Reprinted
February 11, 2025

HOUSE BILL No. 1666

DIGEST OF HB 1666 (Updated February 10, 2025 4:57 pm - DI 147)

Citations Affected: IC 12-15; IC 16-18; IC 16-19; IC 16-21; IC 25-1; IC 25-22.5; IC 27-1.

Synopsis: Ownership of health care providers. Requires reporting of certain ownership information by: (1) a health care entity to the Indiana department of health (state department); (2) a physician group practice to the professional licensing agency; and (3) an insurer, a third party administrator, and a pharmacy benefit manager to the department of insurance. Requires a hospital to include certain ownership information in the hospital's annual fiscal report to the state department. Requires the professional licensing agency and the department of insurance to provide the ownership information to the state department. Requires the state department to post the ownership information on the state department's website. Sets forth penalties for a violation of the ownership reporting requirements. Amends the definition of "health care entity" for provisions governing health care entity mergers and acquisitions. Establishes the health care entity merger approval board (board) to evaluate and approve or deny proposed mergers and

(Continued next page)

Effective: Upon passage; July 1, 2025.

McGuire, Smaltz, Shackleford, Goss-Reaves

January 21, 2025, read first time and referred to Committee on Public Health.
February 4, 2025, amended, reported — Do Pass.
February 10, 2025, read second time, amended, ordered engrossed.

Digest Continued

acquisitions of health care entities. Requires an Indiana health care entity that is involved in a merger or acquisition with another health care entity to provide notice to the office of the attorney general. (Current law specifies that this notice requirement applies to an Indiana health care entity involved in a merger or acquisition with another health care entity with total assets of at least $10,000,000.) Allows the office of the attorney general to investigate the market concentration of a health care entity. Prohibits an Indiana health care entity from engaging in a merger or acquisition with another health care entity or a specified health care provider unless the health care entity has received approval from the board. Sets forth criteria for approving a health care entity merger or acquisition. Allows the attorney general to bring a civil action to enforce these provisions.

Reprinted
February 11, 2025

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 BILL No. 1666

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

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

SECTION 1. IC 12-15-1-18.5, AS ADDED BY P.L.203-2023, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 18.5. (a) The payer affordability penalty fund is established for the purpose of receiving fines collected under **IC 16-19-18-4,** IC 16-21-6-3, **IC 25-22.5-18-5, IC 27-1-4.5-7,** and ~~fines collected under~~ IC 27-2-25.5 to be used for:

(1) the state's share of the Medicaid program; and

(2) a study of hospitals that are impacted by changes made in the disproportionate share hospital methodology payments set forth in Section 203 of the federal Consolidated Appropriations Act of 2021.

The office of the secretary shall perform the study and provide the results of the study described in subdivision (2) to the budget committee.

(b) The fund shall be administered by the office of the secretary.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested. Interest that accrues from these investments shall be deposited in the fund.

(e) Money in the fund at the end of a state fiscal year does not revert to the state general fund.

(f) Money in the fund is continually appropriated.

SECTION 2. IC 16-18-2-79.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 79.1. "Controlling", for purposes of IC 16-19-16.5, has the meaning set forth in IC 16-19-16.5-1. "Controlling", for purposes of IC 16-21-6, has the meaning set forth in IC 16-21-6-0.3.**

SECTION 3. IC 16-18-2-160.5, AS AMENDED BY P.L.3-2008, SECTION 107, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 160.5. **(a) "Health care entity", for purposes of IC 16-19-16.5, has the meaning set forth in IC 16-19-16.5-2.**

(b) "Health care entity", for purposes of IC 16-41-42.1, has the meaning set forth in IC 16-41-42.1-1.

SECTION 4. IC 16-19-3-35 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 35. (a) The state department shall cooperate with the Indiana professional licensing agency and the department of insurance to develop and implement a plan to:**

(1) collect the information described in IC 16-21-6-3(a)(14) through IC 16-21-6-3(a)(17), IC 25-22.5-18-3, and IC 27-1-4.5-5; and

(2) make the information publicly available as set forth in this section.

