SENATE BILL No. 485

DIGEST OF INTRODUCED BILL

Citations Affected: IC 16-21-10; IC 27-1-50.3.

Synopsis: Managed care assessment fee. Provides for the assessment of a fee on managed care organizations to pay the state's share of the cost of Medicaid services provided under the Medicaid program. Changes the use of hospital assessment fees in state fiscal years in which a managed care assessment fee is imposed. Extends the law governing the hospital assessment fee to June 30, 2027.

Effective: Upon passage.

Doriot, Johnson T

January 13, 2025, read first time and referred to Committee on Health and Provider Services.

Introduced

First Regular Session of the 124th General Assembly (2025)

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 2024 Regular Session of the General Assembly.

SENATE BILL No. 485

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

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

1 SECTION 1. IC 16-21-10-14, AS AMENDED BY P.L.213-2015,
2 SECTION 150, IS AMENDED TO READ AS FOLLOWS
3 [EFFECTIVE UPON PASSAGE]: Sec. 14. **(a)** This section does not
4 apply to the use of the incremental fee described in section 13.3 of this
5 chapter.
6 **(b) Subject to subsections (c) and (d),** the fees collected under
7 section 8 of this chapter may be used only as described in this chapter
8 or to pay the state's share of the cost for Medicaid services provided
9 under the federal Medicaid program (42 U.S.C. 1396 et seq.) as
10 follows:
11 (1) Twenty-eight and five-tenths percent (28.5%) may be used by
12 the office for Medicaid expenses.
13 (2) Seventy-one and five-tenths percent (71.5%) to hospitals.
14 **(c) Subject to subsection (d), this section does not apply for any**
15 **state fiscal year for which the managed care assessment fee under**
16 **IC 27-1-50.3 is assessed.**
17 **(d) With respect to the first state fiscal year for which the**

managed care assessment fee under IC 27-1-50.3 is assessed, any fees described in subsection (b)(1) that were collected for that state fiscal year before the assessment of the managed care assessment fee for that state fiscal year shall be used to fund the state's share of the reimbursement described in section 8(a)(2) of this chapter.

SECTION 2. IC 16-21-10-21, AS AMENDED BY P.L.201-2023, SECTION 148, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 21. This chapter expires June 30, ~~2025.~~ **2027.**

SECTION 3. IC 27-1-50.3 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 50.3. Managed Care Assessment Fee

Sec. 1. The following definitions apply throughout this chapter.

(1) "Approval of the state directed payment programs" means CMS's approval of the state directed payment program described in IC 16-21-10-8 and the state directed payment program described in IC 16-21-10-13.3.

(2) "Business day" means a day other than Saturday or Sunday, or a legal holiday listed in IC 1-1-9-1.

(3) "CMS" refers to the federal Centers for Medicare and Medicaid Services.

(4) "Commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(5) "Department" refers to the department of insurance created by IC 27-1-1-1.

(6) "Fee" refers to the fee on managed care organizations authorized by this chapter.

(7) "Managed care organization" means an organization that holds a certificate of authority, license, or other similar authorization issued by the department and that is a managed care organization for purposes of 42 U.S.C. 1396b(w)(7)(A)(viii) and 42 CFR 433.56(a)(8).

(8) "Office" refers to the office of Medicaid policy and planning established by IC 12-8-6.5-1.

(9) "Secretary" refers to the secretary of family and social services appointed under IC 12-8-1.5-2.

(10) "State directed payments" means the payments made under the state directed payment program described in IC 16-21-10-8, and the payments made under the state directed payment program described in IC 16-21-10-13.3.

(11) "State's share" means the portion of allowable Medicaid

expenses funded by the state, by other units of government, or, as permitted by federal Medicaid laws, by other entities other than the federal government.

Sec. 2. (a) Subject to subsections (b) and (c) and this chapter, a fee is authorized. The fee shall be assessed for each state fiscal year for which state directed payments are made to hospitals.

(b) The fee may not be assessed without approval from CMS.

(c) The assessment of the fee shall cease upon CMS's determination that the fee is no longer a permissible health care related tax that is eligible for federal financial participation.

Sec. 3. For each of the state fiscal years described in section 2(a) of this chapter, the office, subject to section 6 of this chapter, shall assess a fee upon managed care organizations in an aggregate amount equal to twenty-eight and five-tenths percent (28.5%) of the fees assessed under IC 16-21-10 for the state fiscal year, excluding the fees collected under IC 16-21-10-13.3.

