PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2022 Regular Session of the General Assembly.

HOUSE ENROLLED ACT No. 1004

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 2-5-47 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 47. Health Care Cost Oversight Task Force

Sec. 1. The definitions in IC 2-5-1.2 apply throughout this chapter.

Sec. 2. As used in this chapter, "task force" refers to the health care cost oversight task force established by section 4 of this chapter.

Sec. 3. The health care cost oversight task force is established.

Sec. 4. (a) The task force consists of the following members of the general assembly:

(1) Two (2) members of the house appointed by the speaker.

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

(3) Two (2) members of the senate appointed by the president pro tempore.

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

(b) A member of the task force serves at the pleasure of the appointing authority.

Sec. 5. Except when inconsistent with this chapter, IC 2-5-1.2 applies to the task force.

Sec. 6. (a) The president pro tempore shall appoint one (1) of the president pro tempore's appointments to serve as chairperson of the task force beginning January 1 of odd-numbered years and vice-chairperson beginning January 1 of even-numbered years.

(b) The speaker shall appoint one (1) of the speaker's appointments to serve as chairperson of the task force beginning January 1 of even-numbered years and vice-chairperson beginning January 1 of odd-numbered years.

(c) The task force shall meet at the call of the chairperson.

Sec. 7. The task force shall do the following:

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

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

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

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

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

(A) whether:

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

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

(B) contract tiering with health carriers;

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

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

(6) Study and make recommendations concerning whether medical consumers would benefit from prohibiting anti-competitive practices or otherwise encouraging increased competition among providers.

(7) Study and make recommendations concerning whether medical consumers overall would benefit from reestablishing the former Indiana comprehensive health insurance

association policies (IC 27-8-10).

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

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

(A) direct contracting;

(B) narrow networks; and

(C) insurance brokers.

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

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

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

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

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

Sec. 8. The following shall provide the task force the data, documents, and other information that the task force deems necessary to perform the task force's duties under section 7 of this chapter:

(1) The office of the secretary of family and social services.

(2) The Indiana department of health.

(3) The department of insurance.

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

Chapter 38. Health Reimbursement Arrangement Credit

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

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

(1) has any state tax liability; and

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

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

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

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

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

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

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

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

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

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

(b) The department shall record the time of filing of each return

claiming a credit under section 6 of this chapter and shall approve the claims if they otherwise qualify for a tax credit under this chapter, in the chronological order in which the claims are filed in the state fiscal year.

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

Sec. 8. (a) The amount of the credit provided by this chapter that a qualified taxpayer uses during a particular taxable year may not exceed the state tax liability of the qualified taxpayer.

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

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

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

SECTION 3. IC 6-3.1-40 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 40. Physician Practice Ownership Tax Credit

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

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

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

(1) Family medicine.

(2) General pediatric medicine.

(3) General internal medicine.

(4) The general practice of medicine.

Sec. 4. As used in this chapter, "state income tax liability" means the taxpayer's total tax liability that is incurred under

IC 6-3-1 through IC 6-3-7 (the adjusted gross income tax), as computed after the application of the credits that, under IC 6-3.1-1-2, are to be applied before the credit provided by this chapter.

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

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

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

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

(4) has any state income tax liability.

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

(1) is established as a legal entity under Indiana law after December 31, 2023;

(2) opens and begins to provide primary health care services to patients in a particular taxable year beginning after December 31, 2023; and

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

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

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

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

(b) A taxpayer may not assign any part of a credit to which the

taxpayer is entitled under this chapter.

Sec. 9. To obtain a credit under this chapter, a taxpayer must claim the credit on the taxpayer's annual state income tax return in the manner prescribed by the department. The taxpayer shall submit to the department all information that the department determines is necessary to verify the taxpayer's eligibility for the credit provided by this chapter.

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

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

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

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

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

SECTION 4. IC 12-8-6.5-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 13.5. (a) Before November 1, 2023, the office of the secretary shall research and compile data concerning the following:**

(1) The total Medicaid reimbursement for:

(A) inpatient hospital services;

(B) outpatient hospital and clinical services; and

(C) professional hospital services;

distinguishing base rates, supplemental payment rates, and any other payment that contributes to total Medicaid reimbursement for Indiana and all states in the United States.

(2) The national average Medicaid reimbursement rate for the services described in subdivision (1).

(b) Not later than December 1, 2023, the office shall prepare a report of the office's findings under subsection (a) and submit the report to:

(1) the health care cost oversight task force established by IC 2-5-47; and

(2) the general assembly in an electronic format under IC 5-14-6.

