January 30, 2024

HOUSE BILL No. 1327

DIGEST OF HB 1327 (Updated January 30, 2024 12:26 pm - DI 147)

Citations Affected: IC 12-15; IC 16-18; IC 16-19; IC 25-22.5; IC 27-1; IC 27-2; IC 27-4.

Synopsis: Health and insurance matters. Requires reporting of certain ownership information by: (1) a hospital to the Indiana department of health (state department); (2) a physician group practice to the professional licensing agency; and (3) an insurer, a third party administrator, and a pharmacy benefit manager to the department of insurance. Requires the professional licensing agency and the department of insurance to provide the ownership information to the state department. Requires the state department to post the ownership information on the state department's website. Sets forth penalties for a violation of the ownership reporting requirements. Allows a contract holder to request an audit of a pharmacy benefit manager at least two times in a calendar year. Requires a contract with a third party administrator, pharmacy benefit manager, or prepaid health care delivery plan to provide that the plan sponsor has ownership of the claims data. Allows a plan sponsor that contracts with a third party administrator, the office of the secretary of family and social services that contracts with a managed care organization to provide services to a Medicaid recipient, or the state personnel department that contracts with a prepaid health care delivery plan to provide group health coverage for state employees to request an audit at least two times in a calendar year. Provides that a violation of the requirements concerning audits of a third party administrator, managed care organization, or prepaid health care delivery plan is an unfair or deceptive act or practice in the business of insurance and allows the department of insurance to adopt rules to set forth fines for a violation.

Effective: Upon passage; July 1, 2024.

Schaibley, Barrett, McGuire, Shackleford

January 10, 2024, read first time and referred to Committee on Public Health.
January 30, 2024, amended, reported — Do Pass.

January 30, 2024

Second Regular Session of the 123rd General Assembly (2024)

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 2023 Regular Session of the General Assembly.

HOUSE BILL No. 1327

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

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

SECTION 1. IC 12-15-1-18.5, AS ADDED BY P.L.203-2023, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 18.5. (a) The payer affordability penalty fund is established for the purpose of receiving fines collected under **IC 16-19-18-5,** IC 16-21-6-3, **IC 25-22.5-18-5, IC 27-1-4.5-7,** 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 2. IC 16-18-2-79.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 79.1. "Controlling", for purposes of IC 16-19-18, has the meaning set forth in IC 16-19-18-1.**

SECTION 3. IC 16-18-2-282.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 282.3. "Physician group practice", for purposes of IC 16-19-18, has the meaning set forth in IC 16-19-18-2.**

SECTION 4. IC 16-19-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 18. Disclosure of Ownership Information

Sec. 1. As used in this chapter, "controlling" has the meaning set forth in IC 23-1-43-8.

Sec. 2. As used in this chapter, "physician group practice" means a physician practice that:

(1) has at least one (1) physical location in Indiana; and

(2) includes as practitioners two (2) or more physicians licensed under IC 25-22.5, regardless of the ownership structure of the practice.

Sec. 3. (a) Before July 1, 2024, and each July 1 thereafter, each hospital that does business in Indiana shall file with the state department a report that includes the following information:

(1) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the hospital.

(2) The business address of each person or entity identified under subdivision (1). The business address must include a:

(A) building number;

(B) street name;
(C) city name;
(D) zip code; and
(E) country name.

The business address may not include a post office box number.

(3) The business website, if applicable, of each person or entity identified under subdivision (1).

(4) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (1):

(A) National provider identifier (NPI).
(B) Taxpayer identification number (TIN).
(C) Employer identification number (EIN).
(D) CMS certification number (CCN).
(E) National Association of Insurance Commissioners (NAIC) identification number.
(F) A personal identification number associated with a license issued by the department of insurance.

A report provided under this section may not include the Social Security number of any individual.

(b) The state department may not charge a fee for a report submitted under this section.

