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HOUSE BILL No. 1004

Proposed Changes to introduced printing by AM100413

DIGEST OF PROPOSED AMENDMENT

Health care. Allows a credit against an employer's state tax liability if the employer has adopted a health reimbursement arrangement in lieu of a traditional employer provided health insurance plan. Provides that certain employers that claim and are allowed the credit must report certain information to the department of insurance. Provides that the amount of credits granted in a particular state fiscal year may not exceed the greater of: (1) the amount of penalties deposited in the state general fund under the Indiana nonprofit hospital system price assessment during the preceding state fiscal year; or (2) $10,000,000. Provides that the credit may be carried over for 10 years, but may not be carried back. Specifies that only a primary care physician is eligible for a physician practice ownership tax credit. Increases the amount of the tax credit to $20,000. Provides that if the department of state revenue determines within five years of a taxpayer's receipt of a tax credit that the taxpayer: (1) has sold, transferred, granted, or otherwise relinquished the taxpayer's ownership interest in a specified entity; and (2) is employed by a health system or another non-physician owned medical practice; the department shall impose an assessment upon the taxpayer equal to the amount of tax credits provided to the taxpayer. Establishes the health care cost oversight board and establishes the duties of the board. Requires the department of insurance (department) to determine certain calculations concerning national and specific Indiana nonprofit hospital system prices and determine whether each Indiana nonprofit hospital system exceeds that national mean. Requires the department to take certain action against an Indiana nonprofit hospital system and certain health insurance carriers if the Indiana nonprofit hospital system exceeds specified calculations of the national mean or a national metric. Requires the department to annually report

to the governor and legislative council the calculations for each Indiana nonprofit hospital system and any corrective action or penalty assessed to an Indiana nonprofit hospital system and a health insurance carrier.

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

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

SECTION 1. IC 6-3.1-~~<40>~~[38] IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE ~~<JULY>~~[JANUARY] 1, 202~~<3>~~[4]]:

Chapter ~~<40>~~[38]. ~~<Physician Practice Ownership Tax>~~[Health Reimbursement Arrangement] Credit

Sec. 1.[] []This chapter applies[only] to taxable years beginning after December 31, 202~~<4>~~[3].

Sec. 2. As used in this chapter, "~~<physician" means an individual who is licensed to practice medicine in Indiana under IC 25-22.5>~~[qualified taxpayer" means an employer that is a corporation, a limited liability company, a partnership, or another entity that:

(1) has any state tax liability; and

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

Sec. 3. As used in this chapter, "state ~~<income >~~tax liability" means ~~<the>~~[a qualified] taxpayer's total tax liability that is incurred under[:

(1)] IC 6-3-1 through IC 6-3-7 (the adjusted gross income tax)~~<,>~~[;

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

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

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

Sec. 4.~~< As used in this chapter, "taxpayer" means a physician~~

~~who:~~

~~(1) has an ownership interest in a corporation, limited liability company, partnership, or other legal entity organized to provide health care services as a physician owned entity;~~

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

~~(3) has any state income tax liability.~~

~~Sec. 5. If a taxpayer has an ownership interest in a physician owned medical practice described in section 4(1) of this chapter that:~~

~~(1) is established as a legal entity under Indiana law after December 31, 2024;~~

~~(2) opens and begins to provide health care services to patients in a particular taxable year beginning after December 31, 2024; and~~

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

~~the taxpayer may, subject to section 6 of this chapter, claim a credit against the taxpayer's state income tax liability.>~~ **Subject to section 7 of this chapter, ~~<t>~~[a qualified taxpayer may claim a credit against the qualified taxpayer's state tax liability for a qualified contribution for a qualified taxpayer with less than fifty (50) employees, up to four hundred dollars ($400) in the first year per covered individual if the amount provided toward the health reimbursement arrangement is equal to or greater than either the level of benefits provided in the previous benefit year, or if the amount the employer contributes toward the health reimbursement arrangement equals the same amount contributed per covered individual toward the employer provided health insurance plan during the previous benefit year. The credit under this section decreases to two hundred dollars ($200) per covered individual in the second year.**

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

amount of the benefit.

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

Sec. 7. (a) The amount of tax credits granted under this chapter in a particular state fiscal year may not exceed the greater of:

(1) the amount of penalties deposited in the state general fund under IC 27-1-47.5 during the preceding state fiscal year; or

(2) ten million dollars ($10,000,000).

(b) The department shall record the time of filing of each return claiming a credit under section 6 of this chapter and shall approve the claims if they otherwise qualify for a tax credit under this chapter, in the chronological order in which the claims are filed in the state fiscal year.

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

Sec. 8. (a) T]he amount of the credit ~~<allowed>~~[provided by this chapter that a qualified taxpayer uses during a particular taxable year may not exceed the state tax liability of the qualified taxpayer.

(b) If the amount of a credit determined] under this chapter for a particular ~~<taxable year is ten thousand dollars ($10,000).~~

~~Sec. 6. A taxpayer may claim a tax credit under this chapter for the taxable year described in section 5 of this chapter and the two (2) immediately following taxable years.~~

~~Sec. 7. (a) If the amount of the credit allowed under section 5 of this chapter for a taxpayer in a>~~[qualified taxpayer and a particular] taxable year exceeds the[qualified] taxpayer's state ~~<income >~~tax liability for that taxable year, ~~<the>~~[then the qualified] taxpayer may carry the excess ~~<credit over for a period not to exceed the taxpayer's following ten (10) taxable years>~~[over to the immediately succeeding taxable years. The credit carryover may not be used for any taxable year that begins more than ten (10) years after the date on which the donation from which the credit results is made]. The amount of the credit carryover from a taxable year ~~<must>~~[shall] be reduced to the extent that the carryover is used by the[qualified] taxpayer to obtain a credit

under this chapter for any subsequent taxable year.[

(c)] A[qualified] taxpayer is not entitled to a carryback or <a >refund of any unused credit< amount.

