the Insurance Institute of Indiana.

(G) One (1) representative of a pharmaceutical manufacturer domiciled in Indiana. In making this appointment, the governor may consider a recommendation of the Indiana Pharmaceutical Research & Manufacturers Association.

(H) One (1) representative of a pharmacy benefit manager licensed under IC 27-1-24.5 that does business in Indiana. In making this appointment, the governor may consider a recommendation of the Indiana Pharmaceutical Care Management Association.

(I) One (1) economist or actuary with expertise in health care.

(J) One (1) individual with accounting experience in health care.

(b) The governor shall designate a member appointed under subsection (a)(5)(A) or (a)(5)(B) as the chairperson of the board.

(c) A member appointed under subsection (a)(5)(A), (a)(5)(B), (a)(5)(I), or (a)(5)(J) may not be employed by any of the following:

(1) The health care industry.

(2) The health insurance industry.

(3) The pharmaceutical industry.

(d) Each member of the board who is not a state employee is not entitled to a salary, compensation, or reimbursement for expenses incurred as a member of the board. Each member of the commission who is a state employee is entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the board member's duties, as provided in the state travel policies and procedures established by the department of administration and approved by the state budget agency.

(e) The affirmative votes of a majority of the members appointed to the board are required for the board to take action on any measure.

(f) Except as provided in subsection (h), a member shall serve a term of two (2) years.

(g) If a vacancy exists on the board, the appointing authority who appointed the former member whose position has become vacant shall appoint an individual to fill the vacancy.

(h) Notwithstanding subsection (f), the initial appointments for the board under subsection (a)(5) are as follows:

(1) The members appointed under subsection (a)(5)(A) shall serve the initial term as follows:

(A) Two (2) members shall serve a term of one (1) year.

(B) One (1) member shall serve a term of two (2) years.

(2) The members appointed under subsection (a)(5)(B) shall serve the initial term as follows:

(A) One (1) member shall serve a term of one (1) year.

(B) One (1) member shall serve a term of two (2) years.

(3) The members appointed under subsection (a)(5)(C), (a)(5)(E), (a)(5)(G), and (a)(5)(I) shall serve a term of one (1) year.

(4) The members appointed under subsection (a)(5)(D), (a)(5)(F), (a)(5)(H), and (a)(5)(J) shall serve a term of two (2) years.

This subsection expires June 30, 2027.

Sec. 4. The board shall meet at least three (3) times per calendar year and at the call of the chairperson.

Sec. 5. The office of the secretary of family and social services shall staff the board.

Sec. 6. The board has the following duties:

(1) Monitoring health care delivery models used in Indiana.

(2) Obtaining and reviewing data and other information from the following:

(A) The Medicaid program.

(B) A hospital licensed under IC 16-21, IC 16-22, or IC 16-23.

(C) National mean price data.

(D) A health carrier (as defined in IC 27-2-26-1).

(E) Information described in IC 27-1-24.5-21 and submitted to the board by a pharmacy benefit manager.

(3) Preparing an annual report as set forth in section 9 of this chapter.

(4) Determining whether any decrease in Indiana mean price by an Indiana nonprofit hospital system is resulting in the health care consumer spending less money on health care.

Sec. 7. (a) A hospital described in section 6(2)(B) of this chapter shall submit the following information to the board not later than March 1 of each year:

(1) The hospital's Indiana specific:

(A) income statement;

(B) balance sheet; and

(C) cash flow statement;

for the previous calendar year and that is prepared according to generally accepted accounting principles.

(2) Information concerning:

(A) the hospital's pricing of health services in comparison to the amounts of reimbursement for the health services under the Medicare program;

(B) the rationale for any pricing of health services by the hospital that is higher than the corresponding

reimbursement for the health services under the Medicare program; and

(C) any increase in the hospital's pricing of health services that occurred in the previous year.

(b) A health carrier (as defined in IC 27-2-26-1) shall submit the following to the board not later than March 1 of each year:

(1) The following financial statements for the preceding calendar years, using statutory accounting principles, at the corporate level and at the Indiana market level:

(A) Income statements.

(B) Balance sheets.

(C) Cash flow statements.

(2) Information concerning the following:

(A) The health carrier's Indiana based profits, if the health carrier is publicly traded.