Sec. 4. The fee collected under this chapter only may be used to pay the state's share of the cost of Medicaid services provided under the Medicaid program (42 U.S.C. 1396 et seq.).

Sec. 5. Not later than May 30, 2025, and after consulting with the secretary or the secretary's designee regarding compliance with 42 U.S.C. 1396b(w)(7)(A)(viii) and 42 CFR 433.56(a)(8) and the types of managed care organizations recognized under Indiana law, the commissioner or the commissioner's designee shall provide the secretary or the secretary's designee with a list of the managed care organizations that hold a certificate of authority, license, or other similar authorization issued by the department and that are managed care organizations for purposes of 42 U.S.C. 1396b(w)(7)(A)(viii) and 42 CFR 433.56(a)(8). Thereafter, the commissioner or the commissioner's designee shall update this list to the secretary or the secretary's designee not sooner than one hundred twenty (120) days, and not later than ninety (90) days, from the start of each state fiscal year for which the fee is assessed.

Sec. 6. (a) The fee must meet the requirements of the federal Medicaid statutes and regulations for permissible health care related taxes.

(b) The office may request a waiver from CMS of the broad based and uniformity requirements under 42 CFR 433.68 as amended, relating to the assessment under this chapter.

(c) Subject to subsection (a):

(1) the office may assess the fee on a tiered basis among the managed care organizations; and

(2) the office may assess the fee based on member months, premium revenue, or any other methodology approved by CMS.

Sec. 7. (a) The managed care assessment fee committee is established. The committee consists of the following five (5) members:

(1) The secretary, or the secretary's designee, who shall serve as chair of the committee.

(2) The commissioner or the commissioner's designee.

(3) The budget director or the budget director's designee.

(4) One (1) member from a managed care organization that has a comprehensive risk contract with the office under IC 12-15, appointed by the governor from a list of at least three (3) individuals submitted by the Insurance Institute of Indiana.

(5) One (1) member from a managed care organization that does not have a comprehensive risk contract with the office under IC 12-15, appointed by the governor from a list of at least three (3) individuals submitted by the Insurance Institute of Indiana.

(b) The committee shall meet at the call of the chair. The members shall serve without compensation.

(c) The committee shall provide recommendations to the secretary, or the secretary's designee, regarding all matters pertaining to the assessment of the fee, including recommendations regarding the matters referenced in section 6(b) and 6(c) of this chapter and section 9(d) through 9(f) of this chapter.

Sec. 8. The office shall submit a written request to CMS for approval of the managed care assessment fee not later than June 30, 2025. Subject to the requirements of this chapter, the office is authorized to negotiate with CMS regarding the terms and conditions for the implementation and maintenance of the fee.

Sec. 9. (a) Pursuant to section 2 of this chapter, the fee shall be assessed for each state fiscal year for which state directed payments are made to hospitals.

(b) With respect to the first state fiscal year for which state directed payments are paid to hospitals, the assessment payable by a managed care organization for that state fiscal year shall be prorated and due and payable in equal monthly installments on the first business day of each calendar month that follows the date such state directed payments are first paid to hospitals. The office shall notify each managed care organization of its assessment and its

1 **installment due dates as soon as reasonably possible following**
2 **CMS's approval of the state directed payment programs. The**
3 **assessment payable by a managed care organization under this**
4 **subsection shall be subject to the reconciliation process set forth in**
5 **subsections (d), (e), and (f).**
6 **(c) Except for the circumstances described in subsection (a), the**
7 **assessment payable by a managed care organization for a state**
8 **fiscal year shall be due and payable in monthly installments, each**
9 **equaling one-twelfth (1/12) of the assessment for the state fiscal**
10 **year, on the first business day of each calendar month of the state**
11 **fiscal year. The office shall notify each managed care organization**
12 **of its annual assessment and its installment due dates not later than**
13 **thirty (30) days prior to the start of each fiscal year. The**
14 **assessment payable by a managed care organization under this**
15 **subsection shall be subject to the reconciliation process set forth in**
16 **subsections (d) and (e) of this section.**
17 **(d) The office shall establish a process for reconciling for a state**
18 **fiscal year:**
19 **(1) the amount of fees actually assessed under IC 16-21-10 for**
20 **the state fiscal year, excluding the fees collected under**
21 **IC 16-21-10-13.3; and**
22 **(2) the amount of fees assessed under this chapter for the state**
23 **fiscal year in relation to the amount that equals twenty-eight**
24 **and five-tenths percent (28.5%) of the fees actually assessed**
25 **under IC 16-21-10 for the state fiscal year, excluding the fees**
26 **collected under IC 16-21-10-13.3.**
27 **(e) The office may assess additional fees under this chapter for**
28 **a state fiscal year if the amount of fees assessed for the state fiscal**
29 **year was less than an amount equaling twenty-eight and five-tenths**
30 **percent (28.5%) of the fees actually assessed under IC 16-21-10 for**
31 **the state fiscal year, excluding the fees collected under**
32 **IC 16-21-10-13.3.**
33 **(f) The office shall refund fees assessed under this chapter for a**
34 **state fiscal year if the amount of fees assessed for the state fiscal**
35 **year was greater than an amount equaling twenty-eight and**
36 **five-tenths percent (28.5%) of the fees actually assessed under**
37 **IC 16-21-10 for the state fiscal year, excluding the fees collected**
38 **under IC 16-21-10-13.3.**
39 **Sec. 10. (a) The managed care assessment fund is established for**
40 **the purpose of holding the fees collected under this chapter.**
41 **(b) The office shall administer the fund.**
42 **(c) Money in the fund consists of the following:**