~~(b) A taxpayer may not assign any part of a credit to which the taxpayer is entitled under this chapter.~~

~~Sec. 8. To obtain a credit under this chapter, a taxpayer must claim the credit on the taxpayer's annual state income tax return in the manner prescribed by the department. The taxpayer shall submit to the department all information that the department determines is necessary to verify the taxpayer's eligibility for the credit provided by>[.~~

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

SECTION 2. ~~<IC 16-18-2-163.6 IS ADDEDTO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 163.6. "Health care services", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-1.~~

~~SECTION 3. IC 16-18-2-167.8 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 167.8. "Health maintenance organization", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-2.~~

~~SECTION 4. IC 16-18-2-188.2 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 188.2. "Individual provider form", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-3.~~

~~SECTION 5. IC 16-18-2-190.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 190.7. "Institutional provider", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-4.~~

~~SECTION 6. IC 16-18-2-190.8 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 190.8. "Institutional provider form", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-5.~~

~~SECTION 7. IC 16-18-2-190.9 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 190.9. "Insurer", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-6.~~

~~SECTION 8. IC 16-18-2-254.7 IS ADDED TO THE INDIANA~~

~~CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 254.7. "Office setting", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-7.**~~

~~SECTION 9. IC 16-18-2-295, AS AMENDED BY P.L.161-2014, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 295. (a) "Provider", for purposes of IC 16-21-8, has the meaning set forth in IC 16-21-8-0.2.~~

~~(b) "Provider", for purposes of IC 16-38-5, IC 16-39 (except for IC 16-39-7), and IC 16-41-1 through IC 16-41-9, means any of the following:~~

~~(1) An individual (other than an individual who is an employee or a contractor of a hospital, a facility, or an agency described in subdivision (2) or (3)) who is licensed, registered, or certified as a health care professional, including the following:~~

~~(A) A physician.~~

~~(B) A psychotherapist.~~

~~(C) A dentist.~~

~~(D) A registered nurse.~~

~~(E) A licensed practical nurse.~~

~~(F) An optometrist.~~

~~(G) A podiatrist.~~

~~(H) A chiropractor.~~

~~(I) A physical therapist.~~

~~(J) A psychologist.~~

~~(K) An audiologist.~~

~~(L) A speech-language pathologist.~~

~~(M) A dietitian.~~

~~(N) An occupational therapist.~~

~~(O) A respiratory therapist.~~

~~(P) A pharmacist.~~

~~(Q) A sexual assault nurse examiner.~~

~~(2) A hospital or facility licensed under IC 16-21-2 or IC 12-25 or described in IC 12-24-1 or IC 12-29.~~

~~(3) A health facility licensed under IC 16-28-2.~~

~~(4) A home health agency licensed under IC 16-27-1.~~

~~(5) An employer of a certified emergency medical technician, a certified advanced emergency medical technician, or a licensed paramedic.~~

~~(6) The state department or a local health department or an employee, agent, designee, or contractor of the state department or local health department.~~

~~(c) "Provider", for purposes of IC 16-39-7-1, has the meaning set~~

~~forth in IC 16-39-7-1(a).~~

~~(d) "Provider", for purposes of IC 16-48-1, has the meaning set forth in IC 16-48-1-3.~~

~~(e) "Provider", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-8.~~

~~SECTION 10. IC 16-21-18>~~[IC 6-3.1-40] IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE ~~<JANUARY 1, 2025]:~~

~~Chapter 18. Hospital Employment of Physicians~~

~~Sec. 1. Except as provided in sections 4(2)(B) and 6 of this chapter, this chapter does not apply to a licensed physician providing services as the following:~~

~~(1) A radiologist.~~

~~(2) An anesthesiologist.~~

~~(3) A pathologist.~~

~~(4) An emergency room physician.~~

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

~~(1) A hospital.~~

~~(2) A hospital system.~~

~~(3) An affiliate of a hospital.~~

~~Sec. 3. (a) A hospital may employ a physician only if the following conditions are met:~~

~~(1) The hospital does not restrict or interfere with medically appropriate diagnostic or treatment decisions.~~

~~(2) The hospital does not restrict or interfere with physician referral decisions.~~

~~(b) If there is a dispute concerning whether the conditions have been met under subsection (a), the hospital has the burden of proving that the hospital has met the requirements of this section.~~

~~Sec. 4. Nothing in this chapter may be construed to prohibit any of the following from employing a physician:~~

~~(1) Another licensed physician.~~

~~(2) A group of licensed physicians, including any of the following:~~

~~(A) A physician's professional corporation (as defined in IC 23-1.5-1-10).~~

~~(B) A domestic nonprofit public benefit corporation (as defined in IC 23-17-2-23) that:~~

~~(i) is exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code;~~

~~(ii) has a purpose to engage in medical education~~

~~and medical research jointly with an accredited medical school in Indiana;~~

~~(iii) restricts the employed physicians to the medical faculty of the medical school; and~~

~~(iv) operates as a faculty practice plan for purposes of 42 U.S.C. 1395 et seq.~~

~~An employee physician who specializes in radiology, pathology, anesthesiology, or emergency medicine shall also be restricted to practice as a faculty practice plan employee at the medical school.~~

~~Sec. 5. (a) A hospital affiliate that employs physicians may not engage in any business other than:~~

~~(1) the employment of physicians;~~

~~(2) the management of physicians and health care facilities;~~

~~(3) the ownership of property and facilities used in the provision of health care services; or~~

~~(4) regulatory compliance and other administrative tasks that do not impact a physician's ability to make medical decisions in treating a patient.~~

~~(b) If there is a dispute concerning whether the conditions have been met under subsection (a), the hospital affiliate has the burden of proving that the hospital affiliate has met the requirements of this section.~~

