February 17, 2026

ENGROSSED
SENATE BILL No. 189

DIGEST OF SB 189 (Updated February 17, 2026 12:23 pm - DI 141)

Citations Affected: IC 27-1; IC 27-4.

Synopsis: Nonparticipating providers. Requires an initiating party that submits a request for independent dispute resolution to provide written notice to the facility not later than three business days after submitting the request. Allows a health carrier to provide notice to an out of network provider and a facility if, during any 90 day period, an initiating party submits requests for independent dispute resolutions that, in the aggregate, include 25 or more qualified disputes. Provides that if a health carrier provides the notice, the health carrier, the out of network provider, and the facility shall engage in good faith efforts to negotiate a resolution. Prohibits a health carrier from assessing a facility or a provider an administrative fee or penalty related to the provision of care to an individual that involves an out of network provider. Provides that if a health carrier assesses a facility or a provider an administrative fee or penalty related to the provision of care to an individual that involves an out of network provider, the health carrier commits an unfair and deceptive act or practice in the business of insurance.

Effective: Upon passage.

Baldwin, Garten, Johnson T,
Randolph Lonnie M, Koch, Brown L
(HOUSE SPONSORS — BARRETT, CARBAUGH)

January 6, 2026, read first time and referred to Committee on Insurance and Financial Institutions.
January 22, 2026, amended, reported favorably — Do Pass.
January 26, 2026, read second time, ordered engrossed. Engrossed.
January 27, 2026, read third time, passed. Yeas 44, nays 1.

HOUSE ACTION

January 29, 2026, read first time and referred to Committee on Insurance.
February 17, 2026, amended, reported — Do Pass.

February 17, 2026

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.

ENGROSSED
SENATE BILL No. 189

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 27-1-45.2 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 45.2. Independent Dispute Resolution

Sec. 1. This chapter applies to any dispute subject to the federal independent dispute resolution process established under Section 2799A-1 of the Public Health Service Act (42 U.S.C. 300gg-111) and its implementing regulations.

Sec. 2. (a) As used in this chapter, "claim specific payment information" means billed charges, allowed amounts, payment amounts, cost sharing amounts, and any other monetary amounts associated with the adjudication of an identifiable health care claim.

(b) The term does not include aggregated or de-identified data that cannot reasonably be used to identify a specific claim, patient, or provider.

Sec. 3. As used in this chapter, "facility" means a licensed health

care facility in which health care services are provided to individuals.

Sec. 4. (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 cost 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 in 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. 5. As used in this chapter, "independent dispute resolution" means the federal independent dispute resolution process established under 42 U.S.C. 300gg-111 and 45 CFR Part 149, Subpart F.

Sec. 6. As used in this chapter, "initiating party" means a health carrier or out of network provider that submits a request for independent dispute resolution under federal law.

Sec. 7. As used in this chapter, "out of network provider" means a provider that is not contracted with a health carrier to provide health care services to covered individuals at not more than a

preestablished rate or amount of compensation.

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

Sec. 9. As used in this chapter, "qualified dispute" means a distinct item or service that is included in a request for independent dispute resolution.

Sec. 10. (a) An initiating party that submits a request for independent dispute resolution shall provide written notice to the facility not later than three (3) business days after submitting the request.

(b) The notice required under subsection (a) must, at a minimum, include a copy of the form used by the initiating party to request independent dispute resolution.

(c) An initiating party that fails to provide notice as required under this section is subject to enforcement as follows:

(1) If the initiating party is an out of network provider, the appropriate board (as defined in IC 25-1-9-1) may take action against the provider:

(A) under IC 25-1-9-9(a)(3) or IC 25-1-9-9(a)(4) for an initial or isolated violation of this section; or

(B) under IC 25-1-9-9(a)(6) for repeated or persistent violations of this section.

(2) If the initiating party is a health carrier, the department may enforce this section in accordance with IC 27-1-3-19.

(3) A penalty under subdivision (1)(B) may not exceed five thousand dollars ($5,000) annually.

(d) An enforcement action under subsection (c) does not relieve any party of the obligation to participate in the conference and good faith negotiation required by this chapter.

Sec. 11. (a) If, during any ninety (90) day period, an initiating party submits requests for independent dispute resolutions that, in the aggregate, include twenty-five (25) or more qualified disputes, the health carrier may:

(1) provide written notice to the out of network provider and the facility that includes:

(A) a description of the independent dispute resolution requests that are the basis for the notice, including applicable dates of service;

(B) identification of the party involved, including the name and tax identification number, if known;

(C) the name and contact information of a representative authorized to negotiate on behalf of the health carrier; and

(D) the requirement to participate in a conference and good faith negotiation; and

(2) deliver the notice to the out of network provider and the facility by:

(A) electronic mail; and

(B) certified mail.