(b) Before December 1 of each year, the state department shall publicly post the information:

(1) collected under IC 16-21-6-3(a)(14) through IC 16-21-6-3(a)(17); and

(2) received from the:

(A) Indiana professional licensing agency under IC 25-22.5-18-4; or

(B) department of insurance under IC 27-1-4.5-6;

on the state department's website.

SECTION 5. IC 16-19-16.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 16.5. Disclosure of Ownership Information

Sec. 1. As used in this chapter, "controlling" has the meaning set forth in IC 23-1-43-8.

Sec. 2. (a) As used in this chapter, except as provided in subsection (b), "health care entity" means any organization or business that provides diagnostic, medical, surgical, dental treatment, or rehabilitative care.

(b) The term does not include the following:

(1) A hospital.

(2) A physician group practice (as defined in IC 25-22.5-18-2).

(3) An insurer (as defined in IC 27-1-4.5-2).

(4) A pharmacy benefit manager (as defined in IC 27-1-4.5-3).

(5) A third party administrator (as defined in IC 27-1-4.5-4).

Sec. 3. (a) Beginning July 1, 2025, and each July 1 thereafter, each health care entity that does business in Indiana shall file with the state department a report that includes the following information:

(1) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the health care entity.

(2) The business address of each person or entity identified under subdivision (1). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) ZIP code; and

(E) country name.

The business address may not include a post office box number.

(3) The business website, if applicable, of each person or entity identified under subdivision (1).

(4) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (1):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a

license issued by the department of insurance.

A report provided under this section may not include the Social Security number of any individual.

(b) The state department may not charge a fee for a report submitted under this section.

Sec. 4. (a) The state department shall cooperate with the Indiana professional licensing agency and the department of insurance to develop and implement a plan to:

(1) collect the information described in section 3 of this chapter, IC 25-22.5-18-3, and IC 27-1-4.5-5; and

(2) make the information publicly available as set forth in this section.

(b) Before December 1 of each year, the state department shall publicly post the information:

(1) collected under section 3 of this chapter; and

(2) received from the:

(A) Indiana professional licensing agency under IC 25-22.5-18-4; or

(B) department of insurance under IC 27-1-4.5-6;

on the state department's website.

Sec. 5. (a) The state department may assess a health care entity that violates section 3 of this chapter a fine of one thousand dollars ($1,000) per day for which the report is past due.

(b) A fine under this section shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

(c) The state department may waive a fine assessed under this section.

(d) The state health commissioner may take action against an ambulatory outpatient surgical center or a birthing center under IC 16-21-3 for repeated violations of section 3 of this chapter.

Sec. 6. (a) In addition to other penalties provided under this chapter, the state department shall adopt rules under IC 4-22-2 that establish a schedule of civil penalties that may be levied upon a health care entity, other than an ambulatory outpatient surgical center or a birthing center, for repeated violations of section 3 of this chapter.

(b) A penalty included in the schedule of civil penalties adopted under this chapter may not exceed ten thousand dollars ($10,000).

(c) The state department may issue an order of compliance, impose a civil penalty included in the schedule of civil penalties adopted under subsection (a), or both, against a health care entity described in subsection (a) that:

(1) fails to comply with section 3 of this chapter or a rule adopted under this section; or

(2) interferes with or obstructs the state department or the state department's designated agent in the performance of duties under this chapter.

(d) An order of compliance may be issued under IC 4-21.5-3-6, IC 4-21.5-3-8, or IC 4-21.5-4. A civil penalty may be imposed only in a proceeding under IC 4-21.5-3-8.

(e) A proceeding commenced to impose a civil penalty may be consolidated with any other proceeding commenced to enforce this chapter or a rule adopted under this chapter.

Sec. 7. (a) Before December 1 of each year, the state department shall submit to the legislative council an annual report of the:

(1) violations assessed; and

(2) fines waived;

under section 5 of this chapter in the previous calendar year.