~~(c) A hospital affiliate that violates this section may be sanctioned by the state department under this article. The hospital with which the hospital affiliate is associated and that has control of the hospital affiliate is also subject to penalties and sanctions by the state department under this article.~~

~~Sec. 6. A hospital may not employ any physician to provide medical services provided by:~~

~~(1) a radiologist;~~

~~(2) an anesthesiologist;~~

~~(3) a pathologist; or~~

~~(4) an emergency room physician;~~

~~except that a hospital may employ a physician to provide emergency services if the physician also provides other medical services.~~

~~SECTION 11. IC 16-51 IS ADDED TO THE INDIANA CODE AS A NEW ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:~~

~~ARTICLE 51. HEALTH CARE REQUIREMENTS~~

~~Chapter 1. Health Care Billing~~

~~Sec. 1. (a) As used in this chapter, "health care services" means health care related services or products rendered or sold by a provider within the scope of the provider's license or legal authorization.~~

~~(b) The term includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.~~

~~Sec. 2. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.~~

~~Sec. 3. (a) As used in this chapter, "individual provider form" means a medical claim form that:~~

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

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

~~(b) The term includes the following:~~

~~(1) The CMS-1500 form.~~

~~(2) The HCFA-1500 form.~~

~~Sec. 4. (a) As used in this chapter, "institutional provider" means any of the following:~~

~~(1) A hospital.~~

~~(2) A skilled nursing facility.~~

~~(3) An end stage renal disease provider.~~

~~(4) A home health agency.~~

~~(5) A hospice organization.~~

~~(6) An outpatient physical therapy, occupational therapy, or speech-language pathology service provider.~~

~~(7) A comprehensive outpatient rehabilitation facility.~~

~~(8) A community mental health center.~~

~~(9) A federally qualified health center.~~

~~(10) A histocompatibility laboratory.~~

~~(11) An Indian health service facility.~~

~~(12) An organ procurement organization.~~

~~(13) A religious nonmedical health care institution.~~

~~(14) A rural health clinic.~~

~~(b) The term does not include the following:~~

~~(1) A critical access hospital.~~

~~(2) A nonprofit hospital that is owned by a county.~~

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

~~(1) is accepted by the federal Centers for Medicare and~~

~~Medicaid Services for use by institutional providers; and~~

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

~~(b) The term includes the following:~~

~~(1) The 8371 Institutional form.~~

~~(2) The CMS-1450 form.~~

~~(3) The UB-04 form.~~

~~Sec. 6. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-11-1(c).~~

~~Sec. 7. As used in this chapter, "office setting" means a location, whether or not physically located within the facility of an institutional provider, where a provider routinely provides health examinations and diagnosis and treatment of illness or injury on an ambulatory basis.~~

~~Sec. 8. As used in this chapter, "provider" means an individual or entity duly licensed or legally authorized to provide health care services.~~

~~Sec. 9. (a) A bill for health care services provided by a provider in an office setting:~~

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

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

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

~~Sec. 10. The state department shall adopt rules under IC 4-22-2 for the enforcement of this chapter.~~

~~SECTION 12. IC 25-22.5-5.5-1.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:~~ **Sec. 1.5. (a) As used in this section, "nonprofit hospital" means a hospital that is organized as a nonprofit corporation or a charitable trust under Indiana law or the laws of any other state or country and that is:**

(1) eligible for tax exempt bond financing; or

(2) exempt from state or local taxes.

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

(1) A nonprofit hospital that is owned by a county.

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

~~**(c) Beginning July 1, 2023, a nonprofit hospital may not enter into, amend, or renew a physician noncompete agreement with a physician.**~~

~~SECTION 13. IC 27-1-37-8, AS ADDED BY P.L.198-2021, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 8. (a) This section applies to a health provider contract entered into, amended, or renewed after June 30, 2021.~~

~~(b) A health provider contract, including a contract with a pharmacy benefit manager, may not contain a provision that does any of the following:~~

~~(1) Limits the ability of either the health carrier or the health provider facility to disclose the allowed amount and fees of services to any insured (as defined in IC 27-8-5.8-3) or enrollee (as defined in IC 27-13-1-12), or to the treating health provider facility or physician of the insured or enrollee.~~

~~(2) Limits the ability of either the health carrier or the health provider facility to disclose out-of-pocket costs to an insured (as defined in IC 27-8-5.8-3) or an enrollee (as defined in IC 27-13-1-12).~~

~~**(3) Limits the ability of the health carrier to introduce or modify a select network plan or tiered network plan by granting the provider a guaranteed right of participation.**~~

~~**(4) Requires the health carrier to place all members of a provider group practice in the same tier of a tiered network plan.**~~

~~**(5) Requires the health carrier to include all members of a provider group in a select network plan on an all-or-nothing basis.**~~

~~**(6) Requires a provider to participate in a new select network or tiered network plan that the carrier introduces without granting the provider the right to opt out of the new plan at least sixty (60) days before the new plan is submitted to the commissioner for approval.**~~

~~**(7) Limits the ability of either the health carrier or the provider to disclose the allowed amount and fees of services to any insured (as defined in IC 27-8-5.8-3) or enrollee (as defined in IC 27-13-1-12), or the treating provider of the insured or enrollee.**~~

~~**(8) Limits the ability of either the health carrier or the provider to disclose out-of-pocket costs to an insured (as defined in IC 27-8-5.8-3) or an enrollee (as defined in IC 27-13-1-12).**~~

~~(9) Results or intends to result in anticompetitive effects.~~

~~(c) Any provision of a health provider contract that includes a provision described in subsection (b) in violation of this section is severable and the provision in violation is null and void. The remaining provisions of the health provider contract, excluding the provision in violation of this section, remain in effect and are enforceable.~~

~~(d) The attorney general may issue a civil investigative demand to obtain information from a party of, or pertaining to, a health provider contract and compliance of this section.~~