Sec. 4. (a) The state department shall cooperate with the Indiana professional licensing agency and the department of insurance to develop and implement a plan to:

(1) collect the information described in section 3 of this chapter, IC 25-22.5-18-3, and IC 27-1-4.5-5; and
(2) make the information publicly available as set forth in this section.

(b) Before December 1 of each year, the state department shall publicly post the information:

(1) collected under section 3 of this chapter; and
(2) received from the:

(A) Indiana professional licensing agency under IC 25-22.5-18-4; or
(B) department of insurance under IC 27-1-4.5-6;

on the state department's website.

Sec. 5. (a) The state department may assess a hospital that violates section 3 of this chapter a fine of one thousand dollars ($1,000) per day for which the report is past due.

(b) A fine under this section shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

(c) The state department may waive a fine assessed under this section.

(d) The state health commissioner may take action against a hospital under IC 16-21-3 for repeated violations of section 3 of this chapter.

Sec. 6. (a) Before December 1 of each year, the state department shall submit to the legislative council an annual report of the:

(1) violations assessed; and

(2) fines waived;

under section 5 of this chapter in the previous calendar year.

(b) A report described in this section must be submitted in an electronic format under IC 5-14-6.

Sec. 7. (a) Before July 1, 2024, the state department shall issue a notice or bulletin on at least two (2) occasions to notify hospitals of the reporting requirements set forth in this chapter.

(b) A notice or bulletin issued under this section must be posted on the state department's website in a manner that is easily accessible to hospitals.

SECTION 5. IC 25-22.5-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 18. Disclosure of Ownership Information

Sec. 1. As used in this chapter, "controlling" has the meaning set forth in IC 23-1-43-8.

Sec. 2. As used in this chapter, "physician group practice" means a physician practice that:

(1) has at least one (1) physical location in Indiana; and

(2) includes as practitioners two (2) or more physicians licensed under this article, regardless of the ownership structure of the practice.

Sec. 3. (a) Before July 1, 2024, and each July 1 thereafter, each physician group practice that does business in Indiana shall file with the agency a report that includes the following information:

(1) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the physician group practice.

(2) The business address of each person or entity identified under subdivision (1). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) zip code; and

(E) country name.

The business address may not include a post office box number.

(3) The business website, if applicable, of each person or entity identified under subdivision (1).

(4) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (1):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a license issued by the department of insurance.

A report provided under this section may not include the Social Security number of any individual.

(b) The agency may not charge a fee for a report submitted under this section.

Sec. 4. (a) The agency shall cooperate with the Indiana department of health and the department of insurance to develop and implement a plan to:

(1) collect the information described in section 3 of this chapter, IC 16-19-18-3, and IC 27-1-4.5-5; and

(2) make the information publicly available as set forth in IC 16-19-18-4.

(b) Before September 1 of each year, the agency shall provide the information collected under section 3 of this chapter to the Indiana department of health.

Sec. 5. (a) The agency may assess a physician group practice that:

(1) has more than five (5) physicians as practitioners in the physician group practice; and

(2) violates section 3 of this chapter;

a fine of one thousand dollars ($1,000) per day for which the report is past due.

(b) The agency may assess a physician group practice that:

(1) has five (5) physicians or less as practitioners in the physician group practice; and

(2) violates section 3 of this chapter;

a fine of one hundred dollars ($100) per day for which the report is past due. A fine assessed under this subsection may not exceed ten thousand dollars ($10,000) in a calendar year.

(c) A fine under this section shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

(d) The agency may waive a fine assessed under this section.

(e) The board may take disciplinary action against a licensee for repeated violations of section 3 of this chapter.

Sec. 6. (a) Before December 1 of each year, the agency shall submit to the legislative council an annual report of the:

(1) violations assessed; and

(2) fines waived;

under section 5 of this chapter in the previous calendar year.

(b) A report described in this section must be submitted in an electronic format under IC 5-14-6.