The report must include base Medicaid reimbursement rates for

each state and a comparison with Indiana base Medicaid reimbursement rates.

(c) This section expires January 1, 2024.

SECTION 5. IC 12-15-1-18.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 18.5. (a) The payer affordability penalty fund is established for the purpose of receiving fines collected under IC 16-21-6-3 and fines collected under IC 27-2-25.5 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 perform the study and provide 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.

(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.

SECTION 6. IC 16-18-2-86 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 86. "County", for ~~the~~ purposes of IC 16-22 **and IC 16-51-1,** means a county that owns and operates a county hospital.

SECTION 7. 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 8. 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 9. IC 16-18-2-182.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2023]: **Sec. 182.5. "Hospital system", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-4.**

SECTION 10. IC 16-18-2-188.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 188.2. "Individual provider form", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-5.**

SECTION 11. 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. "Institutional provider", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-6.**

SECTION 12. IC 16-18-2-190.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 190.8. "Institutional provider form", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-7.**

SECTION 13. IC 16-18-2-190.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 190.9. "Insurer", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-8.**

SECTION 14. IC 16-18-2-246 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 246. "Net patient revenue", for purposes of IC 16-21-6 **and IC 16-51,** has the meaning set forth in IC 16-21-6-2.

SECTION 15. IC 16-18-2-254.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 254.7. "Office setting", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-9.**

SECTION 16. 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 for 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 **and total number of paid claims**, **including providing the information as follows:**

(A) The net patient revenue and total number of paid claims for inpatient services for:

(i) Medicare;

(ii) Medicaid;

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

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services for:

(i) Medicare;

(ii) Medicaid;

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

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims for:

(i) Medicare;

(ii) Medicaid;

(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;

(iv) self-pay; and

(v) any other category of payer.

(8) Net patient revenue and total number of paid claims from facility fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from facility fees for:

(i) Medicare;

(ii) Medicaid;

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

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from facility fees for:

(i) Medicare;

(ii) Medicaid;

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

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue from facility fees provided from facility fees to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(9) Net patient revenue and total number of paid claims from professional fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from professional fees for:

(i) Medicare;

(ii) Medicaid;

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

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from professional fees for:

(i) Medicare;

(ii) Medicaid;

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

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims from professional fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

~~(8)~~ **(10)** 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)~~ **(11)** A statement itemizing donations.

~~(10)~~ **(12)** A statement describing the total cost of reimbursed and unreimbursed research.

~~(11)~~ **(13)** 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 12-15-1-18.5.

(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) through (a)(9) before December 1, 2023. This subsection expires December 31, 2023.

SECTION 17. IC 16-21-9-3.5 IS REPEALED [EFFECTIVE JULY 1, 2023]. ~~Sec. 3.5. (a) This section does not apply to the following:~~

~~(1) A nonprofit critical access hospital that is not:~~

~~(A) part of a hospital system; or~~

~~(B) an affiliate of a hospital or hospital system.~~

~~(2) A hospital that is established and operated under IC 16-22 or IC 16-23.~~

~~(b) Before December 31 of each year, a nonprofit hospital shall hold a public forum in which the nonprofit hospital, including the nonprofit hospital's board of directors, shall:~~

~~(1) obtain feedback from the community about the nonprofit hospital's performance in the previous year;~~

~~(2) discuss the pricing of health services provided at the nonprofit hospital; and~~

~~(3) discuss the contributions made by the nonprofit hospital to the community, including uncompensated care, charitable contributions, and any other charitable assistance programs.~~

~~(c) At least fourteen (14) days before the forum held under subsection (b), the nonprofit hospital shall post on the nonprofit hospital's Internet web site the following:~~

~~(1) A printed notice that:~~

~~(A) is designed, lettered, and featured on the Internet web site so as to be conspicuous to and readable by any individual with normal vision who visits the Internet web site;~~

~~(B) states the date, time, and location of the public forum to be held under subsection (b); and~~

~~(C) states that the purpose of the public forum is to provide members of the community with an opportunity to:~~

~~(i) comment on the nonprofit hospital's performance in the previous year;~~

~~(ii) discuss the pricing of health services provided at the nonprofit hospital; and~~

~~(iii) discuss the contributions made by the hospital to the community, including uncompensated care, charitable contributions, and any other charitable assistance programs.~~

~~(2) The following information relating to the subjects to be discussed at the public forum held under subsection (b):~~

~~(A) The nonprofit hospital's Indiana specific income statement for the previous calendar year that is prepared according to generally accepted accounting principles.~~

~~(B) Information concerning:~~

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

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

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

~~(d) The public forum requirement under this section may be held, either all or in part, through an interactive real time audio and video meeting that is accessible to the community through the Internet.~~

SECTION 18. 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. 0.5. This chapter is effective beginning January 1, 2025.

