



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.

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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:

- 1 SECTION 1. IC 12-15-1-18.5, AS ADDED BY P.L.203-2023,
2 SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 UPON PASSAGE]: Sec. 18.5. (a) The payer affordability penalty fund
4 is established for the purpose of receiving fines collected under
5 **IC 16-19-18-5**, IC 16-21-6-3, **IC 25-22.5-18-5**, **IC 27-1-4.5-7**, and
6 ~~fines collected under IC 27-2-25.5~~ to be used for:
7 (1) the state's share of the Medicaid program; and
8 (2) a study of hospitals that are impacted by changes made in the
9 disproportionate share hospital methodology payments set forth
10 in Section 203 of the federal Consolidated Appropriations Act of
11 2021.
12 The office of the secretary shall perform the study and provide the
13 results of the study described in subdivision (2) to the budget
14 committee.
15 (b) The fund shall be administered by the office of the secretary.

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

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

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

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

10 SECTION 2. IC 16-18-2-79.1 IS ADDED TO THE INDIANA
11 CODE AS A NEW SECTION TO READ AS FOLLOWS
12 [EFFECTIVE UPON PASSAGE]: **Sec. 79.1. "Controlling", for**
13 **purposes of IC 16-19-18, has the meaning set forth in**
14 **IC 16-19-18-1.**

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

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

23 **Chapter 18. Disclosure of Ownership Information**

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

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

- 28 (1) has at least one (1) physical location in Indiana; and
29 (2) includes as practitioners two (2) or more physicians
30 licensed under IC 25-22.5, regardless of the ownership
31 structure of the practice.

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

- 35 (1) The name of each person or entity that has:
36 (A) an ownership interest of at least five percent (5%);
37 (B) a controlling interest; or
38 (C) an interest as a private equity partner;
39 in the hospital.

- 40 (2) The business address of each person or entity identified
41 under subdivision (1). The business address must include a:
42 (A) building number;



- 1 (B) street name;
 2 (C) city name;
 3 (D) zip code; and
 4 (E) country name.
 5 The business address may not include a post office box
 6 number.
 7 (3) The business website, if applicable, of each person or
 8 entity identified under subdivision (1).
 9 (4) Any of the following identification numbers, if applicable,
 10 for a person or entity identified under subdivision (1):
 11 (A) National provider identifier (NPI).
 12 (B) Taxpayer identification number (TIN).
 13 (C) Employer identification number (EIN).
 14 (D) CMS certification number (CCN).
 15 (E) National Association of Insurance Commissioners
 16 (NAIC) identification number.
 17 (F) A personal identification number associated with a
 18 license issued by the department of insurance.
 19 A report provided under this section may not include the
 20 Social Security number of any individual.
 21 (b) The state department may not charge a fee for a report
 22 submitted under this section.
 23 **Sec. 4. (a) The state department shall cooperate with the Indiana**
 24 **professional licensing agency and the department of insurance to**
 25 **develop and implement a plan to:**
 26 (1) collect the information described in section 3 of this
 27 chapter, IC 25-22.5-18-3, and IC 27-1-4.5-5; and
 28 (2) make the information publicly available as set forth in this
 29 section.
 30 (b) Before December 1 of each year, the state department shall
 31 publicly post the information:
 32 (1) collected under section 3 of this chapter; and
 33 (2) received from the:
 34 (A) Indiana professional licensing agency under
 35 IC 25-22.5-18-4; or
 36 (B) department of insurance under IC 27-1-4.5-6;
 37 on the state department's website.
 38 **Sec. 5. (a) The state department may assess a hospital that**
 39 **violates section 3 of this chapter a fine of one thousand dollars**
 40 **(\$1,000) per day for which the report is past due.**
 41 (b) A fine under this section shall be deposited into the payer
 42 affordability penalty fund established by IC 12-15-1-18.5.



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

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

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

- 8 (1) violations assessed; and
9 (2) fines waived;

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

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

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

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

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

22 **Chapter 18. Disclosure of Ownership Information**

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

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

- 27 (1) has at least one (1) physical location in Indiana; and
28 (2) includes as practitioners two (2) or more physicians
29 licensed under this article, regardless of the ownership
30 structure of the practice.