~~SECTION 14. IC 27-2-25.5 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2025]:~~

~~**Chapter 25.5. Employment of Physicians by Health Carriers**~~

~~**Sec. 1. Except as provided in section 4(2)(B) of this chapter, this chapter does not apply to a licensed physician providing the following:**~~

~~**(1) Services as the following:**~~

~~**(A) A radiologist.**~~

~~**(B) An anesthesiologist.**~~

~~**(C) A pathologist.**~~

~~**(D) An emergency room physician.**~~

~~**(2) Services, including the review of health insurance claims, that do not involve providing care to a patient.**~~

~~**Sec. 2. (a) As used in this chapter, "health carrier" means an entity:**~~

~~**(1) that is subject to this title and the administrative rules adopted under this title; and**~~

~~**(2) that enters into a contract to:**~~

~~**(A) provide health care services;**~~

~~**(B) deliver health care services;**~~

~~**(C) arrange for health care services; or**~~

~~**(D) pay for or reimburse any of the costs of health care services.**~~

~~**(b) The term 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).**~~

~~**(2) A health maintenance organization, as defined in IC 27-13-1-19.**~~

~~**(3) An administrator (as defined in IC 27-1-25-1(a)) that is licensed under IC 27-1-25.**~~

~~**(4) A state employee health plan offered under IC 5-10-8.**~~

~~(5) A short term insurance plan (as defined by IC 27-8-5.9-3).~~
~~(6) Any other entity that provides a plan of health insurance, health benefits, or health care services.~~
~~(c) The term does not include:~~
~~(1) an insurer that issues a policy of accident and sickness insurance;~~
~~(2) a limited service health maintenance organization (as defined in IC 27-13-34-4); or~~
~~(3) an administrator;~~
~~that only provides coverage for, or processes claims for, dental or vision care services.~~
~~Sec. 3. (a) A health carrier may employ a physician only if the following conditions are met:~~
~~(1) The health carrier does not restrict or interfere with medically appropriate diagnostic or treatment decisions.~~
~~(2) The health carrier does not restrict or interfere with physician referral decisions.~~
~~(b) If there is a dispute concerning whether the conditions have been met under subsection (a), the health carrier has the burden of proving that the health carrier has met the requirements of this section.~~
~~Sec. 4. Nothing in this chapter may be construed to prohibit any of the following from employing a physician:~~
~~(1) Another licensed physician.~~
~~(2) A group of licensed physicians, including any of the following:~~
~~(A) A physician's professional corporation (as defined in IC 23-1.5-1-10).~~
~~(B) A domestic nonprofit public benefit corporation (as defined in IC 23-17-2-23) that:~~
~~(i) is exempt from federal income taxation under Section 501(c)(3) of the Internal Revenue Code;~~
~~(ii) has a purpose to engage in medical education and medical research jointly with an accredited medical school in Indiana;~~
~~(iii) restricts the employed physicians to the medical faculty of the medical school; and~~
~~(iv) operates as a faculty practice plan for purposes of 42 U.S.C. 1395 et seq.~~
~~An employee physician who specializes in radiology, pathology, anesthesiology, or emergency medicine shall also be restricted to practice as a faculty practice plan~~

~~employee at the medical school.~~

~~SECTION 15. IC 27-2-28 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:~~

~~Chapter 28. Penalty for Excessive Rates for Health Care Services~~

~~>~~[JULY 1, 2023]:

Chapter 40. Physician Practice Ownership Tax Credit

] Sec. 1. This chapter applies [to taxable years]beginning after December 31, 2024.

Sec. 2. As used in this chapter, "~~<health care service" means a health care service provided by a nonprofit hospital, including any item, drug, or procedure, as referenced in the medical billing code that applies to specific health care services, as published in the Current Procedural Terminology code set maintained by the American Medical Association>~~[physician" means an individual who is licensed to practice medicine in Indiana under IC 25-22.5].

Sec. 3. As used in this chapter, "~~<nonprofit hospital" means a nonprofit hospital>~~[primary care physician" refers to a physician practicing in one (1) or more of the following:

(1) Family medicine.

(2) General pediatric medicine.

(3) Internal medicine.

(4) The general practice of medicine.

Sec. 4. As used in this chapter, "state income tax liability" means the taxpayer's total tax liability that is incurred under IC 6-3-1 through IC 6-3-7 (the adjusted gross income tax), as computed after the application of the credits that, under IC 6-3.1-1-2, are to be applied before the credit provided by this chapter.

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

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

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

(3) is not employed by a health system] (as defined in ~~<IC 16-21-9-3) licensed under this article. However, the term does not include a county-owned hospital or a nonprofit critical access hospital.~~

~~Sec. 4. Each nonprofit hospital operating in Indiana shall~~

~~before January 31 of each year, submit to the department the following for the nonprofit hospital's immediately preceding calendar year:~~

~~(1) A certified statement of, and supporting documentation to demonstrate:~~

~~(A) the average price charged by the hospital for each health care service provided to patients; and~~

~~(B) the hospital's total patient service revenue generated from all~~>[IC 16-18-2-168.5); and

(4) has any state income tax liability.

