April 14, 2023

# ENGROSSED
# HOUSE BILL No. 1004

DIGEST OF HB 1004 (Updated April 13, 2023 10:48 am - DI 120)

**Citations Affected:** IC 6-3.1; IC 16-21; IC 27-1; IC 27-2; IC 27-4.

**Synopsis:** Health care matters. Allow 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. Specifies additional information that a

(Continued next page)

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


## Schaibley, Lehman, Pierce K, McGuire

(SENATE SPONSORS — CHARBONNEAU, GARTEN, BROWN L)


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 21, 2023, 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 11.

SENATE ACTION

March 1, 2023, read first time and referred to Committee on Health and Provider Services.
April 6, 2023, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.
April 13, 2023, amended, reported favorably — Do Pass.

hospital must report to the Indiana department of health in the hospital's annual report and establishes a fine for a hospital that fails to timely file the report. Requires each Indiana nonprofit hospital system to submit specified information to the department of insurance (department). Before November 1, 2025, and before November 1 each subsequent year, requires the department to compare certain Indiana nonprofit hospital system facility pricing information with 260% of Medicare. Requires the department to, beginning in 2026, assess a penalty against an Indiana nonprofit hospital system if the Indiana nonprofit hospital system exceeds a specified targeted percentage of Medicare. Establishes the payer affordability penalty fund for specified hospital fines and penalties. Specifies the uses of the fund. Requires the department to review the targeted percentage rate for the penalties every two years to determine if the rate needs to be adjusted. Prohibits any proposed adjusted rate to be implemented until reviewed by the budget committee. Requires a third party administrator, insurer, or health maintenance organization that has contracted with a person to administer a self-funded insurance plan to provide claims data to the person not later than 14 days from a request for the data. Establishes an unfair and deceptive act or practice for a violation concerning the provision of the claims data.

April 14, 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. 1004

A BILL FOR AN ACT to amend the Indiana Code concerning health and to make an appropriation.

*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 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 2. IC 16-21-6-3, AS AMENDED BY P.L.2-2007, SECTION 190, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 3. (a) Each hospital shall file with the state department a report for the preceding fiscal year within one hundred twenty (120) days after the end of the hospital's fiscal year. **For the filing of a report on 2022,** the state department shall grant an extension of the time to file the report if the hospital shows good cause for the extension. The report must contain the following:

(1) A copy of the hospital's balance sheet, including a statement describing the hospital's total assets and total liabilities.

(2) A copy of the hospital's income statement.

(3) A statement of changes in financial position.

(4) A statement of changes in fund balance.

(5) Accountant notes pertaining to the report.

(6) A copy of the hospital's report required to be filed annually under 42 U.S.C. 1395g, and other appropriate utilization and financial reports required to be filed under federal statutory law.

(7) Net patient revenue, **including providing the information as follows:**

**(A) the net patient revenue for inpatient services for:**

**(i) Medicare;**

**(ii) Medicaid; and**

**(iii) commercial insurance, including inpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;**

**(B) the net patient revenue for outpatient services for:**

**(i) Medicare;**

**(ii) Medicaid; and**

**(iii) commercial insurance, including outpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan; and**

**(C) the total net patient revenue for:**

**(i) Medicare;**

**(ii) Medicaid; and**

**(iii) commercial insurance, including the total net patient revenue for services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan.**

(8) A statement including:

(A) Medicare gross revenue;

(B) Medicaid gross revenue;

(C) other revenue from state programs;

(D) revenue from local government programs;

(E) local tax support;

(F) charitable contributions;

(G) other third party payments;

(H) gross inpatient revenue;

(I) gross outpatient revenue;

(J) contractual allowance;

(K) any other deductions from revenue;

(L) charity care provided;

(M) itemization of bad debt expense; and

(N) an estimation of the unreimbursed cost of subsidized health services.

(9) A statement itemizing donations.

(10) A statement describing the total cost of reimbursed and unreimbursed research.

(11) A statement describing the total cost of reimbursed and unreimbursed education separated into the following categories:

(A) Education of physicians, nurses, technicians, and other medical professionals and health care providers.