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

- 34 (1) The name of each person or entity that has:
35 (A) an ownership interest of at least five percent (5%);
36 (B) a controlling interest; or
37 (C) an interest as a private equity partner;
38 in the physician group practice.
39 (2) The business address of each person or entity identified
40 under subdivision (1). The business address must include a:
41 (A) building number;
42 (B) street name;



- 1 (C) city name;
 2 (D) zip code; and
 3 (E) country name.
- 4 The business address may not include a post office box
 5 number.
- 6 (3) The business website, if applicable, of each person or
 7 entity identified under subdivision (1).
- 8 (4) Any of the following identification numbers, if applicable,
 9 for a person or entity identified under subdivision (1):
- 10 (A) National provider identifier (NPI).
 11 (B) Taxpayer identification number (TIN).
 12 (C) Employer identification number (EIN).
 13 (D) CMS certification number (CCN).
 14 (E) National Association of Insurance Commissioners
 15 (NAIC) identification number.
 16 (F) A personal identification number associated with a
 17 license issued by the department of insurance.
- 18 A report provided under this section may not include the
 19 Social Security number of any individual.
- 20 (b) The agency may not charge a fee for a report submitted
 21 under this section.
- 22 Sec. 4. (a) The agency shall cooperate with the Indiana
 23 department of health and the department of insurance to develop
 24 and implement a plan to:
- 25 (1) collect the information described in section 3 of this
 26 chapter, IC 16-19-18-3, and IC 27-1-4.5-5; and
 27 (2) make the information publicly available as set forth in
 28 IC 16-19-18-4.
- 29 (b) Before September 1 of each year, the agency shall provide
 30 the information collected under section 3 of this chapter to the
 31 Indiana department of health.
- 32 Sec. 5. (a) The agency may assess a physician group practice
 33 that:
- 34 (1) has more than five (5) physicians as practitioners in the
 35 physician group practice; and
 36 (2) violates section 3 of this chapter;
 37 a fine of one thousand dollars (\$1,000) per day for which the report
 38 is past due.
- 39 (b) The agency may assess a physician group practice that:
- 40 (1) has five (5) physicians or less as practitioners in the
 41 physician group practice; and
 42 (2) violates section 3 of this chapter;



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

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

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

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

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

11 (1) violations assessed; and

12 (2) fines waived;

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

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

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

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

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

25 **Chapter 4.5. Disclosure of Ownership Information**

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

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

29 (1) An insurer (as defined in IC 27-1-2-3(x)) that issues a
 30 policy of accident and sickness insurance (as defined in
 31 IC 27-8-5-1(a)). However, the term does not include the
 32 coverages described in IC 27-8-5-2.5(a).

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

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

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

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



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

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

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

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

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

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

14 **(B) a controlling interest; or**

15 **(C) an interest as a private equity partner;**

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

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

20 **(A) building number;**

21 **(B) street name;**

22 **(C) city name;**

23 **(D) zip code; and**

24 **(E) country name.**

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

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

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

31 **(A) National provider identifier (NPI).**

32 **(B) Taxpayer identification number (TIN).**

33 **(C) Employer identification number (EIN).**

34 **(D) CMS certification number (CCN).**

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

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

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

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



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

- 4 **(1) collect the information described in section 5 of this**
 5 **chapter, IC 16-19-18-3, and IC 25-22.5-18-3; and**
 6 **(2) make the information publicly available as set forth in**
 7 **IC 16-19-18-4.**

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

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

- 12 **(1) an insurer;**
 13 **(2) a third party administrator; or**
 14 **(3) a pharmacy benefit manager;**

15 **that violates section 5 of this chapter a fine of one thousand dollars**
 16 **(\$1,000) per day for which the report is past due.**

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

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

20 **(d) The department may take disciplinary action against:**

- 21 **(1) an insurer;**
 22 **(2) a third party administrator; or**
 23 **(3) a pharmacy benefit manager;**

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

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

- 28 **(1) violations assessed; and**
 29 **(2) fines waived;**

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

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

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

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

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



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

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

8 (2) a health plan; or

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

12 that contracts with a pharmacy benefit manager to provide
13 services.