(b) If a health carrier provides notice under subsection (a), the health carrier, the out of network provider, and the facility shall engage in good faith efforts to negotiate a resolution not later than thirty (30) days after the notice is provided, including:

(1) at least one (1) conference between authorized representatives; and

(2) a reasonable exchange of information necessary to evaluate and address the conduct described in the notice.

(c) A conference under subsection (b) may not:

(1) adjudicate individual claims;

(2) alter rights or obligations under federal or state law; or

(3) occur more than once per calendar quarter.

Sec. 12. (a) A conference under section 11(b) of this chapter must result in a written memorandum of conference.

(b) The memorandum must include the following information for the disputes reviewed:

(1) Identification of the disputes.

(2) The initial paid claim amount made by the health carrier to the out of network provider.

(3) The health carrier offer made during the applicable federal open negotiation period.

(4) The out of network provider requested amount.

(5) The qualifying payment amount, as determined under federal law.

(c) The memorandum is informational only and does not:

(1) impose penalties, fees, or financial disincentives;

(2) mandate payment outcomes;

(3) affect eligibility for independent dispute resolution; or

(4) alter claim level rights or remedies under federal or state law.

(d) The completed memorandum of conference shall be filed with the department. Claim specific payment information contained in the memorandum is confidential under IC 5-14-3-4 and is exempt from public access and disclosure under Indiana law.

(e) The department may not publish a memorandum that is filed under subsection (d). However, the department shall publish on the

department's website information concerning the aggregate number of memorandums filed with the department.

Sec. 13. (a) A health carrier may not assess a facility or a provider an administrative fee or penalty related to the provision of care to an individual that involves an out of network provider.

(b) If a health carrier assesses an administrative fee or penalty under subsection (a), the health carrier commits an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4 and is subject to the penalties and procedures set forth in IC 27-4-1.

SECTION 2. IC 27-4-1-4, AS AMENDED BY P.L.158-2024, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement:

(A) misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(B) making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(E) making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender the policyholder's insurance.

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to any person in the conduct of the person's insurance business, which is untrue,

deceptive, or misleading.

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Entering into any agreement to commit, or individually or by a concerted action committing any act of boycott, coercion, or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive. Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

(6) Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Making or permitting any of the following:

(A) Unfair discrimination between individuals of the same class and equal expectation of life in the rates or assessments charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract. However, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(B) Unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, assessments, or rates charged or made for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. However, in determining the class, consideration may be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(C) Excessive or inadequate charges for premiums, policy fees, assessments, or rates, or making or permitting any unfair discrimination between persons of the same class involving essentially the same hazards, in the amount of premiums, policy fees, assessments, or rates charged or made for:

(i) policies or contracts of reinsurance or joint reinsurance, or abstract and title insurance;

(ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance; or

(iii) policies or contracts of any other kind or kinds of insurance whatsoever.

However, nothing contained in clause (C) shall be construed to apply to any of the kinds of insurance referred to in clauses (A) and (B) nor to reinsurance in relation to such kinds of insurance. Nothing in clause (A), (B), or (C) shall be construed as making or permitting any excessive, inadequate, or unfairly discriminatory charge or rate or any charge or rate determined by the department or commissioner to meet the requirements of any other insurance rate regulatory law of this state.

(8) Except as otherwise expressly provided by IC 27-1-47 or another law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or

advantage in the dividends, savings, or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract or policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, limited liability company, or partnership, or any dividends, savings, or profits accrued thereon, or anything of value whatsoever not specified in the contract. Nothing in this subdivision and subdivision (7) shall be construed as including within the definition of discrimination or rebates any of the following practices:

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

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

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

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

(9) Requiring, as a condition precedent to loaning money upon the security of a mortgage upon real property, that the owner of the property to whom the money is to be loaned negotiate any policy of insurance covering such real property through a particular

insurance producer or broker or brokers. However, this subdivision shall not prevent the exercise by any lender of the lender's right to approve or disapprove of the insurance company selected by the borrower to underwrite the insurance.

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

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

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

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

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

(B) Insurance employed as a means of guaranteeing the

performance of goods and designed to benefit the purchasers or users of such goods.