(B) Scholarships and funding to medical schools, and other postsecondary educational institutions for health professions education.

(C) Education of patients concerning diseases and home care in response to community needs.

(D) Community health education through informational programs, publications, and outreach activities in response to community needs.

(E) Other educational services resulting in education related costs.

(b) The information in the report filed under subsection (a) must be provided from reports or audits certified by an independent certified public accountant or by the state board of accounts.

**(c) A hospital that fails to file the report required under subsection (a) by the date required shall pay to the state department a fine of one thousand dollars ($1,000) per day for which the report is past due. A fine under this subsection shall be deposited into the payer affordability penalty fund established by IC 27-1-47.5-6.**

**(d) If a hospital submitted the hospital's report for 2022 before July 1, 2023, the hospital must submit a revised report with the data set forth in subsection (a)(7)(A) through (a)(7)(C) before September 1, 2023. This subsection expires December 31, 2023.**

SECTION 3. 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 owns or operates hospitals on not more than three (3) acute care hospital**

**licenses in Indiana. For purposes of this clause, a critical access hospital that meets the criteria under 42 CFR 485.601 et seq. does not count toward the number of acute care hospital licensed operated by an entity.**

**(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 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. 5. (a) Except as provided in section 7 of this chapter, before November 1, 2025, and before November 1 of each subsequent year, the department shall compare the facility pricing information for services and provided to the commercially insured market of an Indiana nonprofit hospital system with two hundred sixty percent (260%) of Medicare.**

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

**(c) Beginning on or after November 1, 2026, the department**

**shall determine whether each Indiana nonprofit hospital is subject to a penalty under this chapter for the Indiana nonprofit hospital's net patient revenue received from the commercially insured market. An Indiana nonprofit hospital's penalty under this section is determined in STEP SIX of the following formula:**

**STEP ONE: Determine the target reimbursement rate set forth in subsection (a) for the Indiana nonprofit hospital, expressed as a percentage of Medicare reimbursement.**

**STEP TWO: Determine the Indiana nonprofit hospital's actual facility reimbursement rate for services provided to the commercial market, expressed as a percentage of Medicare reimbursement.**

**STEP THREE: Determine the greater of:**

**(A) the percentage determined in STEP TWO minus the percentage determined in STEP ONE; or**

**(B) zero (0).**

**STEP FOUR: Determine the STEP THREE result, expressed as a decimal.**

**STEP FIVE: Determine the result of:**

**(A) the amount of the Indiana nonprofit hospital's net patient revenue; minus**

**(B) the amount of net patient revenue that the Indiana nonprofit hospital would have received if the Indiana nonprofit hospital met the target reimbursement rate under subsection (a).**

**STEP SIX: Multiply the STEP FOUR result by the STEP FIVE result.**

**(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 payer affordability penalty fund established by section 6 of this chapter.**

**Sec. 6. (a) The payer affordability penalty fund is established for the purpose of receiving fines assessed under this chapter and the fines collected under IC 16-21-6-3 to be used for:**

**(1) the state's share of the Medicaid program; and**

**(2) a study of hospitals that are impacted by changes made in the disproportionate share hospital methodology payments set forth in Section 203 of the federal Consolidated Appropriations Act of 2021.**

**The office of the secretary shall report the results of the study described in subdivision (2) to the budget committee.**

**(b) The fund shall be administered by the office of the secretary of family and social services.**

**(c) The expenses of administering the fund shall be paid from money in the fund.**

**(d) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested. Interest that accrues from these investments shall be deposited in the fund.**

**(e) Money in the fund at the end of a state fiscal year does not revert to the state general fund.**

**(f) Money in the fund is continually appropriated.**

**Sec. 7. (a) Every odd-numbered year, the department shall review the percentage set forth in section 5(a) of this chapter. The department shall review nationwide health care pricing and determine whether the targeted rate set forth in section 5(a) shall be adjusted, and if a determination is made that the rates need to be adjusted, the appropriate rate.**

**(b) If an adjustment is determined necessary under subsection (a), the adjustment may not take effect until the adjustment is reviewed by the budget committee.**