(B) The premiums (as defined in IC 27-1-2-3(w)) charged by the health carrier.

(C) The health carrier's strategy to lower health care costs.

(D) Any increase in the health carrier's premiums, on average statewide, that occurred in the previous year for each health carrier.

(E) Annual audited financial reports, if required under IC 27-1-3.5-6 and if the health carrier is publicly traded.

(c) A pharmacy benefit manager (as defined in IC 27-1-24.5-12) shall submit the information described in section 6(2)(E) of this chapter to the board not later than March 1 of each year.

(d) Any records or documents disclosed to, received by, or generated by the board are exempt from the requirements of IC 5-14-3.

Sec. 8. A board meeting is subject to IC 5-14-1.5.

Sec. 9. (a) Beginning August 1, 2024, and annually thereafter, the board shall prepare and submit a report based on the board's actions. The board shall submit the report to the governor and to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6.

(b) The report must include the following:

(1) Information concerning national and statewide health care costs, prices, growth, and use in Indiana for the previous calendar year.

(2) Factors that contributed to any health care cost growth in Indiana and the relationship with the increase and:

(A) health care provider costs;

(B) health insurance premium rates;

(C) medical loss ratios of health carriers;

(D) profits of health care providers and health carriers;

(E) pharmaceutical costs paid by hospitals;

(F) supplies costs paid by hospitals; and

(G) salaries, wages, and benefits paid by hospitals.

(3) Growth of health carrier premium rates and the percentage of a health carrier's premium rate growth attributable to the following:

(A) Hospital services.

(B) Physician services.

(C) Medical devices.

(D) Durable medical equipment.

(E) Pharmaceuticals.

(F) The health carrier's medical loss ratio.

(G) Health carrier profits.

(H) Pharmacy benefit managers.

(4) The impact of health care payment and delivery reform efforts on health care costs, including the following:

(A) Limited and tiered networks.

(B) Increased price transparency.

(C) Increased use of electronic medical records.

(D) Use of health technology.

(E) Alternative payment methodologies, including value based purchasing and direct employer models.

(5) Behavioral health costs, cost trends, price, and use.

(6) The information required to be submitted to the board under section 7 of this chapter.

(7) Any recommendations on the following:

(A) The enhancement of transparency of hospital prices and any basis for any increase in hospital prices.

(B) The enhancement of transparency of prescription drug prices and the basis for any increase in prescription drug prices.

(C) The enhancement of transparency of health plan premiums and the basis for any increase in health plan premiums.

(D) The enhancement of transparency of pharmacy benefit managers and the basis for any increase in payments to pharmacy benefit managers.

(E) Payments under the Medicaid program and other

governmental programs for which health care services are provided.

(F) The improvement, efficiency, and cost effective delivery of health care services in Indiana.

(G) An accountability system to ensure health care cost savings are ultimately realized by health care consumers.

SECTION 12. IC 16-51 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

ARTICLE 51. HEALTH CARE REQUIREMENTS

Chapter 1. Health Care Billing

Sec. 1. This chapter is effective beginning January 1, 2025.

Sec. 2. (a) As used in this chapter, "health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization.

(b) The term includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

Sec. 3. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

Sec. 4. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-11-1(e).

Sec. 5. As used in this chapter, "practitioner" means an individual or entity duly licensed or legally authorized to provide health care services.

Sec. 6. As used in this chapter, "provider facility" means any of the following:

(1) A hospital, including a critical access hospital.

(2) A comprehensive care health facility.

(3) An end state renal disease provider.

(4) A home health agency.

(5) A hospice organization.

(6) An outpatient physical therapy, occupational therapy, or speech pathology service provider.

(7) A comprehensive outpatient rehabilitation facility.

(8) A community mental health center.

(9) A federally qualified health center.

(10) A histocompatibility laboratory.

(11) An Indian health service facility.

(12) An organ procurement organization.

(13) A religious nonmedical health care institution.

(14) A rural health clinic.

Sec. 7. As used in this chapter, "service facility location" means the address where the services of a provider facility or practitioner were provided. The term consists of the exact address and place of service codes as required by CMS form 1500 and CMS form 1450, or the equivalent electronic version of each form, including:

(1) an office;

(2) an on campus location of a hospital; and

(3) an off campus location of a hospital.

