SENATE ENROLLED ACT No. 5

AN ACT to amend the Indiana Code concerning insurance.

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

SECTION 1. IC 16-18-2-362.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 362.1. "Urgent care facility", for purposes of IC 16-24.5-1, has the meaning set forth in IC 16-24.5-1-1.**

SECTION 2. IC 16-21-17 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

Chapter 17. Health Care Pricing Information

Sec. 1. (a) Not later than March 31, 2021, a hospital and an ambulatory outpatient surgical center shall post on the Internet web site of the hospital or ambulatory outpatient surgical center pricing and other information specified in this chapter for the following:

(1) For as many of the seventy (70) shoppable services specified in the final rule of the Centers for Medicare and Medicaid Services published in 84 FR 65524 that are provided by the hospital or ambulatory outpatient surgical center.

(2) In addition to the services specified in subdivision (1), the thirty (30) most common services that are provided by the hospital or ambulatory outpatient surgical center not included in subdivision (1).

(b) The following information, to the extent applicable, must be

included on the Internet web site by a hospital and an ambulatory outpatient surgical center for the shoppable and common services described in subsection (a):

(1) A description of the shoppable and common service.

(2) The weighted average negotiated charge per service per provider type for each of the following categories:

(A) Any nongovernment sponsored health benefit plan or insurance plan provided by a health carrier in which the provider is in the network.

(B) Medicare, including fee for service and Medicare Advantage.

(C) Self-pay without charitable assistance from the hospital or ambulatory outpatient surgical center.

(D) Self-pay with charitable assistance from the hospital or ambulatory outpatient surgical center.

Sec. 2. (a) The information displayed on the Internet web site must be in an easy to read, understandable format, and include the negotiated charge as described in section 1 of this chapter for each service by provider type.

(b) A hospital and an ambulatory outpatient surgical center shall update the information on the Internet web site on an annual basis.

SECTION 3. IC 16-24.5 IS ADDED TO THE INDIANA CODE AS A **NEW** ARTICLE TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]:

ARTICLE 24.5. OTHER HEALTH CARE FACILITIES

Chapter 1. Urgent Care Facilities

Sec. 1. (a) As used in this chapter, "urgent care facility" means a freestanding health care facility that offers episodic, walk-in care for the treatment of acute, but not life-threatening, health conditions.

(b) The term does not include an emergency department of a hospital or a nonprofit or government operated health clinic.

Sec. 2. (a) Not later than March 31, 2021, an urgent care facility shall post on the Internet web site of the urgent care facility pricing and other information specified in this chapter for the fifteen (15) most common services that are provided by the urgent care facility.

(b) The following information, to the extent applicable, must be included on the Internet web site by an urgent care facility for the fifteen (15) most common services described in subsection (a):

(1) The number of times each service is provided by the

urgent care facility.

(2) A description of the service.

(3) The weighted average negotiated charge per service per provider type for each of the following categories:

(A) Any nongovernment sponsored health benefit plan or insurance provided by a health carrier in which the provider is in the network.

(B) Medicare, including fee for service and Medicare Advantage.

(C) Self-pay without charitable assistance from the urgent care facility.

(D) Self-pay with charitable assistance from the urgent care facility.

Sec. 3. (a) The information displayed on the Internet web site must be in an easy to read, understandable format, and include the negotiated charge as described in section 2 of this chapter for each service by provider type.

(b) An urgent care facility shall update the information on the Internet web site on an annual basis.

SECTION 4. IC 27-1-15.6-13.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 13.5. (a) This section applies only to the following:**

(1) A group policy of accident and sickness insurance, as defined in IC 27-8-5-1. However, this section does not apply to the types of insurance and coverage described in IC 27-8-5-2.5(a).

(2) A group health maintenance organization contract entered into under IC 27-13.

(b) Except as provided in subsection (e), an insurer that issues an insurance policy or a health maintenance organization that enters into a health maintenance organization contract shall disclose to the policyholder or subscriber in a separate written notification:

(1) any commission, service fee, or brokerage fee that has been or will be paid to an insurance producer for selling, soliciting, or negotiating the policy or contract; and

(2) whether the amount disclosed under subdivision (1) is based on a percentage of total plan premiums or a flat per member fee.

(c) An insurer or health maintenance organization shall provide a copy of the written notification described in subsection (b) to the

policyholder or subscriber:

(1) when the insurance policy is issued or the contract is entered into; and

(2) each time the insurance policy or contract is renewed.

(d) Each copy of a written notification described in subsection (b) must include a signature line on which the policyholder may sign to acknowledge receiving the written notification.

(e) This section does not require the disclosure to the policyholder of a commission, service fee, or brokerage fee in connection with the issuance of an insurance policy if a federal law or regulation requires disclosure of the commission, service fee, or brokerage fee to the policyholder.

SECTION 5. IC 27-1-37-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: **Sec. 7. (a) This section applies to health provider contracts beginning July 1, 2020.**

(b) A health provider contract, including a contract with a pharmacy benefit manager or a health facility, may not contain a provision that prohibits the disclosure of health care service claims data to employers providing the coverage. However, any disclosure of claims data must comply with health privacy laws, including the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191).

(c) A violation of this section constitutes an unfair or deceptive act or practice in the business of insurance under IC 27-4-1-4.

SECTION 6. IC 27-1-44.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 44.5. All Payer Claims Data Base

Sec. 1. As used in this chapter, "data base" refers to the all payer claims data base created under this chapter.

Sec. 2. As used in this chapter, "health payer" includes the following:

(1) Medicare.

(2) Medicaid or a managed care organization (as defined in IC 12-7-2-126.9) that has contracted with Medicaid to provide services to a Medicaid recipient.