SECTION 4. IC 27-2-25.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

**Chapter 25.5. Claims Data**

**Sec. 1. A third party administrator, an insurer (as defined in IC 27-1-2-3(x)) that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1(a)), or a health maintenance organization (as defined in IC 27-13-1-19) that has contracted to administer a self-funded plan shall provide claims data to the person for which the contract was entered into not later than fourteen (14) calendar days from a request for the claims data.**

**Sec. 2. A person described in section 1 of this chapter that willfully violates section 1 of this chapter commits an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4 and is subject to the penalties and procedures set forth in IC 27-4-1.**

SECTION 5. IC 27-4-1-4, AS AMENDED BY P.L.19-2022, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 4. (a) The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or

circulated, any estimate, illustration, circular, or statement:

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

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

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

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

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

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

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

(4) Entering into any agreement to commit, or individually or by a concerted action committing any act of boycott, coercion, or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any

person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive. Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

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

(7) Making or permitting any of the following:

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

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

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

(i) policies or contracts of reinsurance or joint reinsurance,

or abstract and title insurance;

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

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

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

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

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

and for the best interests of the company and its policyholders.

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

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

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

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

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

(11) Monopolizing or attempting to monopolize or combining or conspiring with any other person or persons to monopolize any part of commerce in the business of insurance. However, participation as a member, director, or officer in the activities of any nonprofit organization of insurance producers or other workers in the insurance business shall not be interpreted, in itself, to constitute a combination in restraint of trade or as combining to create a monopoly as provided in this subdivision and subdivision (10). The enumeration in this chapter of specific

unfair methods of competition and unfair or deceptive acts and practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the commissioner or department or of any court of review under section 8 of this chapter.

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

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

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

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

(C) Title insurance.

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

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

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

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

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

(iii) insures against baggage loss during the flight to which

the ticket relates; or

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

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

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

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

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

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

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

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

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

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

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

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

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

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

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

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

consumers.

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

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

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

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

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

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

(33) Violating a requirement of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), that is enforceable by the state.

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

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

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

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

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

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

**(40) Violating IC 27-2-25.5-1 concerning the provision of claims data.**

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

(1) define; and

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

dishonest or predatory insurance practices.

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.

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COMMITTEE REPORT

Mr. Speaker: Your Committee on Ways and Means, 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 do pass.

(Reference is to HB 1004 as printed February 20, 2023.)

THOMPSON

Committee Vote: Yeas 15, Nays 7

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COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1004, 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:

Delete the title and insert the following:

A BILL FOR AN ACT to amend the Indiana Code concerning health and to make an appropriation.

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

"SECTION 1. IC 16-21-6-3, AS AMENDED BY P.L.2-2007, SECTION 190, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 3. (a) Each hospital shall file with the state department a report for the preceding fiscal year within one hundred twenty (120) days after the end of the hospital's fiscal year. **For the filing of a report on 2022,** the state department shall grant an extension of the time to file the report if the hospital shows good cause for the extension. The report must contain the following:

(1) A copy of the hospital's balance sheet, including a statement describing the hospital's total assets and total liabilities.

(2) A copy of the hospital's income statement.

(3) A statement of changes in financial position.

(4) A statement of changes in fund balance.

(5) Accountant notes pertaining to the report.

(6) A copy of the hospital's report required to be filed annually under 42 U.S.C. 1395g, and other appropriate utilization and financial reports required to be filed under federal statutory law.

(7) Net patient revenue, **including providing the information as follows:**

**(A) the net patient revenue for inpatient services for:**

**(i) Medicare;**

**(ii) Medicaid; and**

**(iii) commercial insurance, including inpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;**

**(B) the net patient revenue for outpatient services for:**

**(i) Medicare;**

**(ii) Medicaid; and**

**(iii) commercial insurance, including outpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan; and**

**(C) the total net patient revenue for:**

**(i) Medicare;**

**(ii) Medicaid; and**

**(iii) commercial insurance, including the total net patient revenue for services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan.**

(8) A statement including:

(A) Medicare gross revenue;
(B) Medicaid gross revenue;
(C) other revenue from state programs;
(D) revenue from local government programs;
(E) local tax support;
(F) charitable contributions;
(G) other third party payments;
(H) gross inpatient revenue;
(I) gross outpatient revenue;
(J) contractual allowance;
(K) any other deductions from revenue;
(L) charity care provided;
(M) itemization of bad debt expense; and
(N) an estimation of the unreimbursed cost of subsidized health services.

