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

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2024 Regular Session of the General Assembly.

HOUSE ENROLLED ACT No. 1604

AN ACT to amend the Indiana Code concerning insurance.

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

SECTION 1. IC 27-1-24.5-0.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: **Sec. 0.8. As used in this chapter, "cost sharing" means any copayment, coinsurance, deductible, or other similar charge that is:**

(1) required of a covered individual for a health care service covered by a health plan, including a prescription drug; and

(2) paid:

(A) by; or

(B) on behalf of;

the covered individual.

SECTION 2. IC 27-1-24.5-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: **Sec. 4.5. As used in this chapter, "health care service" means a service or good furnished for the purpose of preventing, alleviating, curing, or healing:**

(1) human illness;

(2) physical disability; or

(3) injury.

SECTION 3. IC 27-1-24.5-5, AS AMENDED BY P.L.207-2021, SECTION 52, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: Sec. 5. As used in this chapter, "health plan"

means **a plan through which coverage is provided for health care services through insurance, prepayment, reimbursement, or otherwise. The term includes** the following:

(1) A state employee health plan (as defined in IC 5-10-8-6.7).

(2) A policy of accident and sickness insurance (as defined in IC 27-8-5-1). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(3) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(4) Any other plan or program that provides payment, reimbursement, or indemnification to a covered individual for the cost of prescription drugs.

SECTION 4. IC 27-1-24.5-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: **Sec. 6.5. As used in this chapter, "insurer" means an insurer subject to state law and rules regulating insurance or subject to the jurisdiction of the department that contracts, or offers to contract, to:**

(1) provide;

(2) deliver;

(3) arrange for;

(4) pay for; or

(5) reimburse;

any of the costs of health care services to a covered individual under a health plan.

SECTION 5. IC 27-1-24.5-11.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: **Sec. 11.5. As used in this chapter, "pharmacy benefit management services" means:**

(1) negotiating the price of prescription drugs, including negotiating and contracting for direct or indirect rebates, discounts, or other price concessions;

(2) managing any aspect of a prescription drug benefit, including:

(A) the processing and payment of claims for prescription drugs;

(B) arranging alternative access to or funding for prescription drugs;

(C) the performance of drug utilization review;

(D) the processing of drug prior authorization requests;

(E) the adjudication of appeals or grievances related to the prescription drug benefit;

(F) contracting with network pharmacies;

(G) controlling the cost of covered prescription drugs;

(H) managing or providing data relating to the prescription drug benefit;

(I) the provision of services related to the prescription drug benefit; or

(J) creating or updating prescription drug formularies;

(3) the performance of any administrative, managerial, clinical, pricing, financial, reimbursement, data administration or reporting, or billing service; and

(4) any other services specified in a rule adopted by the department.

SECTION 6. IC 27-1-24.5-12, AS AMENDED BY P.L.32-2021, SECTION 77, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: Sec. 12. (a) As used in this chapter, "pharmacy benefit manager" means: ~~an entity that, on behalf of a health plan, state agency, insurer, managed care organization, or other third party payor:~~

(1) a person who, under a written agreement with an insurer, health plan, state agency, managed care organization, or other third party payor, directly or indirectly provides one (1) or more pharmacy benefit management services on behalf of the insurer, health plan, state agency, managed care organization, or other third party payor; and

(2) an agent, a contractor, an intermediary, an affiliate, a subsidiary, or a related entity of a person described in subdivision (1) who facilitates, provides, directs, or oversees the provision of the pharmacy benefit management services.

~~(1) contracts directly or indirectly with pharmacies to provide prescription drugs to individuals;~~

~~(2) administers a prescription drug benefit;~~

~~(3) processes or pays pharmacy claims;~~

~~(4) creates or updates prescription drug formularies;~~

~~(5) makes or assists in making prior authorization determinations on prescription drugs;~~

~~(6) administers rebates on prescription drugs; or~~

~~(7) establishes a pharmacy network.~~

(b) The term does not include the following:

(1) A person licensed under IC 16.

(2) A health provider who is:

(A) described in IC 25-0.5-1; and

(B) licensed or registered under IC 25.

(3) A consultant who only provides advice concerning the selection or performance of a pharmacy benefit manager.

SECTION 7. IC 27-1-24.5-20, AS AMENDED BY P.L.158-2024, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: Sec. 20. (a) The commissioner shall do the following:

(1) Prescribe an application for use in applying for a license to operate as a pharmacy benefit manager.

(2) Adopt rules under IC 4-22-2 to establish the following:

(A) Pharmacy benefit manager licensing requirements.

(B) Licensing fees.

(C) A license application.

(D) Financial standards for pharmacy benefit managers.

(E) Reporting requirements described in sections 21 and 29 of this chapter.