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

(1) is established as a legal entity under Indiana law after December 31, 2024;

(2) opens and begins to provide] **health care services** ~~<provided to patients by the hospital;~~

~~in the preceding calendar year.~~

~~(2) The federal Medicare reimbursement rate for each health care service provided to patients by the hospital in the preceding calendar year.~~

~~Sec. 5. (a) The department shall verify the documentation submitted by a nonprofit hospital under section 4 of this chapter and determine whether, and the extent to which, the hospital's average price charged for a health care service for the year exceeded two hundred sixty percent (260%) of the federal Medicare reimbursement rate for the health care service.~~

~~(b) If a nonprofit hospital charged amounts~~>[to patients in a particular taxable year beginning after December 31, 2024; and

(3) has billed] **for health care services** ~~<that exceeded two hundred sixty percent (260%) of the federal Medicare reimbursement rate for the health care service in the immediately preceding calendar year, the department shall assess a penalty against the hospital equal to STEP FOUR of the following formula:~~

~~STEP ONE: Determine the nonprofit hospital's total patient service revenue generated from all health care services provided to patients by the hospital in the preceding calendar year.~~

~~STEP TWO: Determine the total number of health care services by medical billing code that were provided to patients by the hospital in the preceding calendar year for~~

~~which the hospital charged amounts exceeding two hundred sixty percent (260%) of the federal Medicare reimbursement rate.~~

~~STEP THREE: Determine a percentage by multiplying:~~

~~(A) the STEP TWO number; by~~

~~(B) one percent (1%).~~

~~STEP FOUR: Determine the lesser of:~~

~~(A) the STEP ONE amount multiplied by the STEP THREE percentage; or~~

~~(B) the STEP ONE amount multiplied by ten percent (10%).~~

~~Sec. 6. A nonprofit hospital that is assessed a penalty>~~[described in subdivision (2) for at least six (6) months of that taxable year;

the taxpayer may, subject to section 7 of this chapter, claim a credit against the taxpayer's state income tax liability. Subject to section 8 of this chapter, the amount of the credit allowed] under this ~~<chapter may petition the department for reconsideration of the penalty based on a clerical, mathematical, or typographical error in the information submitted to the department by the hospital. A petition for reconsideration must be made in the manner, form, and time>~~[chapter for a particular taxable year is twenty thousand dollars ($20,000).

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

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

(b) A taxpayer may not assign any part of a credit to which the taxpayer is entitled under this chapter.

Sec. 9. To obtain a credit under this chapter, a taxpayer must claim the credit on the taxpayer's annual state income tax return in the manner] prescribed by the department. The ~~<department may revise a penalty based on a hospital's request for~~

~~reconsideration if and when the hospital has:~~

~~(1) provided documentation to establish that a clerical, mathematical, or typographical error was made;~~

~~(2) provided documentation to demonstrate that the error has been corrected (including any adversely impacted patients or any adversely impacted payors, if any); and~~

~~(3) shown that reasonable measures have been instituted to ensure the error will not continue.~~

~~Sec. 7. Revenue collected from the penalty assessed under section 5(b>~~[taxpayer shall submit to the department all information that the department determines is necessary to verify the taxpayer's eligibility for the credit provided by this chapter.

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

(1) has sold, transferred, granted, or otherwise relinquished the taxpayer's ownership interest in an entity described in section 5(2]) of this chapter~~< shall be deposited>~~[; and

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

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

(b) The department shall deposit assessments collected under this section] in the state general fund~~< and may be used to pay the state's share of the cost of Medicaid services provided under the federal Medicaid program.~~

~~SECTION 16. An emergency is declared for this act.>~~[.

SECTION 3. IC 12-15-11-10 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 10. (a) A physician licensed under IC 25-22.5 who was credentialed with an insurer to provide services within the previous twelve (12) months shall be considered provisionally credentialed by the insurer if the physician:

(1) is in good standing with the insurer; and

(2) establishes or joins an independent primary care practice.

(b) The office or a managed care organization or contractor of the office shall complete the credentialing process for an individual who is provisionally credentialed under subsection (a).

SECTION 4. IC 16-18-2-37.5, AS AMENDED BY P.L.3-2008, SECTION 103, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 37.5. (a) "Board", for purposes

of IC 16-21-18, has the meaning set forth in IC 16-21-18-1.

~~(a)~~ **(b)** "Board", for purposes of IC 16-22-8, has the meaning set forth in IC 16-22-8-2.1.

~~(b)~~ **(c)** "Board", for purposes of IC 16-41-42.2, has the meaning set forth in IC 16-41-42.2-1.

SECTION 5. IC 16-18-2-163.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 163.6. "Health care services", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-2.**

SECTION 6. IC 16-18-2-167.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 167.8. "Health maintenance organization", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-3.**

SECTION 7. IC 16-18-2-190.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 190.7. "Insurer", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-4.**

SECTION 8. IC 16-18-2-288, AS AMENDED BY P.L.96-2014, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: Sec. 288. (a) "Practitioner", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-5.

(b) "Practitioner", for purposes of IC 16-41-14, has the meaning set forth in IC 16-41-14-4.

(c) "Practitioner", for purposes of IC 16-42-21, has the meaning set forth in IC 16-42-21-3.

(d) "Practitioner", for purposes of IC 16-42-22 and IC 16-42-25, has the meaning set forth in IC 16-42-22-4.5.

(e) "Practitioner", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-5.

SECTION 9. IC 16-18-2-295.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 295.5. "Provider facility", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-6.**

SECTION 10. IC 16-18-2-327.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 327.7. "Service facility location", for purposes of IC 16-51-1, has the meaning set forth in IC 16-51-1-7.**

SECTION 11. IC 16-21-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 18. Health Care Cost Oversight Board

Sec. 1. As used in this chapter, "board" refers to the health care cost oversight board established by section 2 of this chapter.

Sec. 2. The health care cost oversight board is established.

Sec. 3. (a) The health care cost oversight board consists of the following members:

(1) The secretary of family and social services appointed under IC 12-8-1.5-2 or the secretary's designee.

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

(3) The commissioner of the department of insurance appointed under IC 27-1-1-2 or the commissioner's designee.

(4) Four (4) members of the general assembly as follows:

(A) One (1) member of the senate appointed by the president pro tempore.

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

(C) One (1) member of the house of representatives appointed by the speaker of the house.

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

A member appointed under this subdivision shall serve as a nonvoting member of the board.

(5) Subject to subsection (c), the following members appointed by the governor:

(A) Three (3) individuals representing Indiana consumers of health care.