Sec. 1. (a) This chapter applies to an Indiana nonprofit hospital system.

(b) This chapter does not apply to the following:

(1) A hospital licensed under IC 16-21-2 that is operated by:

(A) a county;

(B) a city pursuant to IC 16-23; or

(C) the health and hospital corporation established under IC 16-22-8.

(2) A critical access hospital that meets the criteria under 42 CFR 485.601 through 42 CFR 485.647.

(3) A rural health clinic (as defined in 42 U.S.C. 1396d(l)(1)).

(4) A federally qualified health center (as defined in 42 U.S.C. 1396d(l)(2)(B)).

(5) An oncology treatment facility, even if owned or operated by a hospital.

(6) A health facility licensed under IC 16-28.

(7) A community mental health center certified under IC 12-21-2-3(5)(C).

(8) A private mental health institution licensed under IC 12-25, including a service facility location for a private mental health institution and reimbursed as a hospital-based outpatient service site.

(9) Services provided for the treatment of individuals with psychiatric disorders or chronic addiction disorders in:

(A) any part of a hospital, whether or not a distinct part; or

(B) an outpatient off campus site that is within thirty-five (35) miles of a hospital.

(10) Billing under the Medicare program or a Medicare advantage plan.

(11) Billing under the Medicaid program.

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, 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, "Indiana nonprofit hospital system" means a hospital that:

(1) 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:

(A) eligible for tax exempt bond financing; or

(B) exempt from state or local taxes;

(2) is licensed under IC 16-21-2;

(3) filed jointly one (1) hospital audited financial statement with the Indiana department of health in 2021; and

(4) has an annual patient service revenue of at least two billion dollars ($2,000,000,000) based on the hospital system's 2021 audited financial statement filed with the Indiana department of health. As used in this subdivision, "patient service revenue" includes similar terms, including net patient service revenue and patient care service revenue.

Sec. 5. (a) As used in this chapter, "individual provider form" means a medical claim form that:

(1) is accepted by the federal Centers for Medicare and Medicaid Services for use by individual providers or groups of providers; and

(2) includes a claim field for disclosure of the site at which the health care services to which the form relates were provided.

(b) The term includes the following:

(1) The CMS-1500 form or its successor form.

(2) The HCFA-1500 form or its successor form.

(3) The HIPAA X12 837P electronic claims transaction for professional services, or its successor transaction.

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

(1) Except as provided in section 1 of this chapter, a hospital.

(2) An end stage renal disease provider.

(3) A home health agency.

(4) A hospice organization.

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

(6) A comprehensive outpatient rehabilitation facility.

(7) A histocompatibility laboratory.

(8) An organ procurement organization.

(9) A religious nonmedical health care institution.

Sec. 7. (a) As used in this chapter, "institutional provider form" means a medical claim form that:

(1) is accepted by the federal Centers for Medicare and Medicaid Services for use by institutional providers; and

(2) does not include a claim field for disclosure of the site at which the health care services to which the form relates were provided.

(b) The term includes the following:

(1) The HIPAA X12 837I institutional form or its successor

form.

(2) The CMS-1450 form or its successor form.

(3) The UB-04 form or its successor form.

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

Sec. 9. As used in this chapter, "office setting" means a location of a qualified provider where health care services are provided and that:

(1) is located more than two hundred fifty (250) yards from the main building of any hospital owned in whole or in part by the Indiana nonprofit hospital system; and

(2) is where a qualified provider routinely provides health examinations, diagnosis, or non-invasive treatment of illness or injury on an ambulatory basis.

Sec. 10. As used in this chapter, "qualified provider" means an individual or entity owned in whole or in part by an Indiana nonprofit hospital system and that is duly licensed or legally authorized to provide health care services.

Sec. 11. (a) A bill for health care services provided by a qualified provider in an office setting:

(1) may not be submitted on an institutional provider form; and

(2) must be submitted on an individual provider form.

(b) An insurer, health maintenance organization, employer, or other person responsible for the payment of the cost of health care services provided by a qualified provider in an office setting shall not accept a bill for the health care services that is submitted on an institutional provider form.

Sec. 12. The state department shall adopt rules under IC 4-22-2 for the enforcement of this chapter.