(b) A report described in this section must be submitted in an electronic format under IC 5-14-6.

Sec. 8. (a) The state department shall issue a notice or bulletin on at least two (2) occasions to notify health care entities of the reporting requirements set forth in this chapter.

(b) A notice or bulletin issued under this section must be posted on the state department's website in a manner that is easily accessible to health care entities.

SECTION 6. IC 16-21-6-0.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 0.3. As used in this chapter, "controlling" has the meaning set forth in IC 23-1-43-8**

SECTION 7. IC 16-21-6-3, AS AMENDED BY P.L.152-2024, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 3. (a) Each hospital shall file with the state department a report for the preceding fiscal year within one hundred twenty (120) days after the end of the hospital's fiscal year. For the filing of a report, the state department may grant an extension of the time to file the report if the hospital shows good cause for the extension. The report must contain the following:

(1) A copy of the hospital's balance sheet, including a statement describing the hospital's total assets and total liabilities.

(2) A copy of the hospital's income statement.

(3) A statement of changes in financial position.

(4) A statement of changes in fund balance.

(5) Accountant notes pertaining to the report.

(6) A copy of the hospital's report required to be filed annually under 42 U.S.C. 1395g, and other appropriate utilization and financial reports required to be filed under federal statutory law.

(7) Net patient revenue and total number of paid claims, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue for services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(8) Net patient revenue and total number of paid claims from facility fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health

insurance plan;
(iv) self-pay; and
(v) any other category of payer.
(B) The net patient revenue and total number of paid claims for outpatient services from facility fees for:
(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including outpatient services from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.
(C) The total net patient revenue and total number of paid claims from facility fees for:
(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including the total net patient revenue from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.
(9) Net patient revenue and total number of paid claims from professional fees, including providing the information as follows:
(A) The net patient revenue and total number of paid claims for inpatient services from professional fees for:
(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including inpatient services from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.
(B) The net patient revenue and total number of paid claims for outpatient services from professional fees for:
(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including outpatient services from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health

insurance plan;
(iv) self-pay; and
(v) any other category of payer.
(C) The total net patient revenue and total number of paid claims from professional fees for:
(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including the total net patient revenue from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.
(10) A statement including:
(A) Medicare gross revenue;
(B) Medicaid gross revenue;
(C) other revenue from state programs;
(D) revenue from local government programs;
(E) local tax support;
(F) charitable contributions;
(G) other third party payments;
(H) gross inpatient revenue;
(I) gross outpatient revenue;
(J) contractual allowance;
(K) any other deductions from revenue;
(L) charity care provided;
(M) itemization of bad debt expense; and
(N) an estimation of the unreimbursed cost of subsidized health services.
(11) A statement itemizing donations.
(12) A statement describing the total cost of reimbursed and unreimbursed research.
(13) A statement describing the total cost of reimbursed and unreimbursed education separated into the following categories:
(A) Education of physicians, nurses, technicians, and other medical professionals and health care providers.
(B) Scholarships and funding to medical schools, and other postsecondary educational institutions for health professions education.
(C) Education of patients concerning diseases and home care in response to community needs.
(D) Community health education through informational

programs, publications, and outreach activities in response to community needs.

(E) Other educational services resulting in education related costs.

(14) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the hospital.

(15) The business address of each person or entity identified under subdivision (14). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) ZIP code; and

(E) country name.

The business address may not include a post office box number.

(16) The business website, if applicable, of each person or entity identified under subdivision (14).

(17) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (14):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a license issued by the department of insurance.

A hospital may not include the Social Security number of any individual.

(b) The information in the report filed under subsection (a) must be provided from reports or audits certified by an independent certified public accountant or by the state board of accounts.