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

14 **(A) requesting an audit under this section; or**

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

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

20 **(A) time period of the audit;**

21 **(B) number of claims analyzed;**

22 **(C) type of analysis conducted;**

23 **(D) data elements used in the analysis; or**

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

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

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

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



1 manner that does not violate confidential or proprietary information
2 laws.

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

6 (g) A pharmacy benefit manager shall:
7 (1) obtain any information requested in an audit under this
8 section from a group purchasing organization or other
9 partner entity of the pharmacy benefit manager; and
10 (2) provide any information requested in an audit under this
11 section to the contract holder not later than twenty (20)
12 business days after the information is requested.

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

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

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

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

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

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

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

36 SECTION 11. IC 27-2-25.5-3 IS ADDED TO THE INDIANA
37 CODE AS A NEW SECTION TO READ AS FOLLOWS
38 [EFFECTIVE JULY 1, 2024]: Sec. 3. (a) This section applies to a
39 contract entered into, issued, amended, or renewed after June 30,
40 2024.

41 (b) A contract between:

42 (1) a:



- 1 (A) third party administrator;
- 2 (B) pharmacy benefit manager (as defined in
- 3 IC 27-1-24.5-12); or
- 4 (C) prepaid health care delivery plan under IC 5-10-8-7(c)
- 5 to provide group health coverage for state employees; and
- 6 (2) a plan sponsor;

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

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

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

- 26 (1) Claims data described in section 1 of this chapter.
- 27 (2) Claims received by the third party administrator,
- 28 managed care organization, or prepaid health care delivery
- 29 plan on any of the following:
 - 30 (A) The CMS-1500 form or its successor form.
 - 31 (B) The HCFA-1500 form or its successor form.
 - 32 (C) The HIPAA X12 837P electronic claims transaction for
 - 33 professional services, or its successor transaction.
 - 34 (D) The HIPAA X12 837I institutional form or its
 - 35 successor form.
 - 36 (E) The CMS-1450 form or its successor form.
 - 37 (F) The UB-04 form or its successor form.

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

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



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

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

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

17 (1) fees for:

18 (A) requesting an audit under this section; or

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

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

24 (A) time period of the audit;

25 (B) number of claims analyzed;

26 (C) type of analysis conducted;

27 (D) data elements used in the analysis; or

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

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

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

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

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



1 **practice in the business of insurance under IC 27-4-1-4.**
2 **(g) The department may also adopt rules under IC 4-22-2 to set**
3 **forth fines for a violation under this section.**
4 SECTION 13. IC 27-4-1-4, AS AMENDED BY P.L.56-2023,
5 SECTION 244, IS AMENDED TO READ AS FOLLOWS
6 [EFFECTIVE JULY 1, 2024]: Sec. 4. (a) The following are hereby
7 defined as unfair methods of competition and unfair and deceptive acts
8 and practices in the business of insurance:
9 (1) Making, issuing, circulating, or causing to be made, issued, or
10 circulated, any estimate, illustration, circular, or statement:
11 (A) misrepresenting the terms of any policy issued or to be
12 issued or the benefits or advantages promised thereby or the
13 dividends or share of the surplus to be received thereon;
14 (B) making any false or misleading statement as to the
15 dividends or share of surplus previously paid on similar
16 policies;
17 (C) making any misleading representation or any
18 misrepresentation as to the financial condition of any insurer,
19 or as to the legal reserve system upon which any life insurer
20 operates;
21 (D) using any name or title of any policy or class of policies
22 misrepresenting the true nature thereof; or
23 (E) making any misrepresentation to any policyholder insured
24 in any company for the purpose of inducing or tending to
25 induce such policyholder to lapse, forfeit, or surrender the
26 policyholder's insurance.
27 (2) Making, publishing, disseminating, circulating, or placing
28 before the public, or causing, directly or indirectly, to be made,
29 published, disseminated, circulated, or placed before the public,
30 in a newspaper, magazine, or other publication, or in the form of
31 a notice, circular, pamphlet, letter, or poster, or over any radio or
32 television station, or in any other way, an advertisement,
33 announcement, or statement containing any assertion,
34 representation, or statement with respect to any person in the
35 conduct of the person's insurance business, which is untrue,
36 deceptive, or misleading.
37 (3) Making, publishing, disseminating, or circulating, directly or
38 indirectly, or aiding, abetting, or encouraging the making,
39 publishing, disseminating, or circulating of any oral or written
40 statement or any pamphlet, circular, article, or literature which is
41 false, or maliciously critical of or derogatory to the financial
42 condition of an insurer, and which is calculated to injure any