SECTION 19. IC 27-1-37.6 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

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

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

Sec. 2. As used in this chapter, "capitated rate reimbursement arrangement" means a fixed amount of money per patient per unit

of time paid in advance to the health care provider for the delivery of health care services.

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

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

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

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

(A) diagnoses;

(B) medicines;

(C) tests;

(D) allergies; and

(E) treatment plans.

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

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

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

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

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

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

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

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

(2) authorized to provide health care services; and

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

Sec. 8. (a) As used in this chapter, "health care service" means a medical or surgical service for the diagnosis, prevention,

treatment, cure, or relief of illness, injury, or disease that is measured at the diagnosis and procedure level for an individual health care provider.

(b) The term does not include the following:

(1) Dental services.

(2) Vision services.

(3) Long term rehabilitation treatment.

(4) Pharmaceutical or pharmacist services or products.

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

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

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

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

(b) The term includes the following:

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

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

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

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

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

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

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

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

Sec. 12. As used in this chapter, "prior authorization" means a

practice implemented by a health plan through which coverage of a health care service is dependent on the covered individual or health care provider obtaining approval from the health plan before the health care service is rendered. The term includes prospective or utilization review procedures conducted before a health care service is rendered.

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

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

Sec. 15. (a) As used in this chapter, "value based health care reimbursement agreement" may include the following:

(1) An accountable care organization that has a contract with a health plan in which the health plan:

(A) does not assume risk for prior authorization to a provider organization; or

(B) delegates risk to a provider organization to manage prior authorization.

(2) Bundled payments.

(3) A capitated rate reimbursement arrangement.

(4) A pay for performance arrangement.

(5) Any other health care reimbursement arrangement in which the health care provider accepts at most ten percent (10%) of the downside risk.

(b) The term does not include any of the following:

(1) Narrow networks.

(2) Fixed fee schedules.

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

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

(2) an electronic medical records access agreement;

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

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

(b) If a health plan determines that a health care provider is

qualified to participate in a program established under section 16 of this chapter, the health plan shall send a notice to the health care provider that contains the following information:

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

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

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

SECTION 20. IC 27-1-44.6-10, AS ADDED BY P.L.195-2021, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 10. (a) The advisory board may make recommendations to the executive director and administrator regarding the data base that:

(1) include specific strategies to measure and collect data related to health care safety and quality, utilization, health outcomes, and cost;

(2) focus on data elements that foster quality improvement and peer group comparisons;

(3) facilitate value based, cost effective purchasing of health care services by public and private purchasers and consumers;

(4) result in usable and comparable information that allows public and private health care purchasers, consumers, and data analysts to identify and compare health plans, health insurers, health care facilities, and health care providers regarding the provision of safe, cost effective, high quality health care services;

(5) use and build upon existing data collection standards and methods to establish and maintain the data base in a cost effective and efficient manner;

(6) are designed to measure the following performance domains:

(A) safety;

(B) timeliness;

(C) effectiveness;

(D) efficiency;

(E) equity; and

(F) patient centeredness;

(7) incorporate and utilize claims, eligibility, and other publicly available data to the extent it is the most cost effective method of collecting data to minimize the cost and administrative burden on

data sources;

(8) include recommendations about whether to include data on the uninsured;

(9) discuss the harmonization of the data base with other state, regional, and federal efforts concerning all payer claims data bases;

(10) discuss the harmonization of the data base with federal legislation concerning all payer claims data bases;

(11) discuss a limit on the number of times the executive director and administrator may require submission of the required data elements;

(12) discuss a limit on the number of times the executive director and administrator may change the required data elements for submission in a calendar year considering administrative costs, resources, and time required to fulfill the requests; ~~and~~

(13) discuss compliance with the federal Health Insurance Portability and Accountability Act (42 U.S.C. 201 et seq.), as amended, and other proprietary information related to collection and release of data;

(14) discuss comparing Indiana's health insurance premium rates, Medicaid reimbursement rates, and Medicare reimbursement rates with all other states; and

(15) discuss auditing and comparing Indiana's health insurance reimbursement claim denials with all other states.

(b) The advisory board shall make recommendations to the executive director regarding how the ongoing oversight of the operations of the data base should function, including where the data base should be housed.

(c) Any recommendations or actions by the advisory board are subject to the approval of the commissioner.