(F) The time frame for the resolution of an appeal under section 22 of this chapter.

(b) The commissioner may do the following:

(1) Charge a license application fee and renewal fees established under subsection (a)(2) in an amount not to exceed five hundred dollars ($500) to be deposited in the department of insurance fund established by IC 27-1-3-28.

(2) Examine or audit the books and records of a pharmacy benefit manager one (1) time per year to determine if the pharmacy benefit manager is in compliance with this chapter.

(3) Adopt rules under IC 4-22-2 to:

(A) implement this chapter; and

(B) specify requirements for the following:

(i) Prohibited market conduct practices.

(ii) Data reporting in connection with violations of state law.

(iii) Maximum allowable cost list compliance and enforcement requirements, including the requirements of sections 22 and 23 of this chapter.

(iv) Prohibitions and limits on pharmacy benefit manager practices that require licensure under IC 25-22.5.

(v) Pharmacy benefit manager affiliate information sharing.

(vi) Lists of health plans administered by a pharmacy benefit manager in Indiana.

(vii) Pharmacy benefit management services included under section 11.5(4) of this chapter.

(c) Financial information and proprietary information submitted by

a pharmacy benefit manager to the department is confidential.

SECTION 8. IC 27-1-24.5-27.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]: **Sec. 27.7. (a) This section applies to a health plan that is issued, delivered, amended, or renewed after December 31, 2025.**

(b) A pharmacy benefit manager shall apply the annual limitation on cost sharing set forth in the federal Patient Protection and Affordable Care Act under 42 U.S.C. 18022(c)(1) to prescription drugs that:

(1) are covered under a health plan administered by the pharmacy benefit manager;

(2) are life-saving or intended to manage chronic pain; and

(3) do not have an approved generic version.

(c) Except as provided in subsection (d), when calculating a covered individual's contribution to an applicable cost sharing requirement, a pharmacy benefit manager must include any cost sharing amounts paid:

(1) by the covered individual; or

(2) on behalf of the covered individual by another person.

(d) If application of subsection (c) would result in a covered individual becoming ineligible for a health savings account under Section 223 of the Internal Revenue Code, the requirement under subsection (c) applies with respect to the deductible of a high deductible health plan after the covered individual satisfies the minimum deductible under Section 223 of the Internal Revenue Code. However, subsection (c) applies to items or services that are preventative care under Section 223(c)(2)(C) of the Internal Revenue Code regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code is satisfied.

(e) A pharmacy benefit manager may not directly or indirectly:

(1) set;

(2) alter;

(3) implement; or

(4) condition;

the terms of health plan coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.

SECTION 9. IC 27-1-48.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 48.5. Out-of-Pocket Expense Credit

Sec. 1. This chapter applies to a health plan entered into or renewed after June 30, 2025.

Sec. 2. As used in this chapter, "covered individual" means an individual entitled to coverage under a health plan.

Sec. 3. As used in this chapter, "health care provider" means an individual or entity that is licensed, certified, registered, or regulated by an entity described in IC 25-0.5-11.

Sec. 4. As used in this chapter, "health care services" means any services or products rendered by a health care provider within the scope of the provider's license or legal authorization.

Sec. 5. (a) As used in this chapter, "health plan" means any of the following:

(1) A self-insurance program established under IC 5-10-8-7(b) to provide group coverage.

(2) A prepaid health care delivery plan through which health services are provided under IC 5-10-8-7(c).

(3) A policy of accident and sickness insurance as defined in IC 27-8-5-1, but not including any insurance, plan, or policy set forth in IC 27-8-5-2.5(a).

(4) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16) with a health maintenance organization that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(b) The term includes a person that administers any of the following:

(1) A self-insurance program established under IC 5-10-8-7(b) to provide group coverage.

(2) A prepaid health care delivery plan through which health services are provided under IC 5-10-8-7(c).

(3) A policy of accident and sickness insurance as defined in IC 27-8-5-1, but not including any insurance, plan, or policy set forth in IC 27-8-5-2.5(a).

(4) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16) with a health maintenance organization that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(c) The term includes hospital, medical, surgical, and pharmaceutical services or products.

Sec. 6. As used in this chapter, "network" means a group of health care providers that:

(1) provide health care services to covered individuals; and

(2) have agreed to, or are otherwise subject to, maximum limits on the prices for the health care services to be provided to the covered individuals.

Sec. 7. A health plan shall credit toward a covered individual's deductible and annual maximum out-of-pocket expenses any amount the covered individual pays directly to any health care provider for a medically necessary covered health care service if a claim for the health care service is not submitted to the health plan and the amount paid by the covered individual to the health care provider is less than the average discounted rate for the health care service paid to a health care provider in the health plan's network.