Sec. 7. (a) Before July 1, 2024, the agency shall issue a notice or bulletin on at least two (2) occasions to notify physician group practices of the reporting requirements set forth in this chapter.

(b) A notice or bulletin issued under this section must be posted on the agency's website in a manner that is easily accessible to physician group practices.

SECTION 6. IC 27-1-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 4.5. Disclosure of Ownership Information

Sec. 1. As used in this chapter, "controlling" has the meaning set forth in IC 23-1-43-8.

Sec. 2. As used in this chapter, "insurer" includes the following:

(1) 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)). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(2) 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 managed care organization (as defined in IC 12-7-2-126.9) that provides services to a Medicaid recipient.

(4) A prepaid health care delivery plan under IC 5-10-8-7(c) that provides group health coverage for state employees.

Sec. 3. As used in this chapter, "pharmacy benefit manager" has the meaning set forth in IC 27-1-24.5-12.

Sec. 4. As used in this chapter, "third party administrator" means an individual or entity that performs administrative services for an insurer or a self-funded health benefit plan, including:

(1) a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.); and

(2) a self-insurance program established under IC 5-10-8-7(b).

Sec. 5. (a) Before July 1, 2024, and each July 1 thereafter, each insurer, third party administrator, and pharmacy benefit manager that does business in Indiana shall file with the department a report that includes the following information:

(1) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the insurer, third party administrator, or pharmacy benefit manager.

(2) The business address of each person or entity identified under subdivision (1). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) zip code; and

(E) country name.

The business address may not include a post office box number.

(3) The business website, if applicable, of each person or entity identified under subdivision (1).

(4) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (1):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a license issued by the department of insurance.

A report provided under this section may not include the Social Security number of any individual.

(b) The department may not charge a fee for a report submitted under this section.

Sec. 6. (a) The department shall cooperate with the Indiana department of health and the Indiana professional licensing agency to develop and implement a plan to:

(1) collect the information described in section 5 of this chapter, IC 16-19-18-3, and IC 25-22.5-18-3; and

(2) make the information publicly available as set forth in IC 16-19-18-4.

(b) Before September 1 of each year, the department shall provide the information collected under section 5 of this chapter to the Indiana department of health.

Sec. 7. (a) The department may assess:

(1) an insurer;

(2) a third party administrator; or

(3) a pharmacy benefit manager;

that violates section 5 of this chapter a fine of one thousand dollars ($1,000) per day for which the report is past due.

(b) A fine under this section shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

(c) The department may waive a fine assessed under this section.

(d) The department may take disciplinary action against:

(1) an insurer;

(2) a third party administrator; or

(3) a pharmacy benefit manager;

that is licensed under this title for repeated violations of section 5 of this chapter.

Sec. 8. (a) Before December 1 of each year, the department shall submit to the legislative council an annual report of the:

(1) violations assessed; and

(2) fines waived;

under section 7 of this chapter in the previous calendar year.

(b) A report described in this section must be submitted in an electronic format under IC 5-14-6.

Sec. 9. (a) Before July 1, 2024, the department shall issue a notice or bulletin on at least two (2) occasions to notify insurers, third party administrators, and pharmacy benefit managers of the reporting requirements set forth in this chapter.

(b) A notice or bulletin issued under this section must be posted on the department's website in a manner that is easily accessible to insurers, third party administrators, and pharmacy benefit managers.

SECTION 7. IC 27-1-24.5-0.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2024]: **Sec. 0.7. As used in this chapter, "contract holder" means:**

(1) an individual or entity that offers health insurance coverage to its employees or members through a self-funded health benefit plan, including a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.);

(2) a health plan; or

(3) Medicaid or a managed care organization (as defined in IC 12-7-2-126.9) that provides services to a Medicaid recipient;

that contracts with a pharmacy benefit manager to provide services.