SECTION 21. 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:

(1) 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:

(A) eligible for tax exempt bond financing; or

(B) exempt from state or local taxes;

(2) is licensed under IC 16-21-2;

(3) filed jointly one (1) hospital audited financial statement with the Indiana department of health in 2021; and

(4) has an annual patient service revenue of at least two billion dollars ($2,000,000,000) based on the hospital system's 2021 audited financial statement filed with the Indiana department of health. As used in this subdivision, "patient service revenue" includes similar terms, including net patient service revenue and patient care service revenue.

(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. As used in this chapter, "prices" means allowables that are paid for patient care services.

Sec. 5. The department shall contract with a third party to do the following:

(1) Calculate an Indiana nonprofit hospital system's prices from the commercially insured market, categorized by:

(A) self-funded plan prices;

(B) fully-funded plan prices;

(C) the individual market prices; and

(D) the total combined prices of clauses (A) through (C);

expressed as a percentage of how much Medicare would have paid for the same services for the 2021 calendar year, the 2022 calendar year, and the 2023 calendar year.

(2) Not later than December 1, 2024, prepare a report of the findings in subdivision (1) and submit the report to the following:

(A) The department.

(B) The health care cost oversight task force established by IC 2-5-47.

(C) The budget committee for review.

Sec. 6. (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 or the department's third party contractor 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) Except as provided in section 8 of this chapter, 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. 7. (a) The department shall contract with a third party to make the calculations required by this section. The third party contractor shall make the calculations described in subsection (b) concerning an Indiana nonprofit hospital system's prices from the commercially insured market, categorized by:

(1) self-funded plan prices;

(2) fully-funded plan prices;

(3) the individual market prices; and

(4) the total combined prices of subdivisions (1) through (3);

expressed as a percentage of how much Medicare would have paid for the same services.

(b) Before November 1, 2024, and before November 1 of each subsequent year, the department's third party contractor shall

compare:

(1) hospital inpatient prices;

(2) hospital outpatient prices; and

(3) practitioner services prices;

calculated separately and combined in total as a percentage of Medicare for all patient care services provided to the commercially insured market. The third party contractor shall make these calculations for each Indiana nonprofit hospital within an Indiana nonprofit hospital system and for the Indiana nonprofit hospital system, expressed as a percentage of how much Medicare would have paid for the same services in comparison to what two hundred eighty-five percent (285%) of Medicare would have been for the same services.

(c) The department and the department's third party contractor shall review the data and resources submitted concerning prices in Indiana specific to each Indiana nonprofit hospital system.

Sec. 8. Before December 1, 2024, and before December 1 of each subsequent year, the department shall submit a report of the third party contractor's findings in section 7 of this chapter in an electronic format under IC 5-14-6 to the health care cost oversight task force established by IC 2-5-47.

Sec. 9. Information under this chapter must be provided in accordance with the federal Health Insurance Portability and Accountability Act,

SECTION 22. 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) Not more than twice annually for a contract holder, 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 group plan or a fully insured group plan shall provide claims data to the contract holder for which the contract was entered into not later than fifteen (15) business days from a request for the claims data. The claims data must include the following:

(1) The effective date of coverage.

(2) The total number of covered individuals.

(3) The total monthly earned premium.

(4) The total monthly dollar value of paid claims, regardless

of the period in which the claims were incurred.

(5) The:

(A) beginning and ending date of the period for which claims were paid; and

(B) percentage of claims that were paid in:

(i) less than thirty (30) days;

(ii) thirty (30) days to sixty (60) days;

(iii) sixty-one (61) days to ninety (90) days; and

(iv) over ninety (90) days.

(6) For groups insuring at least one hundred (100) employees:

(A) the reserve value as of the beginning of the period; and

(B) the reserve value as of the date through which the paid claims data was obtained.

(7) A description of each large or catastrophic claim exceeding fifty thousand dollars ($50,000), including:

(A) the diagnosis;

(B) the dollar amount of the claim;

(C) whether the claim is opened or closed; and

(D) the length of time the claim was open.

(8) Any other claims data requested by the contract holder.

(b) The department may prescribe the format and manner for the submission of the data described in subsection (a) with the purpose of ensuring that the information is provided in an easily readable manner.

(c) Information provided under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act, including 45 CFR Part 160 and Part 164, Subparts A and E.

Sec. 2. (a) The department may assess a third party administrator, an insurer, or a health maintenance organization that violates section 1 of this chapter a fine of one thousand dollars ($1,000) per day for which the claims data is provided after the time frame set forth in section 1 of this chapter. A fine collected under this section shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

(b) A person described in this section may appeal a fine assessed under this section in the manner prescribed by the department.

SECTION 23. 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 24. 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).

SECTION 25. **An emergency is declared for this act.**

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: _____ Time: _____