HOUSE BILL No. 1291

DIGEST OF INTRODUCED BILL

Citations Affected: IC 16-21-6-3; IC 27-8-5-1.5; IC 27-13-20-1.5.

Synopsis: Information about health care and health coverage. Amends the law requiring a hospital to file an annual report with the Indiana department of health: (1) to require that a hospital's report also be filed with the all payer claims data base; and (2) to require a hospital to include in the report additional information concerning the hospital's medical loss ratio, the total funding received by the hospital under the CARES Act, and other matters. Requires the insurance commissioner, when deciding whether to approve a premium rate increase or decrease for an accident and sickness insurance policy or an increase or decrease in the rates to be used by a health maintenance organization (HMO), to consider the median cost sharing for the affected insurance policy or HMO contract, the benefits provided under the policy or contract, the underlying costs of the health services covered by the policy or contract, and other matters.

Effective: July 1, 2023.

Carbaugh

January 11, 2023, read first time and referred to Committee on Insurance.

Introduced

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

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

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

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

HOUSE BILL No. 1291

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

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

1 SECTION 1. IC 16-21-6-3, AS AMENDED BY P.L.2-2007,
2 SECTION 190, IS AMENDED TO READ AS FOLLOWS
3 [EFFECTIVE JULY 1, 2023]: Sec. 3. (a) Each hospital shall file with
4 the state department **and the all payer claims data base created**
5 **under IC 27-1-44.5** a report for the preceding fiscal year within one
6 hundred twenty (120) days after the end of the hospital's fiscal year.
7 The state department shall grant an extension of the time to file the
8 report if the hospital shows good cause for the extension. **Subject to**
9 **subsection (d),** the report must contain the following:
10 (1) A copy of the hospital's balance sheet, including a statement
11 describing the hospital's total assets and total liabilities.
12 (2) A copy of the hospital's income statement.
13 (3) A statement of changes in financial position.
14 (4) A statement of changes in fund balance.
15 (5) Accountant notes pertaining to the report.
16 (6) A copy of the hospital's report required to be filed annually
17 under 42 U.S.C. 1395g, and other appropriate utilization and

1 financial reports required to be filed under federal statutory law.
2 (7) Net patient revenue.
3 (8) A statement including:
4 (A) Medicare gross revenue;
5 (B) Medicaid gross revenue;
6 (C) other revenue from state programs;
7 (D) revenue from local government programs;
8 (E) local tax support;
9 (F) charitable contributions;
10 (G) other third party payments;
11 (H) gross inpatient revenue;
12 (I) gross outpatient revenue;
13 (J) contractual allowance;
14 (K) any other deductions from revenue;
15 (L) charity care provided;
16 (M) itemization of bad debt expense; and
17 (N) an estimation of the unreimbursed cost of subsidized
18 health services.
19 (9) A statement itemizing donations.
20 (10) A statement describing the total cost of reimbursed and
21 unreimbursed research.
22 (11) A statement describing the total cost of reimbursed and
23 unreimbursed education separated into the following categories:
24 (A) Education of physicians, nurses, technicians, and other
25 medical professionals and health care providers.
26 (B) Scholarships and funding to medical schools, and other
27 postsecondary educational institutions for health professions
28 education.
29 (C) Education of patients concerning diseases and home care
30 in response to community needs.
31 (D) Community health education through informational
32 programs, publications, and outreach activities in response to
33 community needs.
34 (E) Other educational services resulting in education related
35 costs.
36 **(12) A statement of the hospital's medical loss ratio expressed**
37 **as the median total reimbursement for all health**
38 **reimbursement claims received, plus health quality expenses,**
39 **divided by the total operational income minus applicable taxes**
40 **(except for taxes paid on investment income).**
41 **(13) A statement of the total median reimbursement received**
42 **by the hospital for drugs designated under Section 340B of the**