(c) A hospital that fails to file the report required under subsection (a) by the date required shall pay to the state department a fine of one thousand dollars ($1,000) per day for which the report is past due. A fine under this subsection shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

SECTION 8. IC 25-1-8.5-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS

[EFFECTIVE UPON PASSAGE]: **Sec. 1.5. As used in this chapter, "approval board" refers to the health care entity merger approval board established by section 3.5 of this chapter.**

SECTION 9. IC 25-1-8.5-2, AS ADDED BY P.L.95-2024, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 2. (a) As used in this chapter, "health care entity" means any of the following:

(1) ~~Any~~ **Except as provided in subsection (b), an** organization or business that provides diagnostic, medical, surgical, dental treatment, or rehabilitative care.

(2) An insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1), except for the following types of coverage:

(A) Accident only, credit, dental, vision, long term care, or disability income insurance.

(B) Coverage issued as a supplement to liability insurance.

(C) Automobile medical payment insurance.

(D) A specified disease policy.

(E) A policy that provides indemnity benefits not based on any expense incurred requirements, including a plan that provides coverage for:

(i) hospital confinement, critical illness, or intensive care; or

(ii) gaps for deductibles or copayments.

(F) Worker's compensation or similar insurance.

(G) A student health plan.

(H) A supplemental plan that always pays in addition to other coverage.

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

(4) A pharmacy benefit manager (as defined in IC 27-1-24.5-12).

(5) An administrator (as defined in IC 27-1-25-1).

(6) A private equity partnership, regardless of where the private equity partnership is located, seeking to enter into a merger or acquisition with an entity described in subdivisions (1) through (5).

(b) The term does not include:

(1) a health care provider (as defined by IC 4-6-14-2) that is wholly owned by practitioners who:

(A) are licensed in Indiana; and

(B) routinely provide health care services in the practitioner owned practice;

(2) the Medicaid program; or

(3) the Medicare program.

SECTION 10. IC 25-1-8.5-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 3.5. (a) The health care entity merger approval board is established to:**

(1) evaluate; and

(2) approve or deny;

proposed mergers and acquisitions of health care entities under section 4.5 of this chapter.

(b) The approval board is comprised of the following members:

(1) The attorney general or the attorney general's designee.

(2) The secretary of health and family or an individual designated by the governor.

(3) The secretary of business affairs or an individual designated by the governor.

(4) Two (2) members appointed by the governor after considering individuals recommended for appointment by the legislative council under subsection (c).

(c) Before July 1, 2025, the legislative council shall recommend at least (2) individuals to the governor for appointment to the approval board under subsection (b)(4). Individuals recommended by the legislative council may not be members of the general assembly.

(d) The office of the attorney general shall provide staff support to the approval board.

(e) The members of the approval board shall annually elect a chair and vice chair from the membership of the board. Before August 1, 2025, the attorney general shall schedule a meeting of the approval board to elect the chair and vice chair. Thereafter, the approval board shall meet at the call of the chair. The chair elected under this subsection shall serve until a successor is elected in the following calendar year.

(f) A member of the approval board serves a four (4) year term that expires June 30 of an odd-numbered year.

(g) A member of the approval board serves at the pleasure of the appointing authority and may be reappointed to successive terms.

(h) A vacancy on the approval board shall be filled by the appropriate appointing authority. An individual appointed to fill a vacancy serves for the unexpired term of the individual's predecessor.

(i) Each member of the approval board who is not a state

employee is entitled to reimbursement for mileage, traveling expenses as provided under IC 4-13-1-4, and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(j) Each member of the approval board who is a state employee is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(k) Expenses paid under subsections (i) and (j) shall be paid from appropriations made to the office of the attorney general.

SECTION 11. IC 25-1-8.5-3.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 3.7. (a) The office of the attorney general may at any time investigate the market concentration of a health care entity. The office of the attorney general may issue a civil investigative demand under IC 4-6-3 to a health care entity subject to an investigation conducted under this section.**

(b) The office of the attorney general shall keep confidential all nonpublic information obtained in the course of an investigation conducted under this section. Confidential information may not be released to the public.