(9) A statement itemizing donations.

(10) A statement describing the total cost of reimbursed and unreimbursed research.

(11) A statement describing the total cost of reimbursed and unreimbursed education separated into the following categories:

(A) Education of physicians, nurses, technicians, and other medical professionals and health care providers.
(B) Scholarships and funding to medical schools, and other postsecondary educational institutions for health professions education.
(C) Education of patients concerning diseases and home care in response to community needs.
(D) Community health education through informational programs, publications, and outreach activities in response to community needs.
(E) Other educational services resulting in education related costs.

(b) The information in the report filed under subsection (a) must be provided from reports or audits certified by an independent certified public accountant or by the state board of accounts.

**(c) A hospital that fails to file the report required under subsection (a) by the date required shall pay to the state department a fine of one thousand dollars ($1,000) per day for which the report is past due. A fine under this subsection shall be deposited into the payer affordability penalty fund established by IC 27-1-47.5-6.**

**(d) If a hospital submitted the hospital's report for 2022 before**

**July 1, 2023, the hospital must submit a revised report with the data set forth in subsection (a)(7)(A) through (a)(7)(C) before September 1, 2023. This subsection expires December 31, 2023.**".

Delete pages 2 through 12.

Page 13, delete lines 1 through 36.

Page 14, line 12, delete "is located in a" and insert "**owns or operates hospitals on not more than three (3) acute care hospital licenses in Indiana. For purposes of this clause, a critical access hospital that meets the criteria under 42 CFR 485.601 et seq. does not count toward the number of acute care hospital licensed operated by an entity.**".

Page 14, delete lines 13 through 14.

Page 14, delete lines 29 through 42, begin a new paragraph and insert:

"**Sec. 4. (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. 5. (a) Except as provided in section 7 of this chapter, before November 1, 2025, and before November 1 of each subsequent year, the department shall compare the facility pricing information for services and provided to the commercially insured market of an Indiana nonprofit hospital system with two hundred sixty percent (260%) of Medicare.**

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

**(c) Beginning on or after November 1, 2026, the department shall determine whether each Indiana nonprofit hospital is subject to a penalty under this chapter for the Indiana nonprofit hospital's net patient revenue received from the commercially insured market. An Indiana nonprofit hospital's penalty under this section is determined in STEP SIX of the following formula:**

**STEP ONE: Determine the target reimbursement rate set forth in subsection (a) for the Indiana nonprofit hospital, expressed as a percentage of Medicare reimbursement.**

**STEP TWO: Determine the Indiana nonprofit hospital's actual facility reimbursement rate for services provided to the commercial market, expressed as a percentage of Medicare reimbursement.**

**STEP THREE: Determine the greater of:**

**(A) the percentage determined in STEP TWO minus the percentage determined in STEP ONE; or**

**(B) zero (0).**

**STEP FOUR: Determine the STEP THREE result, expressed as a decimal.**

**STEP FIVE: Determine the result of:**

**(A) the amount of the Indiana nonprofit hospital's net patient revenue; minus**

**(B) the amount of net patient revenue that the Indiana nonprofit hospital would have received if the Indiana nonprofit hospital met the target reimbursement rate under subsection (a).**

**STEP SIX: Multiply the STEP FOUR result by the STEP FIVE result.**

**(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 payer affordability penalty fund established by section 6 of this chapter.**

**Sec. 6. (a) The payer affordability penalty fund is established for the purpose of receiving fines:**

**(1) assessed under this chapter; and**

**(2) collected under IC 16-21-6-3;**

**to be used for the state's share of the costs of the healthy Indiana plan established by IC 12-15-44.5. The fund shall be administered by the office of the secretary of family and social services.**

**(b) The expenses of administering the fund shall be paid from money in the fund.**

**(c) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested. Interest that accrues from these investments shall be deposited in the fund.**