(B) Two (2) representatives of employers domiciled in Indiana and are as follows:

(i) One (1) representative of an employer that employs less than one hundred fifty (150) employees in Indiana.

(ii) One (1) representative of an employer that employs at least five hundred (500) employees in Indiana.

In making these appointments, the governor may consider a recommendation of the Indiana Chamber of Commerce or the Indiana Manufacturers Association.

(C) One (1) representative of a nonprofit acute care hospital system licensed under IC 16-21 that has at least three (3) acute care hospital members. In making this

appointment, the governor may consider a recommendation of the Indiana Hospital Association.

(D) One (1) representative of an acute care hospital licensed under IC 16-21, IC 16-22, or IC 16-23 and that operates an independent hospital. In making this appointment, the governor may consider a recommendation of the Indiana Hospital Association.

(E) One (1) physician licensed under IC 25-22.5 that is not employed by a hospital, an insurer, or a health maintenance organization. In making this appointment, the governor may consider a recommendation of the Indiana State Medical Association.

(F) One (1) representative of:

(i) an insurer that offers policies of accident and sickness insurance (as defined in IC 27-8-5-1); or

(ii) a health maintenance organization that offers contracts for health care services;

in Indiana. In making this appointment, the governor may consider a recommendation of the Insurance Institute of Indiana.

(G) One (1) representative of a pharmaceutical manufacturer domiciled in Indiana. In making this appointment, the governor may consider a recommendation of the Indiana Pharmaceutical Research & Manufacturers Association.

(H) One (1) representative of a pharmacy benefit manager licensed under IC 27-1-24.5 that does business in Indiana. In making this appointment, the governor may consider a recommendation of the Indiana Pharmaceutical Care Management Association.

(I) One (1) economist or actuary with expertise in health care.

(J) One (1) individual with accounting experience in health care.

(b) The governor shall designate a member appointed under subsection (a)(5)(A) or (a)(5)(B) as the chairperson of the board.

(c) A member appointed under subsection (a)(5)(A), (a)(5)(B), (a)(5)(I), or (a)(5)(J) may not be employed by any of the following:

(1) The health care industry.

(2) The health insurance industry.

(3) The pharmaceutical industry.

(d) Each member of the board who is not a state employee is

not entitled to a salary, compensation, or reimbursement for expenses incurred as a member of the board. Each member of the commission who is a state employee is entitled to reimbursement for traveling expenses and other expenses actually incurred in connection with the board member's duties, as provided in the state travel policies and procedures established by the department of administration and approved by the state budget agency.

(e) The affirmative votes of a majority of the members appointed to the board are required for the board to take action on any measure.

(f) Except as provided in subsection (h), a member shall serve a term of two (2) years.

(g) If a vacancy exists on the board, the appointing authority who appointed the former member whose position has become vacant shall appoint an individual to fill the vacancy.

(h) Notwithstanding subsection (f), the initial appointments for the board under subsection (a)(5) are as follows:

(1) The members appointed under subsection (a)(5)(A) shall serve the initial term as follows:

(A) Two (2) members shall serve a term of one (1) year.

(B) One (1) member shall serve a term of two (2) years.

(2) The members appointed under subsection (a)(5)(B) shall serve the initial term as follows:

(A) One (1) member shall serve a term of one (1) year.

(B) One (1) member shall serve a term of two (2) years.

(3) The members appointed under subsection (a)(5)(C), (a)(5)(E), (a)(5)(G), and (a)(5)(I) shall serve a term of one (1) year.

(4) The members appointed under subsection (a)(5)(D), (a)(5)(F), (a)(5)(H), and (a)(5)(J) shall serve a term of two (2) years.

This subsection expires June 30, 2027.

Sec. 4. The board shall meet at least three (3) times per calendar year and at the call of the chairperson.

Sec. 5. The office of the secretary of family and social services shall staff the board.

Sec. 6. The board has the following duties:

(1) Monitoring health care delivery models used in Indiana.

(2) Obtaining and reviewing data and other information from the following:

(A) The Medicaid program.

(B) A hospital licensed under IC 16-21, IC 16-22, or

IC 16-23.

(C) National mean price data.

(D) A health carrier (as defined in IC 27-2-26-1).

(E) Information described in IC 27-1-24.5-21 and submitted to the board by a pharmacy benefit manager.

(3) Preparing an annual report as set forth in section 9 of this chapter.

(4) Determining whether any decrease in Indiana mean price by an Indiana nonprofit hospital system is resulting in the health care consumer spending less money on health care.

Sec. 7. (a) A hospital described in section 6(2)(B) of this chapter shall submit the following information to the board not later than March 1 of each year:

(1) The hospital's Indiana specific:

(A) income statement;

(B) balance sheet; and

(C) cash flow statement;

for the previous calendar year and that is prepared according to generally accepted accounting principles.

(2) Information concerning:

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

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

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

(b) A health carrier (as defined in IC 27-2-26-1) shall submit the following to the board not later than March 1 of each year:

(1) The following financial statements for the preceding calendar years, using statutory accounting principles, at the corporate level and at the Indiana market level:

(A) Income statements.

(B) Balance sheets.

(C) Cash flow statements.

(2) Information concerning the following:

(A) The health carrier's Indiana based profits, if the health carrier is publicly traded.

(B) The premiums (as defined in IC 27-1-2-3(w)) charged by the health carrier.

(C) The health carrier's strategy to lower health care costs.

(D) Any increase in the health carrier's premiums, on average statewide, that occurred in the previous year for each health carrier.

(E) Annual audited financial reports, if required under IC 27-1-3.5-6 and if the health carrier is publicly traded.

(c) A pharmacy benefit manager (as defined in IC 27-1-24.5-12) shall submit the information described in section 6(2)(E) of this chapter to the board not later than March 1 of each year.

(d) Any records or documents disclosed to, received by, or generated by the board are exempt from the requirements of IC 5-14-3.

