HOUSE BILL No. 1037

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-5; IC 27-13-20.

Synopsis: Insurance rate review. Provides that the insurance commissioner shall discharge the powers and duties of the commissioner's office with respect to policies of accident and sickness insurance and health maintenance organization contracts in a specified manner. Requires the commissioner to consider, before approving or disapproving a rate increase or decrease for a policy of accident and sickness insurance or a health maintenance organization contract, whether the filer's products are affordable and whether the filer has implemented effective strategies to enhance the affordability of the filer's products. Allows the commissioner to disapprove a rate increase if the rate is increased by an amount that exceeds the Consumer Price Index for All Urban Consumers: All Items Less Food and Energy percentage increase plus 1%.

Effective: July 1, 2026.

Garcia Wilburn

December 1, 2025, read first time and referred to Committee on Insurance.

Introduced

Second Regular Session of the 124th General Assembly (2026)

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 2025 Regular Session of the General Assembly.

HOUSE BILL No. 1037

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

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

SECTION 1. IC 27-8-5-1.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 1.3. With respect to a policy of accident and sickness insurance, the commissioner shall discharge the powers and duties of the commissioner's office to:**

(1) protect the public interest and the interests of consumers;

(2) encourage the fair treatment of providers; and

(3) view the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, affordability, improved health care quality, and appropriate access.

SECTION 2. IC 27-8-5-1.5, AS AMENDED BY P.L.190-2023, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 1.5. (a) This section applies to a policy of accident and sickness insurance issued on an individual, a group, a franchise, or a blanket basis, including a policy issued by an assessment company or

a fraternal benefit society.

(b) As used in this section, "commissioner" refers to the insurance commissioner appointed under IC 27-1-1-2.

(c) As used in this section, "grossly inadequate filing" means a policy form filing:

(1) that fails to provide key information, including state specific information, regarding a product, policy, or rate; or

(2) that demonstrates an insufficient understanding of applicable legal requirements.

(d) As used in this section, "policy form" means a policy, a contract, a certificate, a rider, an endorsement, an evidence of coverage, or any amendment that is required by law to be filed with the commissioner for approval before use in Indiana.

(e) As used in this section, "type of insurance" refers to a type of coverage listed on the National Association of Insurance Commissioners Uniform Life, Accident and Health, Annuity and Credit Product Coding Matrix under the heading "Continuing Care Retirement Communities", "Health", "Long Term Care", or "Medicare Supplement".

(f) Each person having a role in the filing process described in subsection (i) shall act in good faith and with due diligence in the performance of the person's duties.

(g) A policy form, including a policy form of a policy, contract, certificate, rider, endorsement, evidence of coverage, or amendment that is issued through a health benefit exchange (as defined in IC 27-19-2-8), may not be issued or delivered in Indiana unless the policy form has been filed with and approved by the commissioner.

(h) The commissioner shall do the following:

(1) Create a document containing a list of all product filing requirements for each type of insurance, with appropriate citations to the law, administrative rule, or bulletin that specifies the requirement, including the citation for the type of insurance to which the requirement applies.

(2) Make the document described in subdivision (1) available on the department of insurance ~~Internet site.~~ **website.**

(3) Update the document described in subdivision (1) at least annually and not more than thirty (30) days following any change in a filing requirement.

(i) The filing process is as follows:

(1) A filer shall submit a policy form filing that:

(A) includes a copy of the document described in subsection (h);

(B) indicates the location within the policy form or supplement that relates to each requirement contained in the document described in subsection (h); and

(C) certifies that the policy form meets all requirements of state law.

(2) The commissioner shall review a policy form filing and, not more than thirty (30) days after the commissioner receives the filing under subdivision (1):

(A) approve the filing; or

(B) provide written notice of a determination:

(i) that deficiencies exist in the filing; or

(ii) that the commissioner disapproves the filing.

A written notice provided by the commissioner under clause (B) must be based only on the requirements set forth in the document described in subsection (h) and must cite the specific requirements not met by the filing. A written notice provided by the commissioner under clause (B)(i) must state the reasons for the commissioner's determination in sufficient detail to enable the filer to bring the policy form into compliance with the requirements not met by the filing.

(3) A filer may resubmit a policy form that:

(A) was determined deficient under subdivision (2) and has been amended to correct the deficiencies; or

(B) was disapproved under subdivision (2) and has been revised.

A policy form resubmitted under this subdivision must meet the requirements set forth as described in subdivision (1) and must be resubmitted not more than thirty (30) days after the filer receives the commissioner's written notice of deficiency or disapproval. If a policy form is not resubmitted within thirty (30) days after receipt of the written notice, the commissioner's determination regarding the policy form is final.