(C) Title insurance.

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

(E) Insurance provided by or through motorists service clubs or associations.

(F) Insurance that is provided to the purchaser or holder of an air transportation ticket and that:

(i) insures against death or nonfatal injury that occurs during the flight to which the ticket relates;

(ii) insures against personal injury or property damage that occurs during travel to or from the airport in a common carrier immediately before or after the flight;

(iii) insures against baggage loss during the flight to which the ticket relates; or

(iv) insures against a flight cancellation to which the ticket relates.

(14) Refusing, because of the for-profit status of a hospital or medical facility, to make payments otherwise required to be made under a contract or policy of insurance for charges incurred by an insured in such a for-profit hospital or other for-profit medical facility licensed by the Indiana department of health.

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(16) Committing or performing, with such frequency as to indicate a general practice, unfair claim settlement practices (as defined in section 4.5 of this chapter).

(17) Between policy renewal dates, unilaterally canceling an individual's coverage under an individual or group health insurance policy solely because of the individual's medical or physical condition.

(18) Using a policy form or rider that would permit a cancellation of coverage as described in subdivision (17).

(19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1

concerning motor vehicle insurance rates.

(20) Violating IC 27-8-21-2 concerning advertisements referring to interest rate guarantees.

(21) Violating IC 27-8-24.3 concerning insurance and health plan coverage for victims of abuse.

(22) Violating IC 27-8-26 concerning genetic screening or testing.

(23) Violating IC 27-1-15.6-3(b) concerning licensure of insurance producers.

(24) Violating IC 27-1-38 concerning depository institutions.

(25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning the resolution of an appealed grievance decision.

(26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).

(27) Violating IC 27-2-21 concerning use of credit information.

(28) Violating IC 27-4-9-3 concerning recommendations to consumers.

(29) Engaging in dishonest or predatory insurance practices in marketing or sales of insurance to members of the United States Armed Forces as:

(A) described in the federal Military Personnel Financial Services Protection Act, P.L.109-290; or

(B) defined in rules adopted under subsection (b).

(30) Violating IC 27-8-19.8-20.1 concerning stranger originated life insurance.

(31) Violating IC 27-2-22 concerning retained asset accounts.

(32) Violating IC 27-8-5-29 concerning health plans offered through a health benefit exchange (as defined in IC 27-19-2-8).

(33) Violating a requirement of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), that is enforceable by the state.

(34) After June 30, 2015, violating IC 27-2-23 concerning unclaimed life insurance, annuity, or retained asset account benefits.

(35) Willfully violating IC 27-1-12-46 concerning a life insurance policy or certificate described in IC 27-1-12-46(a).

(36) Violating IC 27-1-37-7 concerning prohibiting the disclosure of health care service claims data.

(37) Violating IC 27-4-10-10 concerning virtual claims payments.

(38) Violating IC 27-1-24.5 concerning pharmacy benefit managers.

(39) Violating IC 27-7-17-16 or IC 27-7-17-17 concerning the marketing of travel insurance policies.

(40) Violating IC 27-1-49 concerning individual prescription drug rebates.

(41) Violating IC 27-1-50 concerning group prescription drug rebates.

(42) Violating IC 27-1-45.2-13 concerning an administrative fee or penalty imposed on a facility or a provider by a health carrier related to the provision of care to an individual that involves an out of network provider.

(b) Except with respect to federal insurance programs under Subchapter III of Chapter 19 of Title 38 of the United States Code, the commissioner may, consistent with the federal Military Personnel Financial Services Protection Act (10 U.S.C. 992 note), adopt rules under IC 4-22-2 to:

(1) define; and

(2) while the members are on a United States military installation or elsewhere in Indiana, protect members of the United States Armed Forces from;

dishonest or predatory insurance practices.

SECTION 3. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. President: The Senate Committee on Insurance and Financial Institutions, to which was referred Senate Bill No. 189, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Replace the effective date in SECTION 1 with "[EFFECTIVE UPON PASSAGE]".

Page 1, line 12, after "fee" insert "**or penalty**".

Page 1, line 14, after "fee" insert "**or penalty**".

Page 1, line 15, delete "the commissioner shall impose on the health carrier" and insert "**the health carrier commits an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4 and is subject to the penalties and procedures set forth in IC 27-4-1.**

SECTION 2. IC 27-4-1-4, AS AMENDED BY P.L.158-2024, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

(1) Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement:

(A) misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(B) making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(C) making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(D) using any name or title of any policy or class of policies misrepresenting the true nature thereof; or

(E) making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender the policyholder's insurance.