1 **Public Health Service Act (42 U.S.C. 256b), expressed as a**
2 **ratio of the median costs paid for those drugs in the**
3 **aggregate.**
4 **(14) A statement of the total funding received by the hospital**
5 **under the Coronavirus, Aid, Relief, and Economic Security**
6 **(CARES) Act (P.L. 116-136), from the earliest remittance**
7 **until the end of the funding. Reporting under this subdivision**
8 **is not required after the last calendar year in which the**
9 **hospital receives CARES Act funding.**
10 **(15) A statement of the total annual charge master ratio for**
11 **services rendered by the hospital to the median cost for total**
12 **health care services rendered by the hospital in the reporting**
13 **year.**
14 **(16) A statement of the total median reimbursement to total**
15 **cost ratio of specialty drugs infused in a hospital clinic in a**
16 **patient setting or outpatient setting.**
17 (b) The information in the report filed under subsection (a) must be
18 provided from reports or audits certified by an independent certified
19 public accountant or by the state board of accounts.
20 **(c) The information contained in a hospital's report under**
21 **subsection (a)(8)(L) must express:**
22 **(1) the charity care provided by the hospital as a valuation of**
23 **the total charge master rate for services in the aggregate; and**
24 **(2) the care reimbursement that the hospital would have**
25 **received if the charity care had been reimbursed, expressed as**
26 **the median reimbursement.**
27 **(d) A hospital is not required to include the information**
28 **described in subsection (a)(12) through (a)(16) in a report filed**
29 **under this section if the hospital:**
30 **(1) meets the conditions set forth in 42 U.S.C. 1395i–4(e) to be**
31 **designated by the Centers for Medicare and Medicaid**
32 **Services as a critical access hospital; or**
33 **(2) is a county hospital subject to IC 16-22.**
34 SECTION 2. IC 27-8-5-1.5, AS AMENDED BY P.L.124-2018,
35 SECTION 76, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
36 JULY 1, 2023]: Sec. 1.5. (a) This section applies to a policy of accident
37 and sickness insurance issued on an individual, a group, a franchise, or
38 a blanket basis, including a policy issued by an assessment company or
39 a fraternal benefit society.
40 (b) As used in this section, "commissioner" refers to the insurance
41 commissioner appointed under IC 27-1-1-2.
42 (c) As used in this section, "grossly inadequate filing" means a

1 policy form filing:
2 (1) that fails to provide key information, including state specific
3 information, regarding a product, policy, or rate; or
4 (2) that demonstrates an insufficient understanding of applicable
5 legal requirements.
6 (d) As used in this section, "policy form" means a policy, a contract,
7 a certificate, a rider, an endorsement, an evidence of coverage, or any
8 amendment that is required by law to be filed with the commissioner
9 for approval before use in Indiana.
10 (e) As used in this section, "type of insurance" refers to a type of
11 coverage listed on the National Association of Insurance
12 Commissioners Uniform Life, Accident and Health, Annuity and Credit
13 Product Coding Matrix under the heading "Continuing Care Retirement
14 Communities", "Health", "Long Term Care", or "Medicare
15 Supplement".
16 (f) Each person having a role in the filing process described in
17 subsection (i) shall act in good faith and with due diligence in the
18 performance of the person's duties.
19 (g) A policy form, including a policy form of a policy, contract,
20 certificate, rider, endorsement, evidence of coverage, or amendment
21 that is issued through a health benefit exchange (as defined in
22 IC 27-19-2-8), may not be issued or delivered in Indiana unless the
23 policy form has been filed with and approved by the commissioner.
24 (h) The commissioner shall do the following:
25 (1) Create a document containing a list of all product filing
26 requirements for each type of insurance, with appropriate
27 citations to the law, administrative rule, or bulletin that specifies
28 the requirement, including the citation for the type of insurance
29 to which the requirement applies.
30 (2) Make the document described in subdivision (1) available on
31 the department of insurance Internet site.
32 (3) Update the document described in subdivision (1) at least
33 annually and not more than thirty (30) days following any change
34 in a filing requirement.
35 (i) The filing process is as follows:
36 (1) A filer shall submit a policy form filing that:
37 (A) includes a copy of the document described in subsection
38 (h);
39 (B) indicates the location within the policy form or supplement
40 that relates to each requirement contained in the document
41 described in subsection (h); and
42 (C) certifies that the policy form meets all requirements of