SECTION 12. IC 25-1-8.5-4, AS ADDED BY P.L.95-2024, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 4. (a) An Indiana health care entity that is involved in a merger or acquisition with another health care entity ~~with total assets, including combined entities and holdings, of at least ten million dollars ($10,000,000)~~ shall, at least ninety (90) days prior to the date of the merger or acquisition, provide written notice of the merger or acquisition to the office of the attorney general in a manner prescribed by the office of the attorney general.

(b) The notice required by subsection (a) must include the following information from each health care entity:

(1) Business address and federal tax number.

(2) Name and contact information of a representative of the health care entity concerning the merger or acquisition.

(3) Description of the health care entity.

(4) Description of the merger or acquisition, including the anticipated timeline.

(5) A copy of any materials that have been submitted to a federal or state agency concerning the merger or acquisition.

The notice submitted under this section must be certified before a notary public.

(c) The office of the attorney general shall keep confidential all nonpublic information, and the confidential information may not be released to the public.

(d) Not later than forty-five (45) days from the submission of a notice under subsection (a), the office of the attorney general:

(1) shall review the information submitted with the notice; and

(2) may analyze in writing any antitrust concerns with the merger or acquisition.

The office of the attorney general shall provide any written analysis described in subdivision (2) to the person that submitted the notice under subsection (a).

(e) The office of the attorney general may issue a civil investigative demand under IC 4-6-3 to a health care entity that has submitted a notice under this section for additional information.

(f) Any information received or produced by the office of the attorney general under this section is confidential.

SECTION 13. IC 25-1-8.5-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 4.5. (a) An Indiana health care entity may not engage in a merger or acquisition with another health care entity, or a health care provider described in section 2(b) of this chapter, unless the health care entity has received approval from the approval board under this section.**

(b) Except as provided in subsection (c), not later than ninety (90) days after receiving notice under section 4 of this chapter, the approval board shall approve or deny the proposed merger or acquisition.

(c) The approval board may extend the ninety (90) day period described in subsection (b) by not more than ninety (90) days for good cause.

(d) After reviewing the information submitted with the notice under section 4 of this chapter, and any additional information obtained through a civil investigative demand under IC 4-6-3, the approval board shall provide to the person that submitted notice under section 4 of this chapter a written determination approving or denying the merger or acquisition.

(e) The approval board may approve a proposed merger or acquisition. The office of the attorney general shall apply the

following criteria in determining whether to approve a proposed merger or acquisition:

(1) The proposed merger or acquisition does not significantly diminish the availability or accessibility of health care services to the community affected by the merger or acquisition.

(2) The proposed merger or acquisition is in the public interest.

(3) The health care entity involved in the proposed merger or acquisition exercised due diligence in:

(A) deciding to engage in the merger or acquisition;

(B) identifying each person to engage in the merger or acquisition; and

(C) negotiating the terms and conditions of the merger or acquisition.

(4) The procedure used by the health care entity agreeing to merge or be acquired was adequate, including the use of appropriate expert assistance.

(5) That any conflict of interest that potentially impacts competition in the relevant markets was disclosed to each health care entity or party involved in the merger or acquisition, including a conflict of interest related to:

(A) board of director memberships of;

(B) executives of;

(C) experts retained by;

(D) partnerships of; or

(E) joint ventures of;

each health care entity or party involved in the merger or acquisition.

(6) That any management contract proposed under the merger or acquisition is for reasonably fair value.

(7) This subdivision applies to an acquisition between health care entities. That the health care entity being acquired will receive full and fair market value under the proposed acquisition.

(8) The proposed merger or acquisition complies with applicable state or federal law.

(f) In determining whether the procedure described in subsection (e)(4) was adequate, the approval board may employ, at the expense of the health care entity initiating the merger or acquisition, reasonably necessary expert assistance.

(g) The attorney general may bring a civil action to enforce this

section.

(h) In bringing a civil action under subsection (g), the office of the attorney general may seek one (1) or more of the following, together with the costs and expenses of the suit, including reasonable attorney's fees, expenses related to litigation, and expert fees, in connection with a violation of this section:

(A) Appropriate injunctive relief or other equitable relief, including disgorgement of any gains derived from the violation.