SECTION 8. IC 27-1-24.5-25, AS AMENDED BY P.L.32-2021, SECTION 81, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: Sec. 25. (a) A ~~party that has contracted with a pharmacy benefit manager to provide services~~ **contract holder** may, at least ~~one (1) time~~ **two (2) times** in a calendar year, request an audit of compliance with the contract. **If requested by the contract holder,** the audit ~~may~~ **shall** include full disclosure of **the following:**

(1) Rebate amounts secured on prescription drugs, whether product specific or general rebates, that were provided by a pharmaceutical manufacturer. **The information provided under this subdivision must identify the prescription drugs by therapeutic category.** ~~and~~

(2) Pharmaceutical and device claims received by the pharmacy benefit manager on any of the following:

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

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

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

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

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

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

The forms or transaction may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(3) Pharmaceutical and device claims payments or electronic funds transfer or remittance advice notices provided by the pharmacy benefit manager as ASC X12N 835 files or a successor format. The files may be modified only as necessary

to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). In the event that paper claims are provided, the pharmacy benefit manager shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

(4) Any other revenue and fees derived by the pharmacy benefit manager from the contract, **including all direct and indirect remuneration from pharmaceutical manufacturers regardless of whether the remuneration is classified as a rebate, fee, or another term.**

(b) A ~~contract~~ **pharmacy benefit manager** may not ~~contain provisions that~~ impose:

(1) ~~unreasonable~~ fees **for:**

(A) requesting an audit under this section; or

(B) selecting an auditor other than an auditor designated by the pharmacy benefit manager;

(2) conditions that would ~~severely~~ restrict a ~~party's~~ **contract holder's** right to conduct an audit under this ~~subsection,~~ **section, including restrictions on the:**

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

(E) selection of an auditor as long as the auditor is a professional with contract auditing experience.

~~(b)~~ **(c)** A pharmacy benefit manager shall disclose, upon request from a ~~party that has contracted with a pharmacy benefit manager,~~ **contract holder,** to the ~~party~~ **contract holder** the actual amounts **directly or indirectly** paid by the pharmacy benefit manager to **the pharmacist or** ~~any~~ pharmacy **for the drug or for pharmacist services related to the drug.**

~~(c)~~ **(d)** A pharmacy benefit manager shall provide notice to a ~~party~~ **contract holder** contracting with the pharmacy benefit manager of any consideration, **including direct or indirect remuneration,** that the pharmacy benefit manager receives from a ~~pharmacy~~ **pharmaceutical** manufacturer **or group purchasing organization** for ~~any name brand dispensing of a prescription when a generic or biologically similar product is available for the prescription.~~ **formulary placement or any other reason.**

~~(d)~~ **(e)** The commissioner may establish a procedure to release information from an audit performed by the department to a ~~party~~ **contract holder** that has requested an audit under this section in a

manner that does not violate confidential or proprietary information laws.

~~(c)~~ **(f)** ~~Any provision of~~ A contract **that is** entered into, issued, **amended,** or renewed after June 30, ~~2020,~~ **2024, may not contain a provision** that violates this section. ~~is unenforceable.~~

(g) A pharmacy benefit manager shall:

(1) obtain any information requested in an audit under this section from a group purchasing organization or other partner entity of the pharmacy benefit manager; and

(2) provide any information requested in an audit under this section to the contract holder not later than twenty (20) business days after the information is requested.

(h) Information provided in an audit under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

SECTION 9. IC 27-2-25.5-0.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 0.5. As used in this chapter, "plan sponsor" means an individual or entity that offers health insurance coverage to its employees or members through a self-funded health benefit plan, including:**

(1) a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.); and

(2) a self-insurance program established under IC 5-10-8-7(b).

SECTION 10. IC 27-2-25.5-0.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 0.7. As used in sections 3 and 4 of this chapter, "third party administrator" means an individual or entity that performs administrative services for a self-funded health benefit plan, including:**

(1) a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.); and

(2) a self-insurance program established under IC 5-10-8-7(b).