Sec. 8. (a) A health plan shall:

(1) establish a procedure by which a covered individual may claim a credit under section 7 of this chapter; and

(2) identify documentation necessary to support a claim for a credit under section 7 of this chapter.

(b) A health plan may either:

(1) publish average discounted rates that the health plan has negotiated to pay health care providers for health care services; or

(2) refer to average or typical rates on the all payer claims data base established under IC 27-1-44.5;

for purposes of a covered individual claiming a credit under section 7 of this chapter.

(c) A covered individual may use the data on average or typical rates reported on the all payer claims data base established under IC 27-1-44.5 to determine the average discounted rate for a health care service under section 7 of this chapter.

Sec. 9. A health plan shall display information about the procedure and documentation described in section 8 of this chapter on the health plan's website, including a link to the website for the all payer claims data base established under IC 27-1-44.5.

Sec. 10. The department shall adopt rules under IC 4-22-2 to effectuate the provisions of this chapter.

SECTION 10. IC 27-1-51 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026]:

Chapter 51. Cost Sharing for Health Insurance Coverage

Sec. 1. This chapter applies to a policy of health insurance coverage that is issued, delivered, amended, or renewed after December 31, 2025.

Sec. 2. As used in this chapter, "administrator" means a person

who, directly or indirectly and on behalf of an insurer:

(1) underwrites; or

(2) collects charges or premiums from or adjusts or settles claims on:

(A) residents of Indiana; or

(B) residents of another state from offices in Indiana;

in connection with health insurance coverage offered or provided by an insurer.

Sec. 3. As used in this chapter, "cost sharing" means any copayment, coinsurance, deductible, or other similar charge that is:

(1) required of a covered individual for a health care service covered by a policy of health insurance coverage, including a prescription drug; and

(2) paid:

(A) by; or

(B) on behalf of;

the covered individual.

Sec. 4. As used in this chapter, "covered individual" means an individual who is entitled to health insurance coverage.

Sec. 5. As used in this chapter, "health care service" means a service or good furnished for the purpose of preventing, alleviating, curing, or healing:

(1) human illness;

(2) physical disability; or

(3) injury.

Sec. 6. (a) As used in this chapter, "health insurance coverage" means:

(1) an individual or group policy of accident and sickness insurance (as defined in IC 27-8-5-1);

(2) an individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16) that provides coverage for basic health care services (as defined in IC 27-13-1-4); and

(3) any other health plan that is issued on an individual or group basis;

that is subject to state law and rules regulating insurance or subject to the jurisdiction of the department. The term includes coverage of a dependent of the covered individual under a policy or contract described in subdivisions (1) through (3).

(b) The term does not include a self-funded health benefit plan that complies with the federal Employee Retirement Income

Security Act (ERISA) of 1974 (29 U.S.C. 1001 et seq.).

Sec. 7. As used in this chapter, "insurer" means an insurer that provides health insurance coverage to a covered individual.

Sec. 8. As used in this chapter, "person" means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, not-for-profit corporation, unincorporated organization, government, or governmental subdivision or agency.

Sec. 9. An insurer and an administrator shall apply the annual limitation on cost sharing set forth in the federal Patient Protection and Affordable Care Act under 42 U.S.C. 18022(c)(1) to prescription drugs that:

(1) are covered under a policy or contract of health insurance coverage offered or issued by the insurer;

(2) are life-saving or intended to manage chronic pain; and

(3) do not have an approved generic version.

Sec. 10. (a) Except as provided in subsection (b), when calculating a covered individual's contribution to an applicable cost sharing requirement, an insurer and administrator must include any cost sharing amounts paid:

(1) by the covered individual; and

(2) on behalf of the covered individual by another person.

(b) If application of subsection (a) would result in a covered individual becoming ineligible for a health savings account under Section 223 of the Internal Revenue Code, the requirement under subsection (a) applies with respect to the deductible of a high deductible health plan after the covered individual satisfies the minimum deductible under Section 223 of the Internal Revenue Code. However, subsection (a) applies to items or services that are preventative care under Section 223(c)(2)(C) of the Internal Revenue Code regardless of whether the minimum deductible under Section 223 of the Internal Revenue Code is satisfied.

Sec. 11. An insurer and an administrator may not directly or indirectly:

(1) set;

(2) alter;

(3) implement; or

(4) condition;

the terms of health insurance coverage, including the benefit design, based in part or entirely on information about the availability or amount of financial or product assistance available for a prescription drug.

Sec. 12. Before December 31 of each year, each insurer and administrator shall certify to the commissioner that the insurer or administrator has fully and completely complied with the requirements of this chapter during the previous calendar year. The certification must be signed by the chief executive officer or chief financial officer of the insurer or administrator.

Sec. 13. The commissioner may adopt rules under IC 4-22-2 to implement this chapter.

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: _____ Time: _____