(B) Civil penalty not to exceed fifteen million dollars ($15,000,000).

(i) A denial under this section is subject to appeal under IC 4-21.5.

SECTION 14. IC 25-22.5-18 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 18. Disclosure of Ownership Information

Sec. 1. As used in this chapter, "controlling" has the meaning set forth in IC 23-1-43-8.

Sec. 2. As used in this chapter, "physician group practice" means a physician practice that:

(1) has at least one (1) physical location in Indiana; and

(2) includes as practitioners two (2) or more physicians licensed under this article, regardless of the ownership structure of the practice.

Sec. 3. (a) Beginning July 1, 2025, and each July 1 thereafter, each physician group practice that does business in Indiana shall file with the agency a report that includes the following information:

(1) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the physician group practice.

(2) The business address of each person or entity identified under subdivision (1). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) ZIP code; and

(E) country name.

The business address may not include a post office box

number.

(3) The business website, if applicable, of each person or entity identified under subdivision (1).

(4) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (1):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a license issued by the department of insurance.

A report provided under this section may not include the Social Security number of any individual.

(b) The agency may not charge a fee for a report submitted under this section.

Sec. 4. (a) The agency shall cooperate with the Indiana department of health and the department of insurance to develop and implement a plan to:

(1) collect the information described in section 3 of this chapter, IC 16-19-16.5-3, IC 16-21-6-3(a)(14) through IC 16-21-6-3(a)(17), and IC 27-1-4.5-5; and

(2) make the information publicly available as set forth in IC 16-19-3-35. IC 16-19-16.5-4.

(b) Before September 1 of each year, the agency shall provide the information collected under section 3 of this chapter to the Indiana department of health.

Sec. 5. (a) The agency may assess a physician group practice that:

(1) has more than five (5) physicians as practitioners in the physician group practice; and

(2) violates section 3 of this chapter;

a fine of one thousand dollars ($1,000) per day for which the report is past due.

(b) The agency may assess a physician group practice that:

(1) has five (5) physicians or less as practitioners in the physician group practice; and

(2) violates section 3 of this chapter;

a fine of one hundred dollars ($100) per day for which the report is past due. A fine assessed under this subsection may not exceed ten thousand dollars ($10,000) in a calendar year.

(c) A fine under this section shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

(d) The agency may waive a fine assessed under this section.

(e) The board may take disciplinary action against a licensee for repeated violations of section 3 of this chapter.

Sec. 6. (a) Before December 1 of each year, the agency shall submit to the legislative council an annual report of the:

(1) violations assessed; and

(2) fines waived;

under section 5 of this chapter in the previous calendar year.

(b) A report described in this section must be submitted in an electronic format under IC 5-14-6.

Sec. 7. (a) The agency shall issue a notice or bulletin on at least two (2) occasions to notify physician group practices of the reporting requirements set forth in this chapter.

(b) A notice or bulletin issued under this section must be posted on the agency's website in a manner that is easily accessible to physician group practices.

SECTION 15. IC 27-1-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 4.5. Disclosure of Ownership Information

Sec. 1. As used in this chapter, "controlling" has the meaning set forth in IC 23-1-43-8.

Sec. 2. As used in this chapter, "insurer" 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)). However, the term does not include the coverages described in IC 27-8-5-2.5(a).

(2) A health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

(3) A managed care organization (as defined in IC 12-7-2-126.9) that provides services to a Medicaid recipient.

(4) A prepaid health care delivery plan under IC 5-10-8-7(c) that provides group health coverage for state employees.

Sec. 3. As used in this chapter, "pharmacy benefit manager" has the meaning set forth in IC 27-1-24.5-12.

Sec. 4. As used in this chapter, "third party administrator" means an individual or entity that performs administrative services for an insurer or a self-funded health benefit plan, including:

(1) 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.); and

(2) a self-insurance program established under IC 5-10-8-7(b).