(4) The commissioner shall review a policy form filing resubmitted under subdivision (3) and, not more than thirty (30) days after the commissioner receives the resubmission:

(A) approve the resubmitted policy form; or

(B) provide written notice that the commissioner disapproves the resubmitted policy form.

A written notice of disapproval provided by the commissioner under clause (B) must be based only on the requirements set forth in the document described in subsection (h), must cite the specific requirements not met by the filing, and must state the reasons for

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

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

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

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

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

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

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

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

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

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

(1) the benefits provided under the policy form are not reasonable

in relation to the premium charged; or

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

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

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

(2) The number of covered lives affected.

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

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

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

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

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

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

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

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

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

(12) If applicable, historical rebates paid to the policyholder from the most recent health plan year under the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

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

(14) Whether the insurer's products are affordable.

(15) Whether the insurer has implemented effective strategies to enhance the affordability of the insurer's products.

(n) The commissioner shall not approve a new product unless the commissioner has, at a minimum, considered the matters set forth in subsection (m)(1) through ~~(m)(13).~~ **(m)(15).**

(o) The information compiled, prepared, and considered by the commissioner under subsection (m)(1) through ~~(m)(13)~~ **(m)(15)** is

subject to the requirements of IC 5-14-3. However, the commissioner's approval of a new product or a rate increase or decrease may take effect before the information compiled, prepared, and considered by the commissioner under subsection (m)(1) through ~~(m)(13)~~ **(m)(15)** is made accessible to the public under IC 5-14-3.

(p) When considering whether to approve a premium rate increase, the commissioner shall consider whether the current rate is appropriate for achieving the insurer's target loss ratio.

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

(1) consider network adequacy;

(2) conduct form review to ensure:

(A) minimum essential health benefits; and

(B) nondiscriminatory benefit design;

(3) perform accreditation confirmation; and

(4) confirm quality measures.

(r) The commissioner may disapprove a premium rate increase if the premium rate is increased by an amount that exceeds the Consumer Price Index for All Urban Consumers: All Items Less Food and Energy (CPI-Urban) percentage increase based on the most recently published United States Bureau of Labor Statistics data plus one percent (1%).

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

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

(1) retroactively disapprove the policy form; or

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

SECTION 3. IC 27-13-20-1.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 1.4. With respect to a health maintenance organization, the commissioner shall discharge the powers and duties of the commissioner's office to:**

(1) protect the public interest and the interests of consumers;

(2) encourage the fair treatment of providers; and

(3) view the health care system as a comprehensive entity and encourage and direct health maintenance organizations

towards policies that advance the welfare of the public through overall efficiency, affordability, improved health care quality, and appropriate access.

SECTION 4. IC 27-13-20-1.5, AS ADDED BY P.L.190-2023, SECTION 34, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 1.5. (a) Before approving or disapproving an increase or decrease in the rates to be used by a health maintenance organization, the commissioner shall review the following:

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

(2) The number of covered lives affected.

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

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

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

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

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

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

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

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

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

(12) If applicable, historical rebates paid to the enrollee from the most recent health plan year under the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

(13) The median cost sharing amount for a member enrolled in the product, or the actuarial value information as required under the Patient Protection and Affordable Care Act, if applicable.

(14) Whether the health maintenance organization's products are affordable.

(15) Whether the health maintenance organization has implemented effective strategies to enhance the affordability of the health maintenance organization's products.

(b) The commissioner shall not approve a rate increase or decrease

for an existing product unless the commissioner has, at a minimum, considered the matters set forth in subsection (a)(1) through ~~(a)(13).~~ **(a)(15).**

(c) The information compiled, prepared, and considered by the commissioner under subsection (a)(1) through ~~(a)(13)~~ **(a)(15)** is subject to the requirements of IC 5-14-3. However, the commissioner's approval of a rate increase or decrease may take effect before the information compiled, prepared, and considered by the commissioner under subsection (a)(1) through ~~(a)(13)~~ **(a)(15)** is made accessible to the public under IC 5-14-3.

(d) When considering whether to approve a premium rate increase, the commissioner shall consider whether the current rate is appropriate for achieving the target loss ratio of the health maintenance organization.

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

(1) consider network adequacy;

(2) conduct form review to ensure:

(A) minimum essential health benefits; and

(B) nondiscriminatory benefit design;

(3) perform accreditation confirmation; and

(4) confirm quality measures.

(f) The commissioner may disapprove a rate increase if the rate is increased by an amount that exceeds the Consumer Price Index for All Urban Consumers: All Items Less Food and Energy (CPI-Urban) percentage increase based on the most recently published United States Bureau of Labor Statistics data plus one percent (1%).