SECTION 11. IC 27-2-25.5-3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 3. (a) This section applies to a contract entered into, issued, amended, or renewed after June 30, 2024.**

(b) A contract between:

(1) a:

(A) third party administrator;

(B) pharmacy benefit manager (as defined in IC 27-1-24.5-12); or

(C) prepaid health care delivery plan under IC 5-10-8-7(c) to provide group health coverage for state employees; and

(2) a plan sponsor;

must provide that the plan sponsor owns the claims data relating to the contract.

(c) Any claims data provided under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

SECTION 12. IC 27-2-25.5-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: **Sec. 4. (a) A plan sponsor that contracts with a third party administrator, the office of the secretary of family and social services that contracts with a managed care organization (as defined in IC 12-7-2-126.9) to provide services to a Medicaid recipient, or the state personnel department that contracts with a prepaid health care delivery plan under IC 5-10-8-7(c) to provide group health coverage for state employees may, at least two (2) times in a calendar year, request an audit of compliance with the contract. If requested by the plan sponsor, office of the secretary of family and social services, or state personnel department, the audit shall include full disclosure of the following:**

(1) Claims data described in section 1 of this chapter.

(2) Claims received by the third party administrator, managed care organization, or prepaid health care delivery plan on any of the following:

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

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

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

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

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

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

The forms or transaction may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(3) Claims payments, electronic funds transfer, or remittance advice notices provided by the third party administrator,

managed care organization, or prepaid health care delivery plan as ASC X12N 835 files or a successor format. The files may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). In the event that paper claims are provided, the third party administrator, managed care organization, or prepaid health care delivery plan shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

(4) Any fees charged to the plan sponsor, office of the secretary of family and social services, or state personnel department related to plan administration and claims processing, including renegotiation fees, access fees, repricing fees, or enhanced review fees.

(b) A third party administrator, managed care organization, or prepaid health care delivery plan may not impose:

(1) fees for:

(A) requesting an audit under this section; or

(B) selecting an auditor other than an auditor designated by the third party administrator, managed care organization, or prepaid health care delivery plan; or

(2) conditions that would restrict a party's right to conduct an audit under this section, including restrictions on the:

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

(E) selection of an auditor, as long as the auditor is a professional with contract auditing experience.

(c) A third party administrator, managed care organization, or prepaid health care delivery plan shall provide any information requested in an audit under this section to the plan sponsor, office of the secretary of family and social services, or state personnel department not later than twenty (20) business days after the information is requested.

(d) Information provided in an audit under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(e) A contract that is entered into, issued, amended, or renewed after June 30, 2024, may not contain a provision that violates this section.

(f) A violation of this section is an unfair or deceptive act or

practice in the business of insurance under IC 27-4-1-4.

(g) The department may also adopt rules under IC 4-22-2 to set forth fines for a violation under this section.

SECTION 13. IC 27-4-1-4, AS AMENDED BY P.L.56-2023, SECTION 244, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2024]: 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 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 27-2-25.5-4 concerning audits of a third party administrator, managed care organization, or prepaid health care delivery plan.

(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.

SECTION 14. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1327, 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, line 5, delete "IC 16-19-18-7," and insert "**IC 16-19-18-5,**".

Page 1, line 5, after "IC 16-21-6-3," insert "**IC 25-22.5-18-5, IC 27-1-4.5-7,**".

Page 2, delete lines 15 through 30, begin a new paragraph and insert:

"SECTION 3. IC 16-18-2-282.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 282.3. "Physician group practice", for purposes of IC 16-19-18, has the meaning set forth in IC 16-19-18-2.**".

Page 2, line 34, delete "or Controlling Interest" and insert "**Information**".

Page 2, delete lines 37 through 42.

Delete page 3.

Page 4, delete lines 1 through 3, begin a new paragraph and insert:

"**Sec. 2. As used in this chapter, "physician group practice" means a physician practice that:**

(1) has at least one (1) physical location in Indiana; and

(2) includes as practitioners two (2) or more physicians licensed under IC 25-22.5, regardless of the ownership structure of the practice.