(2) Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public,

in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.

(3) Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Entering into any agreement to commit, or individually or by a concerted action committing any act of boycott, coercion, or intimidation resulting or tending to result in unreasonable restraint of, or a monopoly in, the business of insurance.

(5) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive. Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to which such insurer is required by law to report, or which has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

(6) Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

(7) Making or permitting any of the following:

(A) Unfair discrimination between individuals of the same class and equal expectation of life in the rates or assessments charged for any contract of life insurance or of life annuity or

in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract. However, in determining the class, consideration may be given to the nature of the risk, plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(B) Unfair discrimination between individuals of the same class involving essentially the same hazards in the amount of premium, policy fees, assessments, or rates charged or made for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. However, in determining the class, consideration may be given to the nature of the risk, the plan of insurance, the actual or expected expense of conducting the business, or any other relevant factor.

(C) Excessive or inadequate charges for premiums, policy fees, assessments, or rates, or making or permitting any unfair discrimination between persons of the same class involving essentially the same hazards, in the amount of premiums, policy fees, assessments, or rates charged or made for:

(i) policies or contracts of reinsurance or joint reinsurance, or abstract and title insurance;

(ii) policies or contracts of insurance against loss or damage to aircraft, or against liability arising out of the ownership, maintenance, or use of any aircraft, or of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance; or

(iii) policies or contracts of any other kind or kinds of insurance whatsoever.

However, nothing contained in clause (C) shall be construed to apply to any of the kinds of insurance referred to in clauses (A) and (B) nor to reinsurance in relation to such kinds of insurance. Nothing in clause (A), (B), or (C) shall be construed as making or permitting any excessive, inadequate, or unfairly discriminatory charge or rate or any charge or rate determined by the department or commissioner to meet the requirements of any other insurance rate regulatory law of this state.

(8) Except as otherwise expressly provided by IC 27-1-47 or another law, knowingly permitting or offering to make or making any contract or policy of insurance of any kind or kinds

whatsoever, including but not in limitation, life annuities, or agreement as to such contract or policy other than as plainly expressed in such contract or policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance, or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends, savings, or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract or policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to such insurance or annuity or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, limited liability company, or partnership, or any dividends, savings, or profits accrued thereon, or anything of value whatsoever not specified in the contract. Nothing in this subdivision and subdivision (7) shall be construed as including within the definition of discrimination or rebates any of the following practices:

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

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

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

(D) Paying by an insurer or insurance producer thereof duly licensed as such under the laws of this state of money, commission, or brokerage, or giving or allowing by an insurer or such licensed insurance producer thereof anything of value, for or on account of the solicitation or negotiation of policies or other contracts of any kind or kinds, to a broker, an insurance producer, or a solicitor duly licensed under the laws of this state, but such broker, insurance producer, or solicitor receiving such consideration shall not pay, give, or allow

credit for such consideration as received in whole or in part, directly or indirectly, to the insured by way of rebate.

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

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

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

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

(13) Issuing, offering, or participating in a plan to issue or offer, any policy or certificate of insurance of any kind or character as an inducement to the purchase of any property, real, personal, or mixed, or services of any kind, where a charge to the insured is not made for and on account of such policy or certificate of

insurance. However, this subdivision shall not apply to any of the following:

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

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

(C) Title insurance.

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

(E) Insurance provided by or through motorists service clubs or associations.

(F) Insurance that is provided to the purchaser or holder of an air transportation ticket and that:

(i) insures against death or nonfatal injury that occurs during the flight to which the ticket relates;

(ii) insures against personal injury or property damage that occurs during travel to or from the airport in a common carrier immediately before or after the flight;

(iii) insures against baggage loss during the flight to which the ticket relates; or

(iv) insures against a flight cancellation to which the ticket relates.

(14) Refusing, because of the for-profit status of a hospital or medical facility, to make payments otherwise required to be made under a contract or policy of insurance for charges incurred by an insured in such a for-profit hospital or other for-profit medical facility licensed by the Indiana department of health.

(15) Refusing to insure an individual, refusing to continue to issue insurance to an individual, limiting the amount, extent, or kind of coverage available to an individual, or charging an individual a different rate for the same coverage, solely because of that individual's blindness or partial blindness, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(16) Committing or performing, with such frequency as to indicate a general practice, unfair claim settlement practices (as defined in section 4.5 of this chapter).