1 **(1) Fees collected under this chapter, including penalty**
2 **payments under section 12 of this chapter.**
3 **(2) Donations, gifts, appropriations by the general assembly,**
4 **and money received from any other source.**
5 **(3) Interest accrued under this section.**
6 **(d) Money remaining in the fund at the end of a state fiscal year**
7 **does not revert to the state general fund.**
8 **(e) The treasurer of state shall invest the money in the fund not**
9 **currently needed to meet the obligations of the fund in the same**
10 **manner as other public funds may be invested. Interest that**
11 **accrues from these investments shall be deposited in the fund.**
12 **Sec. 11. A managed care organization that is liable for an**
13 **assessment under this chapter shall keep accurate and complete**
14 **records and pertinent documents that are relevant to the**
15 **organization's assessment under this chapter, as may be required**
16 **by the department or the office. The department or the office may**
17 **audit all records necessary to ensure compliance with this chapter**
18 **and make adjustments to assessment amounts previously**
19 **calculated based on the results of any the audit.**
20 **Sec. 12. (a) For good cause shown by a managed care**
21 **organization due to financial or other difficulties, as determined by**
22 **the office, the office is authorized to grant grace periods, of up to**
23 **thirty (30) days, for the managed care organization's payment of**
24 **an installment payment due under this chapter.**
25 **(b) If a managed care organization that is liable for an**
26 **assessment under this chapter fails to make an installment**
27 **payment by the payment's due date, and no grace period has been**
28 **granted to the managed care organization for the payment of the**
29 **installment payment, the managed care organization shall pay a**
30 **penalty of ten percent (10%) of the amount of the installment**
31 **payment not paid, plus ten percent (10%) of the portion remaining**
32 **unpaid on the last day of every thirty (30) day period thereafter.**
33 **These penalty payments shall be deposited into the managed care**
34 **assessment fund.**
35 **(c) If a managed care organization that is liable for an**
36 **assessment under this chapter is granted a grace period but fails to**
37 **make its installment payment by the end of the grace period, the**
38 **managed care organization shall pay a penalty of five percent (5%)**
39 **of the amount of the installment payment not paid, plus five**
40 **percent (5%) of the portion remaining unpaid on the last day of**
41 **every thirty (30) day period thereafter. These penalty payments**
42 **shall be deposited into the managed care assessment fund.**

1 **(d) Notwithstanding subsections (b) and (c), with respect to a**
2 **managed care organization that has a comprehensive risk contract**
3 **with the office under IC 12-15 that fails to make an installment**
4 **payment not later than sixty (60) days after the due date or, if**
5 **applicable, not later than sixty (60) days after the end of a grace**
6 **period, the office may additionally impose a contractual sanction**
7 **allowed against the managed care organization, and may terminate**
8 **the contract with the office.**
9 **(e) Notwithstanding subsections (b) through (d), with respect to**
10 **a managed care organization that fails to make an installment**
11 **payment not later than sixty (60) days after the due date or, if**
12 **applicable, not later than sixty (60) days after the end of a grace**
13 **period, the department may suspend or revoke, after notice and**
14 **hearing, the managed care organization's certificate of authority,**
15 **license, or other authority to operate in Indiana.**
16 **Sec. 13. The office may adopt rules under IC 4-22-2 to**
17 **implement this chapter. Notwithstanding the effective dates**
18 **specified for rules in IC 4-22-2, rules adopted to implement this**
19 **chapter may be retroactive to May 1, 2025.**
20 SECTION 4. **An emergency is declared for this act.**