Sec. 3. (a) Before July 1, 2024, and each July 1 thereafter, each hospital that does business in Indiana shall file with the state department a report that includes the following information:

(1) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the hospital.

(2) The business address of each person or entity identified under subdivision (1). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) zip code; and

(E) country name.

The business address may not include a post office box

number.

(3) The business website, if applicable, of each person or entity identified under subdivision (1).

(4) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (1):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a license issued by the department of insurance.

A report provided under this section may not include the Social Security number of any individual.

(b) The state department may not charge a fee for a report submitted under this section.

Sec. 4. (a) The state department shall cooperate with the Indiana professional licensing agency and the department of insurance to develop and implement a plan to:

(1) collect the information described in section 3 of this chapter, IC 25-22.5-18-3, and IC 27-1-4.5-5; and

(2) make the information publicly available as set forth in this section.

(b) Before December 1 of each year, the state department shall publicly post the information:

(1) collected under section 3 of this chapter; and

(2) received from the:

(A) Indiana professional licensing agency under IC 25-22.5-18-4; or

(B) department of insurance under IC 27-1-4.5-6;

on the state department's website.

Sec. 5. (a) The state department may assess a hospital that violates section 3 of this chapter a fine of one thousand dollars ($1,000) per day for which the report is past due.".

Page 4, between lines 5 and 6, begin a new paragraph and insert:

"**(c) The state department may waive a fine assessed under this section.**".

Page 4, line 6, delete "(c)" and insert "**(d)**".

Page 4, line 7, delete "5" and insert "**3**".

Page 4, delete lines 9 through 40, begin a new paragraph and insert:

"**Sec. 6. (a) Before December 1 of each year, the state**

department shall submit to the legislative council an annual report of the:

(1) violations assessed; and

(2) fines waived;

under section 5 of this chapter in the previous calendar year.

(b) A report described in this section must be submitted in an electronic format under IC 5-14-6.

Sec. 7. (a) Before July 1, 2024, the state department shall issue a notice or bulletin on at least two (2) occasions to notify hospitals of the reporting requirements set forth in this chapter.

(b) A notice or bulletin issued under this section must be posted on the state department's website in a manner that is easily accessible to hospitals.

SECTION 5. IC 25-22.5-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 18. Disclosure of Ownership Information

Sec. 1. As used in this chapter, "controlling" has the meaning set forth in IC 23-1-43-8.

Sec. 2. As used in this chapter, "physician group practice" means a physician practice that:

(1) has at least one (1) physical location in Indiana; and

(2) includes as practitioners two (2) or more physicians licensed under this article, regardless of the ownership structure of the practice.

Sec. 3. (a) Before July 1, 2024, and each July 1 thereafter, each physician group practice that does business in Indiana shall file with the agency a report that includes the following information:

(1) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the physician group practice.

(2) The business address of each person or entity identified under subdivision (1). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) zip code; and

(E) country name.

The business address may not include a post office box number.

(3) The business website, if applicable, of each person or entity identified under subdivision (1).

(4) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (1):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a license issued by the department of insurance.

A report provided under this section may not include the Social Security number of any individual.

(b) The agency may not charge a fee for a report submitted under this section.

Sec. 4. (a) The agency shall cooperate with the Indiana department of health and the department of insurance to develop and implement a plan to:

(1) collect the information described in section 3 of this chapter, IC 16-19-18-3, and IC 27-1-4.5-5; and

(2) make the information publicly available as set forth in IC 16-19-18-4.

(b) Before September 1 of each year, the agency shall provide the information collected under section 3 of this chapter to the Indiana department of health.

Sec. 5. (a) The agency may assess a physician group practice that:

(1) has more than five (5) physicians as practitioners in the physician group practice; and

(2) violates section 3 of this chapter;

a fine of one thousand dollars ($1,000) per day for which the report is past due.