Sec. 8. A board meeting is subject to IC 5-14-1.5.

Sec. 9. (a) Beginning August 1, 2024, and annually thereafter, the board shall prepare and submit a report based on the board's actions. The board shall submit the report to the governor and to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6.

(b) The report must include the following:

(1) Information concerning national and statewide health care costs, prices, growth, and use in Indiana for the previous calendar year.

(2) Factors that contributed to any health care cost growth in Indiana and the relationship with the increase and:

(A) health care provider costs;

(B) health insurance premium rates;

(C) medical loss ratios of health carriers;

(D) profits of health care providers and health carriers;

(E) pharmaceutical costs paid by hospitals;

(F) supplies costs paid by hospitals; and

(G) salaries, wages, and benefits paid by hospitals.

(3) Growth of health carrier premium rates and the percentage of a health carrier's premium rate growth attributable to the following:

(A) Hospital services.

(B) Physician services.

(C) Medical devices.

(D) Durable medical equipment.

(E) Pharmaceuticals.

(F) The health carrier's medical loss ratio.

(G) Health carrier profits.

(H) Pharmacy benefit managers.

(4) The impact of health care payment and delivery reform efforts on health care costs, including the following:

(A) Limited and tiered networks.

(B) Increased price transparency.

(C) Increased use of electronic medical records.

(D) Use of health technology.

(E) Alternative payment methodologies, including value based purchasing and direct employer models.

(5) Behavioral health costs, cost trends, price, and use.

(6) The information required to be submitted to the board under section 7 of this chapter.

(7) Any recommendations on the following:

(A) The enhancement of transparency of hospital prices and any basis for any increase in hospital prices.

(B) The enhancement of transparency of prescription drug prices and the basis for any increase in prescription drug prices.

(C) The enhancement of transparency of health plan premiums and the basis for any increase in health plan premiums.

(D) The enhancement of transparency of pharmacy benefit managers and the basis for any increase in payments to pharmacy benefit managers.

(E) Payments under the Medicaid program and other governmental programs for which health care services are provided.

(F) The improvement, efficiency, and cost effective delivery of health care services in Indiana.

(G) An accountability system to ensure health care cost savings are ultimately realized by health care consumers.

SECTION 12. IC 16-51 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

ARTICLE 51. HEALTH CARE REQUIREMENTS

Chapter 1. Health Care Billing

Sec. 1. This chapter is effective beginning January 1, 2025.

Sec. 2. (a) As used in this chapter, "health care services" means health care related services or products rendered or sold by

a provider within the scope of the provider's license or legal authorization.

(b) The term includes hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

Sec. 3. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

Sec. 4. As used in this chapter, "insurer" has the meaning set forth in IC 27-8-11-1(e).

Sec. 5. As used in this chapter, "practitioner" means an individual or entity duly licensed or legally authorized to provide health care services.

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

(1) A hospital, including a critical access hospital.
(2) A comprehensive care health facility.
(3) An end state renal disease provider.
(4) A home health agency.
(5) A hospice organization.
(6) An outpatient physical therapy, occupational therapy, or speech pathology service provider.
(7) A comprehensive outpatient rehabilitation facility.
(8) A community mental health center.
(9) A federally qualified health center.
(10) A histocompatibility laboratory.
(11) An Indian health service facility.
(12) An organ procurement organization.
(13) A religious nonmedical health care institution.
(14) A rural health clinic.

Sec. 7. As used in this chapter, "service facility location" means the address where the services of a provider facility or practitioner were provided. The term consists of the exact address and place of service codes as required by CMS form 1500 and CMS form 1450, or the equivalent electronic version of each form, including:

(1) an office;
(2) an on campus location of a hospital; and
(3) an off campus location of a hospital.

Sec. 8. (a) A provider facility or practitioner shall include the address of the service facility location as required by CMS form 1500 and CMS form 1450, or the equivalent electronic version of each form, in order to obtain reimbursement for a commercial claim for health care services from:

(1) an insurer;

(2) a health maintenance organization;

(3) an employer; or

(4) another person responsible for the payment of the cost of health care services.

(b) A person described in subsection (a) is not required to accept a bill for health care services that does not contain the service facility location.

Sec. 9. A patient is not liable for any additional payment that is the result of a practitioner or provider facility filing an incorrect form or not including the correct service facility location as required under this chapter.

SECTION 13. IC 27-1-47.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]:

Chapter 47.5. Oversight of Health Care Costs

Sec. 1. As used in this chapter, "governmental hospital" means an acute care hospital licensed under IC 16-21-2 that is governed by:

(1) IC 16-22-2;

(2) IC 16-22-8; or

(3) IC 16-23.

Sec. 2. As used in this chapter, "independent hospital" means a private nonprofit acute care hospital licensed under IC 16-21-2 that meets the following criteria:

(1) Is either:

(A) not directly or indirectly owned or controlled by an entity that is headquartered outside of the county where the hospital is located; or

(B) owned or controlled by an entity that is located in a contiguous county and operates not more than two (2) hospitals.

(2) Except as provided in subdivision (1)(B), does not directly or indirectly own another acute care hospital.

Sec. 3. (a) As used in this chapter, "Indiana nonprofit hospital system" means a hospital that is organized as a nonprofit corporation or a charitable trust under Indiana law or the laws of any other state or country and that is:

(1) eligible for tax exempt bond financing; or

(2) exempt from state or local taxes.

(b) The term does not apply to the following:

(1) A nonprofit hospital that is owned by a county.

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

(3) An independent hospital.

(4) A governmental hospital.

Sec. 4. (a) Before August 1, 2024, and before August every subsequent year, the department shall determine the method or means in which to calculate, and calculate, the following:

(1) Either:

(A) the national mean hospital facility price for commercially insured individuals as a percentage of Medicare for all nonprofit hospital:

(i) inpatient facility; and

(ii) outpatient facility;

services; or

(B) a nationally recognized metric to measure the national mean hospital facility price for commercially insured patients for all nonprofit hospital:

(i) inpatient facility; and

(ii) outpatient facility;

services.