(17) Between policy renewal dates, unilaterally canceling an

individual's coverage under an individual or group health insurance policy solely because of the individual's medical or physical condition.

(18) Using a policy form or rider that would permit a cancellation of coverage as described in subdivision (17).

(19) Violating IC 27-1-22-25, IC 27-1-22-26, or IC 27-1-22-26.1 concerning motor vehicle insurance rates.

(20) Violating IC 27-8-21-2 concerning advertisements referring to interest rate guarantees.

(21) Violating IC 27-8-24.3 concerning insurance and health plan coverage for victims of abuse.

(22) Violating IC 27-8-26 concerning genetic screening or testing.

(23) Violating IC 27-1-15.6-3(b) concerning licensure of insurance producers.

(24) Violating IC 27-1-38 concerning depository institutions.

(25) Violating IC 27-8-28-17(c) or IC 27-13-10-8(c) concerning the resolution of an appealed grievance decision.

(26) Violating IC 27-8-5-2.5(e) through IC 27-8-5-2.5(j) (expired July 1, 2007, and removed) or IC 27-8-5-19.2 (expired July 1, 2007, and repealed).

(27) Violating IC 27-2-21 concerning use of credit information.

(28) Violating IC 27-4-9-3 concerning recommendations to consumers.

(29) Engaging in dishonest or predatory insurance practices in marketing or sales of insurance to members of the United States Armed Forces as:

(A) described in the federal Military Personnel Financial Services Protection Act, P.L.109-290; or

(B) defined in rules adopted under subsection (b).

(30) Violating IC 27-8-19.8-20.1 concerning stranger originated life insurance.

(31) Violating IC 27-2-22 concerning retained asset accounts.

(32) Violating IC 27-8-5-29 concerning health plans offered through a health benefit exchange (as defined in IC 27-19-2-8).

(33) Violating a requirement of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), that is enforceable by the state.

(34) After June 30, 2015, violating IC 27-2-23 concerning unclaimed life insurance, annuity, or retained asset account benefits.

(35) Willfully violating IC 27-1-12-46 concerning a life insurance

policy or certificate described in IC 27-1-12-46(a).

(36) Violating IC 27-1-37-7 concerning prohibiting the disclosure of health care service claims data.

(37) Violating IC 27-4-10-10 concerning virtual claims payments.

(38) Violating IC 27-1-24.5 concerning pharmacy benefit managers.

(39) Violating IC 27-7-17-16 or IC 27-7-17-17 concerning the marketing of travel insurance policies.

(40) Violating IC 27-1-49 concerning individual prescription drug rebates.

(41) Violating IC 27-1-50 concerning group prescription drug rebates.

(42) Violating IC 27-1-37-11 concerning an administrative fee or penalty imposed on a health provider facility or a provider by a health carrier related to the provision of care to an individual that involves an out of network provider.

(b) Except with respect to federal insurance programs under Subchapter III of Chapter 19 of Title 38 of the United States Code, the commissioner may, consistent with the federal Military Personnel Financial Services Protection Act (10 U.S.C. 992 note), adopt rules under IC 4-22-2 to:

(1) define; and

(2) while the members are on a United States military installation or elsewhere in Indiana, protect members of the United States Armed Forces from;

dishonest or predatory insurance practices.

SECTION 3. **An emergency is declared for this act.**".

Page 1, delete lines 16 through 17.

Delete page 2.

and when so amended that said bill do pass.

(Reference is to SB 189 as introduced.)

BALDWIN, Chairperson

Committee Vote: Yeas 6, Nays 1.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred Senate Bill 189, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Page 1, delete lines 1 through 17.

Page 2, delete line 1, begin a new paragraph and insert:

"SECTION 1. IC 27-1-45.2 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 45.2. Independent Dispute Resolution

Sec. 1. This chapter applies to any dispute subject to the federal independent dispute resolution process established under Section 2799A-1 of the Public Health Service Act (42 U.S.C. 300gg-111) and its implementing regulations.

Sec. 2. (a) As used in this chapter, "claim specific payment information" means billed charges, allowed amounts, payment amounts, cost sharing amounts, and any other monetary amounts associated with the adjudication of an identifiable health care claim.

(b) The term does not include aggregated or de-identified data that cannot reasonably be used to identify a specific claim, patient, or provider.

Sec. 3. As used in this chapter, "facility" means a licensed health care facility in which health care services are provided to individuals.