(b) The agency may assess a physician group practice that:

(1) has five (5) physicians or less as practitioners in the physician group practice; and

(2) violates section 3 of this chapter;

a fine of one hundred dollars ($100) per day for which the report is past due. A fine assessed under this subsection may not exceed ten thousand dollars ($10,000) in a calendar year.

(c) A fine under this section shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

(d) The agency may waive a fine assessed under this section.

(e) The board may take disciplinary action against a licensee for repeated violations of section 3 of this chapter.

Sec. 6. (a) Before December 1 of each year, the agency shall submit to the legislative council an annual report of the:

(1) violations assessed; and

(2) fines waived;

under section 5 of this chapter in the previous calendar year.

(b) A report described in this section must be submitted in an electronic format under IC 5-14-6.

Sec. 7. (a) Before July 1, 2024, the agency shall issue a notice or bulletin on at least two (2) occasions to notify physician group practices of the reporting requirements set forth in this chapter.

(b) A notice or bulletin issued under this section must be posted on the agency's website in a manner that is easily accessible to physician group practices.

SECTION 6. IC 27-1-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 4.5. Disclosure of Ownership Information

Sec. 1. As used in this chapter, "controlling" has the meaning set forth in IC 23-1-43-8.

Sec. 2. As used in this chapter, "insurer" includes the following:

(1) 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)). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(2) 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 managed care organization (as defined in IC 12-7-2-126.9) that provides services to a Medicaid recipient.

(4) A prepaid health care delivery plan under IC 5-10-8-7(c) that provides group health coverage for state employees.

Sec. 3. As used in this chapter, "pharmacy benefit manager" has the meaning set forth in IC 27-1-24.5-12.

Sec. 4. As used in this chapter, "third party administrator" means an individual or entity that performs administrative services for an insurer or a self-funded health benefit plan, including:

(1) a self-funded health benefit plan that complies with the federal Employee Retirement Income Security Act (ERISA)

of 1974 (29 U.S.C. 1001 et seq.); and

(2) a self-insurance program established under IC 5-10-8-7(b).

Sec. 5. (a) Before July 1, 2024, and each July 1 thereafter, each insurer, third party administrator, and pharmacy benefit manager that does business in Indiana shall file with the department a report that includes the following information:

(1) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the insurer, third party administrator, or pharmacy benefit manager.

(2) The business address of each person or entity identified under subdivision (1). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) zip code; and

(E) country name.

The business address may not include a post office box number.

(3) The business website, if applicable, of each person or entity identified under subdivision (1).

(4) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (1):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a license issued by the department of insurance.

A report provided under this section may not include the Social Security number of any individual.

(b) The department may not charge a fee for a report submitted under this section.

Sec. 6. (a) The department shall cooperate with the Indiana department of health and the Indiana professional licensing agency to develop and implement a plan to:

(1) collect the information described in section 5 of this chapter, IC 16-19-18-3, and IC 25-22.5-18-3; and

(2) make the information publicly available as set forth in IC 16-19-18-4.

(b) Before September 1 of each year, the department shall provide the information collected under section 5 of this chapter to the Indiana department of health.

Sec. 7. (a) The department may assess:

(1) an insurer;

(2) a third party administrator; or

(3) a pharmacy benefit manager;

that violates section 5 of this chapter a fine of one thousand dollars ($1,000) per day for which the report is past due.

(b) A fine under this section shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

(c) The department may waive a fine assessed under this section.

(d) The department may take disciplinary action against:

(1) an insurer;

(2) a third party administrator; or

(3) a pharmacy benefit manager;

that is licensed under this title for repeated violations of section 5 of this chapter.

Sec. 8. (a) Before December 1 of each year, the department shall submit to the legislative council an annual report of the:

(1) violations assessed; and

(2) fines waived;

under section 7 of this chapter in the previous calendar year.

(b) A report described in this section must be submitted in an electronic format under IC 5-14-6.