Sec. 8. (a) A provider facility or practitioner shall include the address of the service facility location as required by CMS form 1500 and CMS form 1450, or the equivalent electronic version of each form, in order to obtain reimbursement for a commercial claim for health care services from:

(1) an insurer;

(2) a health maintenance organization;

(3) an employer; or

(4) another person responsible for the payment of the cost of health care services.

(b) A person described in subsection (a) is not required to accept a bill for health care services that does not contain the service facility location.

Sec. 9. A patient is not liable for any additional payment that is the result of a practitioner or provider facility filing an incorrect form or not including the correct service facility location as required under this chapter.

SECTION 13. IC 27-1-47.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 47.5. Oversight of Health Care Costs

Sec. 1. As used in this chapter, "governmental hospital" means an acute care hospital licensed under IC 16-21-2 that is governed by:

(1) IC 16-22-2;

(2) IC 16-22-8; or

(3) IC 16-23.

Sec. 2. As used in this chapter, "independent hospital" means a private nonprofit acute care hospital licensed under IC 16-21-2 that meets the following criteria:

(1) Is either:

(A) not directly or indirectly owned or controlled by an entity that is headquartered outside of the county where the hospital is located; or

(B) owned or controlled by an entity that is located in a contiguous county and operates not more than two (2) hospitals.

(2) Except as provided in subdivision (1)(B), does not directly or indirectly own another acute care hospital.

Sec. 3. (a) As used in this chapter, "Indiana nonprofit hospital system" means a hospital that is organized as a nonprofit corporation or a charitable trust under Indiana law or the laws of any other state or country and that is:

(1) eligible for tax exempt bond financing; or

(2) exempt from state or local taxes.

(b) The term does not apply to the following:

(1) A nonprofit hospital that is owned by a county.

(2) A critical access hospital that meets the criteria under 42 CFR 485.601 et seq.

(3) An independent hospital.

(4) A governmental hospital.

Sec. 4. (a) Before August 1, 2024, and before August every subsequent year, the department shall determine the method or means in which to calculate, and calculate, the following:

(1) Either:

(A) the national mean hospital facility price for commercially insured individuals as a percentage of Medicare for all nonprofit hospital:

(i) inpatient facility; and

(ii) outpatient facility;

services; or

(B) a nationally recognized metric to measure the national mean hospital facility price for commercially insured patients for all nonprofit hospital:

(i) inpatient facility; and

(ii) outpatient facility;

services.

(2) Either:

(A) the Indiana mean price for commercially insured individuals as a percentage of Medicare for each Indiana nonprofit hospital system:

(i) inpatient facility; and

(ii) outpatient facility;

services; or

(B) a nationally recognized metric to measure the Indiana mean hospital facility price for commercially insured

patients for each Indiana nonprofit hospital system's:

(i) inpatient facility; and

(ii) outpatient facility;

services.

(b) The department may contract with a consultant in the performance of the duties specified in this section.

(c) If the department determines to use a metric calculation described in subsection (a)(1)(B) or (a)(2)(B), the department shall report to the budget committee to review the metric before the department may use the metric.

Sec. 5. (a) Before March 1, 2024, and before March 1 of each subsequent year, an Indiana nonprofit hospital system shall submit the following:

(1) Information the department determines is necessary to make the assessments required in this chapter.

(2) Standard charge information required to be made public by the federal Centers for Medicare and Medicaid Services for price transparency for each hospital facility within the Indiana nonprofit hospital system.

(b) Information required under this section shall be submitted to the department in a manner prescribed by the department.

(c) Any records or documents disclosed to, received by, or generated by the department for purposes of this chapter are exempt from the requirements of IC 5-14-3.

Sec. 6. (a) Before November 1, 2025, and before November 1 of each subsequent year, the department shall compare the pricing information of an Indiana nonprofit hospital system using the calculation described in section 4(a)(2) of this chapter to the national pricing level using the calculation described in section 4(a)(1) of this chapter. Before November 1, 2026, and before November 1 of each subsequent year, the department shall assess corrective action or penalties under subsection (c) for each Indiana nonprofit hospital system that the department determines is pricing in excess of the national pricing level calculated under section 4 of this chapter.