Sec. 5. (a) Beginning July 1, 2025, and each July 1 thereafter, each insurer, third party administrator, and pharmacy benefit manager that does business in Indiana shall file with the department a report that includes the following information:

(1) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the insurer, third party administrator, or pharmacy benefit manager.

(2) The business address of each person or entity identified under subdivision (1). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) ZIP code; and

(E) country name.

The business address may not include a post office box number.

(3) The business website, if applicable, of each person or entity identified under subdivision (1).

(4) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (1):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a license issued by the department of insurance.

A report provided under this section may not include the Social Security number of any individual.

(b) The department may not charge a fee for a report submitted under this section.

Sec. 6. (a) The department shall cooperate with the Indiana department of health and the Indiana professional licensing agency to develop and implement a plan to:

(1) collect the information described in section 5 of this chapter, IC 16-19-16.5-3, IC 16-21-6-3(a)(14) through IC 16-21-6-3(a)(17), and IC 25-22.5-18-3; and

(2) make the information publicly available as set forth in IC 16-19-3-35. IC 16-19-16.5-4.

(b) Before September 1 of each year, the department shall provide the information collected under section 5 of this chapter to the Indiana department of health.

Sec. 7. (a) The department may assess:

(1) an insurer;

(2) a third party administrator; or

(3) a pharmacy benefit manager;

that violates section 5 of this chapter a fine of one thousand dollars ($1,000) per day for which the report is past due.

(b) A fine under this section shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

(c) The department may waive a fine assessed under this section.

(d) The department may take disciplinary action against:

(1) an insurer;

(2) a third party administrator; or

(3) a pharmacy benefit manager;

that is licensed under this title for repeated violations of section 5 of this chapter.

Sec. 8. (a) Before December 1 of each year, the department shall submit to the legislative council an annual report of the:

(1) violations assessed; and

(2) fines waived;

under section 7 of this chapter in the previous calendar year.

(b) A report described in this section must be submitted in an electronic format under IC 5-14-6.

Sec. 9. (a) The department shall issue a notice or bulletin on at least two (2) occasions to notify insurers, third party administrators, and pharmacy benefit managers of the reporting requirements set forth in this chapter.

(b) A notice or bulletin issued under this section must be posted on the department's website in a manner that is easily accessible to insurers, third party administrators, and pharmacy benefit managers.

SECTION 16. **An emergency is declared for this act.**

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred House Bill 1666, 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 4, line 8, after "entity" strike "with".

Page 4, strike line 9.

Page 4, line 10, strike "million dollars ($10,000,000)".

Page 4, delete line 42.

Page 5, delete lines 1 through 19, begin a new paragraph and insert:

"SECTION 5. IC 25-1-8.5-4.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 4.5. (a) An Indiana health care entity may not engage in a merger or acquisition with another health care entity unless the health care entity has received approval from the office of the attorney general under this section.**

(b) Except as provided in subsection (c), not later than ninety (90) days after receiving notice under section 4 of this chapter, the office of the attorney general shall approve or deny the proposed merger or acquisition.

(c) The office of the attorney general may extend the ninety (90) day period described in subsection (b) by not more than ninety (90) days for good cause.

(d) After reviewing the information submitted with the notice under section 4 of this chapter, and any additional information obtained through a civil investigative demand under IC 4-6-3, the office of the attorney general shall provide to the person that submitted notice under section 4 of this chapter a written determination approving or denying the merger or acquisition.

(e) The office of the attorney general shall approve a proposed merger or acquisition if the following criteria are met:

(1) The proposed merger or acquisition does not significantly diminish the availability or accessibility of health care services to the community affected by the merger or acquisition.

(2) The proposed merger or acquisition is in the public interest.

(3) The health care entity involved in the proposed merger or acquisition exercised due diligence in:

(A) deciding to engage in the merger or acquisition;

(B) identifying each person to engage in the merger or acquisition; and

(C) negotiating the terms and conditions of the merger or acquisition.

(4) The procedure used by the health care entity agreeing to merge or be acquired was adequate, including the use of appropriate expert assistance.