- 1 person engaged in the business of insurance.
- 2 (4) Entering into any agreement to commit, or individually or by
3 a concerted action committing any act of boycott, coercion, or
4 intimidation resulting or tending to result in unreasonable
5 restraint of, or a monopoly in, the business of insurance.
- 6 (5) Filing with any supervisory or other public official, or making,
7 publishing, disseminating, circulating, or delivering to any person,
8 or placing before the public, or causing directly or indirectly, to
9 be made, published, disseminated, circulated, delivered to any
10 person, or placed before the public, any false statement of
11 financial condition of an insurer with intent to deceive. Making
12 any false entry in any book, report, or statement of any insurer
13 with intent to deceive any agent or examiner lawfully appointed
14 to examine into its condition or into any of its affairs, or any
15 public official to which such insurer is required by law to report,
16 or which has authority by law to examine into its condition or into
17 any of its affairs, or, with like intent, willfully omitting to make a
18 true entry of any material fact pertaining to the business of such
19 insurer in any book, report, or statement of such insurer.
- 20 (6) Issuing or delivering or permitting agents, officers, or
21 employees to issue or deliver, agency company stock or other
22 capital stock, or benefit certificates or shares in any common law
23 corporation, or securities or any special or advisory board
24 contracts or other contracts of any kind promising returns and
25 profits as an inducement to insurance.
- 26 (7) Making or permitting any of the following:
- 27 (A) Unfair discrimination between individuals of the same
28 class and equal expectation of life in the rates or assessments
29 charged for any contract of life insurance or of life annuity or
30 in the dividends or other benefits payable thereon, or in any
31 other of the terms and conditions of such contract. However,
32 in determining the class, consideration may be given to the
33 nature of the risk, plan of insurance, the actual or expected
34 expense of conducting the business, or any other relevant
35 factor.
- 36 (B) Unfair discrimination between individuals of the same
37 class involving essentially the same hazards in the amount of
38 premium, policy fees, assessments, or rates charged or made
39 for any policy or contract of accident or health insurance or in
40 the benefits payable thereunder, or in any of the terms or
41 conditions of such contract, or in any other manner whatever.
42 However, in determining the class, consideration may be given



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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



1 dividends, savings, or profits accrued thereon, or anything of
 2 value whatsoever not specified in the contract. Nothing in this
 3 subdivision and subdivision (7) shall be construed as including
 4 within the definition of discrimination or rebates any of the
 5 following practices:

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

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

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

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

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

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



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

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

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

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

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

38 (C) Title insurance.