(b) The department shall review the data and resources submitted concerning health care costs in Indiana specific to each Indiana nonprofit hospital system.

(c) Beginning with determinations under subsection (a) made on or after November 1, 2026, the department shall annually make the calculations described in section 4 of this chapter for each Indiana nonprofit hospital system and do the following;

(1) If the department determines that the pricing of an Indiana nonprofit hospital system exceeds either:

(A) the national mean pricing level expressed as a percentage of Medicare pricing by fewer than twenty-five (25) percentage points; or

(B) the national mean pricing level determined using another metric by an amount equivalent to the amount described in clause (A);

the department shall issue a notice for corrective action to the Indiana nonprofit hospital system for a time period not to exceed six (6) months to decrease the Indiana nonprofit hospital system's prices. If the Indiana nonprofit hospital system does not meet the corrective action, the department shall assess the Indiana nonprofit hospital system a penalty equal to one percent (1%) of the Indiana nonprofit hospital system's commercial net patient revenue in that calendar year.

(2) If the department determines that the pricing of an Indiana nonprofit hospital system exceeds either:

(A) the national mean pricing level expressed as a percentage of Medicare pricing by at least twenty-five (25) percentage points; or

(B) the national mean pricing level determined using another metric by an amount equivalent to the amount described in clause (A);

the department shall assess the Indiana nonprofit hospital system a penalty equal to one percent (1%) of the Indiana nonprofit hospital system's commercial net patient revenue in that calendar year.

(3) If the department determines that the pricing of an Indiana nonprofit hospital system is less than or equal to either:

(A) the national mean pricing level expressed as a percentage of Medicare pricing; or

(B) the national mean pricing level determined using another metric;

the department shall not take any action.

(d) A department's determination under this section is subject to administrative review.

(e) A penalty collected under this section shall be deposited into the state general fund for use of the health reimbursement arrangement credit established under IC 6-3.1-38.

Sec. 7. (a) For purposes of this section, in calculating the twenty-five percent (25%) in subsection (b), the calculation may not include coverage of individuals participating in the federal Medicare program or the Medicaid program.

(b) The department shall assess a health carrier (as defined in IC 27-1-37-1.5) that has at least twenty-five percent (25%) of the share of premiums in Indiana an assessment that is equal to the health carrier's share of the one percent (1%) of commercial revenue for each Indiana nonprofit hospital system that is assessed a penalty under section 6(c) of this chapter.

(c) A penalty collected under this section shall be deposited into the state general fund for use of the health reimbursement arrangement credit established under IC 6-3.1-38.

(d) A department's determination under this section is subject to administrative review.

Sec. 8. Before November 1 of each year, the department shall prepare and submit a report to the governor and the legislative council in an electronic format under IC 5-14-6 including the following:

(1) The calculations determined for each Indiana nonprofit hospital under section 4 of this chapter.

(2) Any corrective action or penalties assessed to an Indiana nonprofit hospital or insurance carrier under this chapter.

Sec. 9. The department may adopt rules under IC 4-22-2, including emergency rules under IC 4-22-2-37.1, necessary to implement this chapter.

SECTION 14. IC 27-8-11-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 7.5. (a) A physician licensed under IC 25-22.5 who was credentialed to provide services under Medicaid within the previous twelve (12) months shall be considered provisionally credentialed if the physician:**

(1) is in good standing with the office or a managed care organization or contractor of the office; and

(2) establishes or joins an independent primary care practice.

(b) The insurer shall complete the credentialing process for an individual who is provisionally credentialed under subsection (a).

SECTION 15. IC 27-13-43-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 3.5. (a) A physician licensed under IC 25-22.5 who was credentialed with a health maintenance organization to provide services within the previous twelve (12)**

months shall be considered provisionally credentialed if the physician:

(1) is in good standing with the health maintenance organization; and

(2) establishes or joins an independent primary care practice.

(b) The health maintenance organization shall complete the credentialing process for an individual who is provisionally credentialed under subsection (a).".

Delete pages 3 through 13.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1004 as introduced.)

BARRETT

Committee Vote: yeas 10, nays 2.