(2) Either:

(A) the Indiana mean price for commercially insured individuals as a percentage of Medicare for each Indiana nonprofit hospital system:

(i) inpatient facility; and

(ii) outpatient facility;

services; or

(B) a nationally recognized metric to measure the Indiana mean hospital facility price for commercially insured patients for each Indiana nonprofit hospital system's:

(i) inpatient facility; and

(ii) outpatient facility;

services.

(b) The department may contract with a consultant in the performance of the duties specified in this section.

(c) If the department determines to use a metric calculation described in subsection (a)(1)(B) or (a)(2)(B), the department shall report to the budget committee to review the metric before the department may use the metric.

Sec. 5. (a) Before March 1, 2024, and before March 1 of each subsequent year, an Indiana nonprofit hospital system shall submit

the following:

(1) Information the department determines is necessary to make the assessments required in this chapter.

(2) Standard charge information required to be made public by the federal Centers for Medicare and Medicaid Services for price transparency for each hospital facility within the Indiana nonprofit hospital system.

(b) Information required under this section shall be submitted to the department in a manner prescribed by the department.

(c) Any records or documents disclosed to, received by, or generated by the department are exempt from the requirements of IC 5-14-3.

Sec. 6. (a) Before November 1, 2025, and before November 1 of each subsequent year, the department shall compare the pricing information of an Indiana nonprofit hospital system using the calculation described in section 4(a)(2) of this chapter to the national pricing level using the calculation described in section 4(a)(1) of this chapter. Before November 1, 2026, and before November 1 of each subsequent year, the department shall assess corrective action or penalties under subsection (c) for each Indiana nonprofit hospital system that the department determines is pricing in excess of the national pricing level calculated under section 4 of this chapter.

(b) The department shall review the data and resources submitted concerning health care costs in Indiana specific to each Indiana nonprofit hospital system.

(c) Beginning with determinations under subsection (a) made on or after November 1, 2026, the department shall annually make the calculations described in section 4 of this chapter for each Indiana nonprofit hospital system and do the following;

(1) If the department determines that the pricing of an Indiana nonprofit hospital system exceeds either:

(A) the national mean pricing level expressed as a percentage of Medicare pricing by fewer than twenty-five (25) percentage points; or

(B) the national mean pricing level determined using another metric by an amount equivalent to the amount described in clause (A);

the department shall issue a notice for corrective action to the Indiana nonprofit hospital system for a time period not to exceed six (6) months to decrease the Indiana nonprofit hospital system's prices. If the Indiana nonprofit hospital

system does not meet the corrective action, the department shall assess the Indiana nonprofit hospital system a penalty equal to one percent (1%) of the Indiana nonprofit hospital system's commercial net patient revenue in that calendar year.

(2) If the department determines that the pricing of an Indiana nonprofit hospital system exceeds either:

(A) the national mean pricing level expressed as a percentage of Medicare pricing by at least twenty-five (25) percentage points; or

(B) the national mean pricing level determined using another metric by an amount equivalent to the amount described in clause (A);

the department shall assess the Indiana nonprofit hospital system a penalty equal to one percent (1%) of the Indiana nonprofit hospital system's commercial net patient revenue in that calendar year.

(3) If the department determines that the pricing of an Indiana nonprofit hospital system is less than or equal to either:

(A) the national mean pricing level expressed as a percentage of Medicare pricing; or

(B) the national mean pricing level determined using another metric;

the department shall not take any action.

(d) A department's determination under this section is subject to administrative review.

(e) A penalty collected under this section shall be deposited into the state general fund for use of the health reimbursement arrangement credit established under IC 6-3.1-38.

Sec. 7. (a) For purposes of this section, in calculating the twenty-five percent (25%) in subsection (b), the calculation may not include coverage of individuals participating in the federal Medicare program or the Medicaid program.

(b) The department shall assess a health carrier (as defined in IC 27-1-37-1.5) that has at least twenty-five percent (25%) of the share of premiums in Indiana an assessment that is equal to the health carrier's share of the one percent (1%) of commercial revenue for each Indiana nonprofit hospital system that is assessed a penalty under section 6(c) of this chapter.

(c) A penalty collected under this section shall be deposited into the state general fund for use of the health reimbursement

arrangement credit established under IC 6-3.1-38.

(d) A department's determination under this section is subject to administrative review.

Sec. 8. Before November 1 of each year, the department shall prepare and submit a report to the governor and the legislative council in an electronic format under IC 5-14-6 including the following:

(1) The calculations determined for each Indiana nonprofit hospital under section 4 of this chapter.

(2) Any corrective action or penalties assessed to an Indiana nonprofit hospital or insurance carrier under this chapter.

Sec. 9. The department may adopt rules under IC 4-22-2, including emergency rules under IC 4-22-2-37.1, necessary to implement this chapter.

SECTION 14. IC 27-8-11-7.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 7.5. (a) A physician licensed under IC 25-22.5 who was credentialed to provide services under Medicaid within the previous twelve (12) months shall be considered provisionally credentialed if the physician:**

(1) is in good standing with the office or a managed care organization or contractor of the office; and

(2) establishes or joins an independent primary care practice.

(b) The insurer shall complete the credentialing process for an individual who is provisionally credentialed under subsection (a).

SECTION 15. IC 27-13-43-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2023]: **Sec. 3.5. (a) A physician licensed under IC 25-22.5 who was credentialed with a health maintenance organization to provide services within the previous twelve (12) months shall be considered provisionally credentialed if the physician:**

(1) is in good standing with the health maintenance organization; and

(2) establishes or joins an independent primary care practice.

(b) The health maintenance organization shall complete the credentialing process for an individual who is provisionally credentialed under subsection (a).

]