Sec. 9. (a) Before July 1, 2024, the department shall issue a notice or bulletin on at least two (2) occasions to notify insurers, third party administrators, and pharmacy benefit managers of the reporting requirements set forth in this chapter.

(b) A notice or bulletin issued under this section must be posted on the department's website in a manner that is easily accessible to insurers, third party administrators, and pharmacy benefit managers.".

Page 5, line 4, delete "a health plan".

Page 5, line 5, delete "or".

Page 5, delete lines 15 through 20.

Page 5, line 25, reset in roman "at least".

Page 5, line 25, delete "up to".

Page 5, line 25, strike "one (1) time" and insert "**two (2) times**".

Page 5, line 25, reset in roman "in a calendar year,".

Page 5, line 25, delete "each quarter,".

Page 5, delete lines 28 through 42, begin a new line block indented and insert:

"**(1)** Rebate amounts secured on prescription drugs, whether product specific or general rebates, that were provided by a pharmaceutical manufacturer. **The information provided under this subdivision must identify the prescription drugs by therapeutic category.** ~~and~~

(2) Pharmaceutical and device claims received by the pharmacy benefit manager on any of the following:

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

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

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

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

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

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

The forms or transaction may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(3) Pharmaceutical and device claims payments or electronic funds transfer or remittance advice notices provided by the pharmacy benefit manager as ASC X12N 835 files or a successor format. The files may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). In the event that paper claims are provided, the pharmacy benefit manager shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.

(4) Any other revenue and fees derived by the pharmacy benefit manager from the contract, **including all direct and indirect remuneration from pharmaceutical manufacturers regardless of whether the remuneration is classified as a rebate, fee, or another term.**

(b) A ~~contract~~ **pharmacy benefit manager** may not ~~contain provisions that~~ impose:

(1) ~~unreasonable~~ fees **for:**

(A) requesting an audit under this section; or

(B) selecting an auditor other than an auditor designated by the pharmacy benefit manager;

(2) conditions that would ~~severely~~ restrict a ~~party's~~ **contract**

holder's right to conduct an audit under this ~~subsection,~~ **section, including restrictions on the:**

(A) time period of the audit;

(B) number of claims analyzed;

(C) type of analysis conducted;

(D) data elements used in the analysis; or

(E) selection of an auditor as long as the auditor is a professional with contract auditing experience.".

Page 6, delete lines 1 through 22.

Page 7, line 8, delete "fifteen (15)" and insert "**twenty (20)**".

Page 7, delete lines 13 through 42.

Page 8, delete lines 1 through 10.

Page 9, between lines 3 and 4, begin a new paragraph and insert:

"**(c) Any claims data provided under this section must be provided in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).**".

Page 9, line 13, delete "up to one (1) time each quarter," and insert "**at least two (2) times in a calendar year,**".

Page 9, delete lines 19 through 33, begin a new line block indented and insert:

"**(2) Claims received by the third party administrator, managed care organization, or prepaid health care delivery plan on any of the following:**

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

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

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

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

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

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

The forms or transaction may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(3) Claims payments, electronic funds transfer, or remittance advice notices provided by the third party administrator, managed care organization, or prepaid health care delivery plan as ASC X12N 835 files or a successor format. The files may be modified only as necessary to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). In the event that paper claims are provided, the third party administrator, managed care organization, or

prepaid health care delivery plan shall convert the paper claims to the ASC X12N 835 electronic format or a successor format.".

Page 9, line 41, delete "for an audit conducted under this section; or" and insert "**for:**

(A) requesting an audit under this section; or

(B) selecting an auditor other than an auditor designated by the third party administrator, managed care organization, or prepaid health care delivery plan; or".

Page 10, line 6, delete "auditor." and insert "**auditor, as long as the auditor is a professional with contract auditing experience.**".

Page 10, line 11, delete "fifteen (15)" and insert "**twenty (20)**".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1327 as introduced.)

BARRETT

Committee Vote: yeas 10, nays 0.