1 state law.
2 (2) The commissioner shall review a policy form filing and, not
3 more than thirty (30) days after the commissioner receives the
4 filing under subdivision (1):
5 (A) approve the filing; or
6 (B) provide written notice of a determination:
7 (i) that deficiencies exist in the filing; or
8 (ii) that the commissioner disapproves the filing.
9 A written notice provided by the commissioner under clause (B)
10 must be based only on the requirements set forth in the document
11 described in subsection (h) and must cite the specific
12 requirements not met by the filing. A written notice provided by
13 the commissioner under clause (B)(i) must state the reasons for
14 the commissioner's determination in sufficient detail to enable the
15 filer to bring the policy form into compliance with the
16 requirements not met by the filing.
17 (3) A filer may resubmit a policy form that:
18 (A) was determined deficient under subdivision (2) and has
19 been amended to correct the deficiencies; or
20 (B) was disapproved under subdivision (2) and has been
21 revised.
22 A policy form resubmitted under this subdivision must meet the
23 requirements set forth as described in subdivision (1) and must be
24 resubmitted not more than thirty (30) days after the filer receives
25 the commissioner's written notice of deficiency or disapproval. If
26 a policy form is not resubmitted within thirty (30) days after
27 receipt of the written notice, the commissioner's determination
28 regarding the policy form is final.
29 (4) The commissioner shall review a policy form filing
30 resubmitted under subdivision (3) and, not more than thirty (30)
31 days after the commissioner receives the resubmission:
32 (A) approve the resubmitted policy form; or
33 (B) provide written notice that the commissioner disapproves
34 the resubmitted policy form.
35 A written notice of disapproval provided by the commissioner
36 under clause (B) must be based only on the requirements set forth
37 in the document described in subsection (h), must cite the specific
38 requirements not met by the filing, and must state the reasons for
39 the commissioner's determination in detail. The commissioner's
40 approval or disapproval of a resubmitted policy form under this
41 subdivision is final, except that the commissioner may allow the
42 filer to resubmit a further revised policy form if the filer, in the

filer's resubmission under subdivision (3), introduced new provisions or materially modified a substantive provision of the policy form. If the commissioner allows a filer to resubmit a further revised policy form under this subdivision, the filer must resubmit the further revised policy form not more than thirty (30) days after the filer receives notice under clause (B), and the commissioner shall issue a final determination on the further revised policy form not more than thirty (30) days after the commissioner receives the further revised policy form.

(5) If the commissioner disapproves a policy form filing under this subsection, the commissioner shall notify the filer, in writing, of the filer's right to a hearing as described in subsection ~~(m).~~ **(r).** A disapproved policy form filing may not be used for a policy of accident and sickness insurance unless the disapproval is overturned in a hearing conducted under this subsection.

(6) If the commissioner does not take any action on a policy form that is filed or resubmitted under this subsection in accordance with any applicable period specified in subdivision (2), (3), or (4), the policy form filing is considered to be approved.

(j) Except as provided in this subsection, the commissioner may not disapprove a policy form resubmitted under subsection (i)(3) or (i)(4) for a reason other than a reason specified in the original notice of determination under subsection (i)(2)(B). The commissioner may disapprove a resubmitted policy form for a reason other than a reason specified in the original notice of determination under subsection (i)(2) if:

(1) the filer has introduced a new provision in the resubmission;

(2) the filer has materially modified a substantive provision of the policy form in the resubmission;

(3) there has been a change in requirements applying to the policy form; or

(4) there has been reviewer error and the written disapproval fails to state a specific requirement with which the policy form does not comply.

(k) The commissioner may return a grossly inadequate filing to the filer without triggering a deadline set forth in this section.

(l) The commissioner may disapprove a policy form if:

(1) the benefits provided under the policy form are not reasonable in relation to the premium charged; or

(2) the policy form contains provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.

(m) Before approving or disapproving a premium rate increase or decrease, the commissioner shall consider the following:

(1) The products affected, by line of business.

(2) The number of covered lives affected.

(3) Whether the product is open or closed to new members in the product block.

(4) Applicable median cost sharing for the product, as allowed by state or federal law.

(5) The benefits provided and the underlying costs of the health services rendered.

(6) The implementation date of the increase or decrease.

(7) The overall percent premium rate increase or decrease that is requested.

(8) The actual percent premium rate increase or decrease to be approved.

(9) Incurred claims paid each year for the past three (3) years, if applicable.

(10) Earned premiums for each of the past three (3) years, if applicable.

(11) Projected medical cost trends in the geographic service region, if the product for which a rate increase or decrease is requested is not a product offered statewide.

(12) If applicable, historical rebates paid to the policyholder from the most recent health plan year under 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).