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

42 (E) Insurance provided by or through motorists service clubs



- 1 or associations.
- 2 (F) Insurance that is provided to the purchaser or holder of an
- 3 air transportation ticket and that:
- 4 (i) insures against death or nonfatal injury that occurs during
- 5 the flight to which the ticket relates;
- 6 (ii) insures against personal injury or property damage that
- 7 occurs during travel to or from the airport in a common
- 8 carrier immediately before or after the flight;
- 9 (iii) insures against baggage loss during the flight to which
- 10 the ticket relates; or
- 11 (iv) insures against a flight cancellation to which the ticket
- 12 relates.
- 13 (14) Refusing, because of the for-profit status of a hospital or
- 14 medical facility, to make payments otherwise required to be made
- 15 under a contract or policy of insurance for charges incurred by an
- 16 insured in such a for-profit hospital or other for-profit medical
- 17 facility licensed by the Indiana department of health.
- 18 (15) Refusing to insure an individual, refusing to continue to issue
- 19 insurance to an individual, limiting the amount, extent, or kind of
- 20 coverage available to an individual, or charging an individual a
- 21 different rate for the same coverage, solely because of that
- 22 individual's blindness or partial blindness, except where the
- 23 refusal, limitation, or rate differential is based on sound actuarial
- 24 principles or is related to actual or reasonably anticipated
- 25 experience.
- 26 (16) Committing or performing, with such frequency as to
- 27 indicate a general practice, unfair claim settlement practices (as
- 28 defined in section 4.5 of this chapter).
- 29 (17) Between policy renewal dates, unilaterally canceling an
- 30 individual's coverage under an individual or group health
- 31 insurance policy solely because of the individual's medical or
- 32 physical condition.
- 33 (18) Using a policy form or rider that would permit a cancellation
- 34 of coverage as described in subdivision (17).
- 35 (19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1
- 36 concerning motor vehicle insurance rates.
- 37 (20) Violating IC 27-8-21-2 concerning advertisements referring
- 38 to interest rate guarantees.
- 39 (21) Violating IC 27-8-24.3 concerning insurance and health plan
- 40 coverage for victims of abuse.
- 41 (22) Violating IC 27-8-26 concerning genetic screening or testing.
- 42 (23) Violating IC 27-1-15.6-3(b) concerning licensure of



- 1 insurance producers.
- 2 (24) Violating IC 27-1-38 concerning depository institutions.
- 3 (25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning
- 4 the resolution of an appealed grievance decision.
- 5 (26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired
- 6 July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1,
- 7 2007, and repealed).
- 8 (27) Violating IC 27-2-21 concerning use of credit information.
- 9 (28) Violating IC 27-4-9-3 concerning recommendations to
- 10 consumers.
- 11 (29) Engaging in dishonest or predatory insurance practices in
- 12 marketing or sales of insurance to members of the United States
- 13 Armed Forces as:
- 14 (A) described in the federal Military Personnel Financial
- 15 Services Protection Act, P.L.109-290; or
- 16 (B) defined in rules adopted under subsection (b).
- 17 (30) Violating IC 27-8-19.8-20.1 concerning stranger originated
- 18 life insurance.
- 19 (31) Violating IC 27-2-22 concerning retained asset accounts.
- 20 (32) Violating IC 27-8-5-29 concerning health plans offered
- 21 through a health benefit exchange (as defined in IC 27-19-2-8).
- 22 (33) Violating a requirement of the federal Patient Protection and
- 23 Affordable Care Act (P.L. 111-148), as amended by the federal
- 24 Health Care and Education Reconciliation Act of 2010 (P.L.
- 25 111-152), that is enforceable by the state.
- 26 (34) After June 30, 2015, violating IC 27-2-23 concerning
- 27 unclaimed life insurance, annuity, or retained asset account
- 28 benefits.
- 29 (35) Willfully violating IC 27-1-12-46 concerning a life insurance
- 30 policy or certificate described in IC 27-1-12-46(a).
- 31 (36) Violating IC 27-1-37-7 concerning prohibiting the disclosure
- 32 of health care service claims data.
- 33 (37) Violating IC 27-4-10-10 concerning virtual claims payments.
- 34 (38) Violating IC 27-1-24.5 concerning pharmacy benefit
- 35 managers.
- 36 (39) Violating IC 27-7-17-16 or IC 27-7-17-17 concerning the
- 37 marketing of travel insurance policies.
- 38 **(40) Violating IC 27-2-25.5-4 concerning audits of a third**
- 39 **party administrator, managed care organization, or prepaid**
- 40 **health care delivery plan.**
- 41 (b) Except with respect to federal insurance programs under
- 42 Subchapter III of Chapter 19 of Title 38 of the United States Code, the



1 commissioner may, consistent with the federal Military Personnel
2 Financial Services Protection Act (10 U.S.C. 992 note), adopt rules
3 under IC 4-22-2 to:
4 (1) define; and
5 (2) while the members are on a United States military installation
6 or elsewhere in Indiana, protect members of the United States
7 Armed Forces from;
8 dishonest or predatory insurance practices.
9 **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.