**(d) Money in the fund at the end of a state fiscal year does not revert to the state general fund.**

**(e) Money in the fund is continually appropriated.**

**Sec. 7. (a) Every odd-numbered year, the department shall review the percentage set forth in section 5(a) of this chapter. The department shall review nationwide health care pricing and determine whether the targeted rate set forth in section 5(a) shall be adjusted, and if a determination is made that the rates need to be adjusted, the appropriate rate.**

**(b) If an adjustment is determined necessary under subsection (a), the adjustment may not take effect until the adjustment is reviewed by the budget committee.**".

Delete pages 15 through 18, begin a new paragraph and insert:

"SECTION 13. IC 27-2-25.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

**Chapter 25.5. Claims Data**

**Sec. 1. A third party administrator, an insurer (as defined in IC 27-1-2-3(x)) that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1(a)) , or a health maintenance organization (as defined in IC 27-13-1-19) that has contracted to administer a self-funded plan shall provide claims data to the person for which the contract was entered into not later than fourteen (14) calendar days from a request for the claims data.**

**Sec. 2. A person described in section 1 of this chapter that willfully violates section 1 of this chapter commits an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4 and is subject to the penalties and procedures set forth in IC 27-4-1.**

SECTION 14. IC 27-4-1-4, AS AMENDED BY P.L.19-2022, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 4. (a) The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

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

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

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

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer,

or as to the legal reserve system upon which any life insurer operates;

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

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

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

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

(4) Entering into any agreement to commit, or individually or by a concerted action committing any act of boycott, coercion, or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

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

insurer in any book, report, or statement of such insurer.

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

(7) Making or permitting any of the following:

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

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

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

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

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

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

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

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

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

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense.

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first year or of any subsequent year of insurance

thereunder, which may be made retroactive only for such policy year.

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

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

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

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

(12) Requiring as a condition precedent to the sale of real or personal property under any contract of sale, conditional sales contract, or other similar instrument or upon the security of a chattel mortgage, that the buyer of such property negotiate any

policy of insurance covering such property through a particular insurance company, insurance producer, or broker or brokers. However, this subdivision shall not prevent the exercise by any seller of such property or the one making a loan thereon of the right to approve or disapprove of the insurance company selected by the buyer to underwrite the insurance.

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

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

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

(C) Title insurance.

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

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

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

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

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

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

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

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

(15) Refusing to insure an individual, refusing to continue to issue

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(33) Violating a requirement of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), that is enforceable by the state.

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

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

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

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

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

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

**(40) Violating IC 27-2-25.5-1 concerning the provision of claims data.**

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

(1) define; and

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

dishonest or predatory insurance practices.".

Renumber all SECTIONS consecutively.

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

(Reference is to HB 1004 as printed February 21, 2023.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 6, Nays 5.

COMMITTEE REPORT

Madam President: The Senate Committee on Appropriations, to which was referred House Bill No. 1004, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

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

"SECTION 1. IC 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.**".

Page 5, delete lines 39 through 42, begin a new paragraph and insert:

"**Sec. 6. (a) The payer affordability penalty fund is established for the purpose of receiving fines assessed under this chapter and the fines collected under IC 16-21-6-3 to be used for:**

**(1) the state's share of the Medicaid program; and**

**(2) a study of hospitals that are impacted by changes made in the disproportionate share hospital methodology payments set forth in Section 203 of the federal Consolidated Appropriations Act of 2021.**

**The office of the secretary shall report the results of the study described in subdivision (2) to the budget committee.**

**(b) The fund shall be administered by the office of the secretary of family and social services.**

**(c) The expenses of administering the fund shall be paid from money in the fund.**

**(d) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested. Interest that accrues from these investments shall be deposited in the fund.**

**(e) Money in the fund at the end of a state fiscal year does not revert to the state general fund.**

**(f) Money in the fund is continually appropriated.**".

Page 6, delete lines 1 through 12.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to EHB 1004 as printed April 7, 2023.)

MISHLER, Chairperson

Committee Vote: Yeas 11, Nays 0.