Sec. 4. (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 cost 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 in 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. 5. As used in this chapter, "independent dispute resolution" means the federal independent dispute resolution process established under 42 U.S.C. 300gg-111 and 45 CFR Part 149, Subpart F.

Sec. 6. As used in this chapter, "initiating party" means a health carrier or out of network provider that submits a request for independent dispute resolution under federal law.

Sec. 7. As used in this chapter, "out of network provider" means a provider that is not contracted with a health carrier to provide health care services to covered individuals at not more than a preestablished rate or amount of compensation.

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

Sec. 9. As used in this chapter, "qualified dispute" means a distinct item or service that is included in a request for independent dispute resolution.

Sec. 10. (a) An initiating party that submits a request for independent dispute resolution shall provide written notice to the facility not later than three (3) business days after submitting the request.

(b) The notice required under subsection (a) must, at a minimum, include a copy of the form used by the initiating party to request independent dispute resolution.

(c) An initiating party that fails to provide notice as required under this section is subject to enforcement as follows:

(1) If the initiating party is an out of network provider, the appropriate board (as defined in IC 25-1-9-1) may take action against the provider:

(A) under IC 25-1-9-9(a)(3) or IC 25-1-9-9(a)(4) for an initial or isolated violation of this section; or

(B) under IC 25-1-9-9(a)(6) for repeated or persistent violations of this section.

(2) If the initiating party is a health carrier, the department may enforce this section in accordance with IC 27-1-3-19.

(3) A penalty under subdivision (1)(B) may not exceed five thousand dollars ($5,000) annually.

(d) An enforcement action under subsection (c) does not relieve any party of the obligation to participate in the conference and good faith negotiation required by this chapter.

Sec. 11. (a) If, during any ninety (90) day period, an initiating party submits requests for independent dispute resolutions that, in the aggregate, include twenty-five (25) or more qualified disputes, the health carrier may:

(1) provide written notice to the out of network provider and the facility that includes:

(A) a description of the independent dispute resolution requests that are the basis for the notice, including applicable dates of service;

(B) identification of the party involved, including the name and tax identification number, if known;

(C) the name and contact information of a representative authorized to negotiate on behalf of the health carrier; and

(D) the requirement to participate in a conference and good faith negotiation; and

(2) deliver the notice to the out of network provider and the facility by:

(A) electronic mail; and

(B) certified mail.

(b) If a health carrier provides notice under subsection (a), the health carrier, the out of network provider, and the facility shall engage in good faith efforts to negotiate a resolution not later than thirty (30) days after the notice is provided, including:

(1) at least one (1) conference between authorized representatives; and

(2) a reasonable exchange of information necessary to evaluate and address the conduct described in the notice.

(c) A conference under subsection (b) may not:

(1) adjudicate individual claims;

(2) alter rights or obligations under federal or state law; or

(3) occur more than once per calendar quarter.

Sec. 12. (a) A conference under section 11(b) of this chapter must result in a written memorandum of conference.

(b) The memorandum must include the following information for the disputes reviewed:

(1) Identification of the disputes.

(2) The initial paid claim amount made by the health carrier to the out of network provider.

(3) The health carrier offer made during the applicable federal open negotiation period.

(4) The out of network provider requested amount.

(5) The qualifying payment amount, as determined under federal law.

(c) The memorandum is informational only and does not:

(1) impose penalties, fees, or financial disincentives;

(2) mandate payment outcomes;

(3) affect eligibility for independent dispute resolution; or

(4) alter claim level rights or remedies under federal or state law.

(d) The completed memorandum of conference shall be filed with the department. Claim specific payment information contained in the memorandum is confidential under IC 5-14-3-4 and is exempt from public access and disclosure under Indiana law.

(e) The department may not publish a memorandum that is filed under subsection (d). However, the department shall publish on the department's website information concerning the aggregate number of memorandums filed with the department.

Sec. 13. (a) A health carrier may not assess a facility or a provider an administrative fee or penalty related to the provision of care to an individual that involves an out of network provider.

(b) If a health carrier assesses an administrative fee or penalty under subsection (a), the health carrier commits an unfair and deceptive act or practice in the business of insurance under IC 27-4-1-4 and is subject to the penalties and procedures set forth in IC 27-4-1.".

Page 8, line 40, delete "IC 27-1-37-11" and insert "**IC 27-1-45.2-13**".

Page 8, line 41, delete "health provider".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 189 as printed January 23, 2026.)

CARBAUGH

Committee Vote: yeas 10, nays 0.