(13) The median cost sharing amount for an individual covered by the product, or the actuarial value information as required under the Patient Protection and Affordable Care Act, if applicable.

(n) The commissioner shall not approve a new product unless the commissioner has, at a minimum, considered the matters set forth in subsection (m)(1) through (m)(13).

(o) The information compiled, prepared, and considered by the commissioner under subsection (m)(1) through (m)(13) is subject to the requirements of IC 5-14-3. However, the commissioner's approval of a new product or a rate increase or decrease may take effect before the information compiled, prepared, and considered by the commissioner under subsection (m)(1) through (m)(13) is made accessible to the public under IC 5-14-3.

(p) When considering whether to approve a premium rate

increase, the commissioner shall consider whether the current rate is appropriate for achieving the insurer's target loss ratio.

(q) To the extent authorized by the Patient Protection and Affordable Care Act and other federal law, the commissioner, under this section, may:

(1) consider network adequacy;

(2) conduct form review to ensure:

(A) minimum essential health benefits; and

(B) nondiscriminatory benefit design;

(3) perform accreditation confirmation; and

(4) confirm quality measures.

~~(m)~~ **(r)** Upon disapproval of a filing under this section, the commissioner shall provide written notice to the filer or insurer of the right to a hearing within twenty (20) days of a request for a hearing.

~~(n)~~ **(s)** Unless a policy form approved under this chapter contains a material error or omission, the commissioner may not:

(1) retroactively disapprove the policy form; or

(2) examine the filer of the policy form during a routine or targeted market conduct examination for compliance with a policy form filing requirement that was not in existence at the time the policy form was filed.

SECTION 3. IC 27-13-20-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 1.5. (a) Before approving or disapproving an increase or decrease in the rates to be used by a health maintenance organization, the commissioner shall review the following:**

(1) The products affected, by line of business.

(2) The number of covered lives affected.

(3) Whether the product is open or closed to new members in the product block.

(4) Applicable median cost sharing for the product, as allowed by state or federal law.

(5) The benefits provided and the underlying costs of the health services rendered.

(6) The implementation date of the increase or decrease.

(7) The overall percent premium rate increase or decrease that is requested.

(8) The actual percent premium rate increase or decrease to be approved.

(9) Incurred claims paid each year for the past three (3) years, if applicable.

1 **(10) Earned premiums for each of the past three (3) years, if**
2 **applicable.**
3 **(11) Projected medical cost trends in the geographic service**
4 **region, if the product for which a rate increase or decrease is**
5 **requested is not a product offered statewide.**
6 **(12) If applicable, historical rebates paid to the enrollee from**
7 **the most recent health plan year under the federal Patient**
8 **Protection and Affordable Care Act (P.L. 111-148), as**
9 **amended by the federal Health Care and Education**
10 **Reconciliation Act of 2010 (P.L. 111-152).**
11 **(13) The median cost sharing amount for a member enrolled**
12 **in the product, or the actuarial value information as required**
13 **under the Patient Protection and Affordable Care Act, if**
14 **applicable.**
15 **(b) The commissioner shall not approve a rate increase or**
16 **decrease for an existing product unless the commissioner has, at a**
17 **minimum, considered the matters set forth in subsection (a)(1)**
18 **through (a)(13).**
19 **(c) The information compiled, prepared, and considered by the**
20 **commissioner under subsection (a)(1) through (a)(13) is subject to**
21 **the requirements of IC 5-14-3. However, the commissioner's**
22 **approval of a rate increase or decrease may take effect before the**
23 **information compiled, prepared, and considered by the**
24 **commissioner under subsection (a)(1) through (a)(13) is made**
25 **accessible to the public under IC 5-14-3.**
26 **(d) When considering whether to approve a premium rate**
27 **increase, the commissioner shall consider whether the current rate**
28 **is appropriate for achieving the target loss ratio of the health**
29 **maintenance organization.**
30 **(e) To the extent authorized by the Patient Protection and**
31 **Affordable Care Act and other federal law, the commissioner,**
32 **under this section, may:**
33 **(1) consider network adequacy;**
34 **(2) conduct form review to ensure:**
35 **(A) minimum essential health benefits; and**
36 **(B) nondiscriminatory benefit design;**
37 **(3) perform accreditation confirmation; and**
38 **(4) confirm quality measures.**