(3) An insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1).

(4) A health maintenance organization (as defined in IC 27-13-1-19).

(5) A pharmacy benefit manager (as defined in

IC 27-1-24.8-3).

(6) A third party administrator.

(7) An insurer (as defined in IC 27-1-26-1), excluding insurers of life insurance.

(8) Any other person identified by the commissioner for participation in the data base described in this chapter.

Sec. 3. (a) Before July 1, 2020, the department shall issue a request for information in compliance with IC 5-23-4.5 concerning the creation, operation, and maintenance of a data base.

(b) The request for information must include the following questions:

(1) How the person would collect all relevant claims data for the data base from a health payer in a manner that would minimize technical barriers for a health payer to submit a claim.

(2) How the person would promote and encourage self-funded plans to voluntarily submit claims data for inclusion in the data base.

(3) What funding sources the person would seek to offset costs to implement and maintain the data base.

(4) How the person would make data from the data base available, including what sufficient fee would need to be assessed, to researchers, companies, and other interested parties in analyzing the data.

(5) How the person would ensure the following:

(A) That data is submitted and released in a machine readable format.

(B) That the data from the data base is used in an ethical manner.

(C) That the data is not personally identifiable and is properly secured and maintained, and that the person complies with federal and state health care privacy laws.

(6) How the person would establish a public web portal for individuals to quickly and easily compare prices for the full spectrum of medical billing codes as well as check quality ratings of providers.

(7) What threshold should be set for health payers to submit data for the data base.

(8) How the person would work with other states and relevant stakeholders to either:

(A) use a data language that is already available; or

(B) facilitate the establishment of a common data language

to be used by states for the data.

(9) Whether any changes to state law would increase the functionality and effectiveness of the data base and recommendations of the statutes and necessary changes.

(10) Any other questions the department determines are relevant to the implementation of a robust and transparent data base.

(c) The department shall set the deadline for submissions of the request for information under this section that may be not later than November 30, 2020.

Sec. 4. (a) After May 30, 2021, the department shall issue a request for an entity that is not a state agency or political subdivision to create, operate, and maintain the data base under this chapter. In addition to the requirements of IC 5-22-9, the request for proposals must include the considerations contained in the request for information under section 3 of this chapter.

(b) The request for proposals must state that the data base's purpose is to facilitate the following:

(1) Identifying health care needs and informing health care policy.

(2) Comparing costs between various treatment settings and approaches.

(3) Providing information to consumers and purchasers of health care.

(4) Improving the quality and affordability of patient health care and health care coverage.

(c) The department shall publish the department's decision concerning the submissions not later than November 30, 2021, on the department's Internet web site.

(d) If the department accepts a submission for the request for proposals, the department shall enter into a contract with the person to act as administrator of the data base and develop the data base.

(e) The administrator shall ensure that the data base is secure and compliant with the federal Health Insurance Portability and Accountability Act (HIPAA).

Sec. 5. (a) A health payer shall begin submitting the required data in a format specified by the administrator of the data base not later than three (3) months from the first day the department declares the data base to be fully operational.

(b) An employer may opt-in to share claims data with the data base.

SECTION 7. IC 27-4-1-4, AS AMENDED BY P.L.124-2018, SECTION 64, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2020]: 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 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 state 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.

(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 8. IC 27-8-11-13 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2021]: **Sec. 13. (a) A fully credentialed provider shall**

be reimbursed for eligible services provided at any in-network hospital if the following conditions are met:

(1) The provider submits the documentation required by the insurer to be loaded under the provider group or hospital.

(2) The provider, provider group, or hospital is a network provider with the insurer.

(3) The services are provided in accordance with all terms and conditions of the provider's, group provider's, or hospital's agreement or contract with the insurer.

(4) Prior authorization is obtained in accordance with IC 27-1-37.5 when required by the insurer for an eligible service.

(b) The insurer shall reimburse the provider or hospital for services described in subsection (a) at the rates determined by the contract between the provider and the insurer.

(c) An insurer is not required to credential a provider. However, if:

(1) a provider is employed by a hospital that is part of the hospital's network that is covered by the insurer; and

(2) the provider meets the insurer's credentialing requirements;

the insurer shall reimburse the provider for any reimbursable services from the date that the provider was employed by the hospital.

SECTION 9. IC 27-13-43-4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2021]: **Sec. 4. (a) A fully credentialed provider shall be reimbursed for eligible services provided at any in-network hospital if the following conditions are met:**

(1) The provider submits the documentation required by the health maintenance organization to be loaded under the provider group or hospital.

(2) The provider, provider group, or hospital is a network provider with the health maintenance organization.

(3) The services are provided in accordance with all terms and conditions of the provider's, group provider's, or hospital's agreement or contract with the health maintenance organization.

(4) Prior authorization is obtained in accordance with IC 27-1-37.5 when required by the health maintenance organization for an eligible service.

(b) The health maintenance organization shall reimburse the

provider or hospital for services described in subsection (a) at the rates determined by the contract between the provider and the health maintenance organization.

(c) A health maintenance organization is not required to credential a provider. However, if:

(1) a provider is employed by a hospital that is part of the hospital's network that is covered by the health maintenance organization; and

(2) the provider meets the health maintenance organization's credentialing requirements;

the health maintenance organization shall reimburse the provider for any reimbursable services from the date that the provider was employed by the hospital.

SECTION 10. **An emergency is declared for this act.**

President of the Senate

President Pro Tempore

Speaker of the House of Representatives

Governor of the State of Indiana

Date: _____ Time: _____

SEA 5 — Concur