(5) That any conflict of interest that potentially impacts competition in the relevant markets was disclosed to each health care entity or party involved in the merger or acquisition, including a conflict of interest related to:

(A) board of director memberships of;

(B) executives of;

(C) experts retained by;

(D) partnerships of; or

(E) joint ventures of;

each health care entity or party involved in the merger or acquisition.

(6) That any management contract proposed under the merger or acquisition is for reasonably fair value.

(7) This subdivision applies to an acquisition between health care entities. That the health care entity being acquired will receive full and fair market value under the proposed acquisition.

(8) The proposed merger or acquisition complies with applicable state or federal law.

(f) In determining whether the procedure described in subsection (e)(4) was adequate, the office of the attorney general may employ, at the expense of the health care entity initiating the merger or acquisition, reasonably necessary expert assistance.

(g) The attorney general may bring a civil action to enforce this section.

(h) In bringing a civil action under subsection (g), the office of the attorney general may seek one (1) or more of the following, together with the costs and expenses of the suit, including reasonable attorney's fees, expenses related to litigation, and expert fees, in connection with a violation of this section:

(A) Appropriate injunctive relief or other equitable relief, including disgorgement of any gains derived from the violation.

(B) Civil penalty not to exceed fifteen million dollars ($15,000,000).

(i) A denial under this section is subject to appeal under IC 4-21.5.".

and when so amended that said bill do pass.

(Reference is to HB 1666 as introduced.)

BARRETT

Committee Vote: yeas 9, nays 3.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1666 be amended to read as follows:

Page 2, line 11, delete "16-19-18," and insert "**16-19-16.5,**".

Page 2, line 11, delete "16-19-18-1." and insert "**16-19-16.5-1.**".

Page 2, delete line 12 through 42, begin a new paragraph and insert:

"SECTION 3. IC 16-18-2-160.5, AS AMENDED BY P.L.3-2008, SECTION 107, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 160.5. **(a) "Health care entity", for purposes of IC 16-19-16.5, has the meaning set forth in IC 16-19-16.5-2.**

(b) "Health care entity", for purposes of IC 16-41-42.1, has the meaning set forth in IC 16-41-42.1-1.".

SECTION 3. IC 16-19-16.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]:

Chapter 16.5. Disclosure of Ownership Information

Sec. 1. As used in this chapter, "controlling" has the meaning set forth in IC 23-1-43-8.

Sec. 2. (a) As used in this chapter, except as provided in subsection (b), "health care entity" means any organization or business that provides diagnostic, medical, surgical, dental treatment, or rehabilitative care.

(b) The term does not include the following:

(1) A hospital.

(2) A physician group practice (as defined in IC 25-22.5-18-2).

(3) An insurer (as defined in IC 27-1-4.5-2).

(4) A pharmacy benefit manager (as defined in IC 27-1-4.5-3).

(5) A third party administrator (as defined in IC 27-1-4.5-4).

Sec. 3. (a) Beginning July 1, 2025, and each July 1 thereafter, each health care entity that does business in Indiana shall file with the state department a report that includes the following

information:

(1) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the health care entity.

(2) The business address of each person or entity identified under subdivision (1). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) ZIP code; and

(E) country name.

The business address may not include a post office box number.

(3) The business website, if applicable, of each person or entity identified under subdivision (1).

(4) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (1):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a license issued by the department of insurance.

A report provided under this section may not include the Social Security number of any individual.

(b) The state department may not charge a fee for a report submitted under this section.

Sec. 4. (a) The state department shall cooperate with the Indiana professional licensing agency and the department of insurance to develop and implement a plan to:

(1) collect the information described in section 3 of this chapter, IC 25-22.5-18-3, and IC 27-1-4.5-5; and

(2) make the information publicly available as set forth in this section.

(b) Before December 1 of each year, the state department shall publicly post the information:

(1) collected under section 3 of this chapter; and

(2) received from the:

(A) Indiana professional licensing agency under IC 25-22.5-18-4; or

(B) department of insurance under IC 27-1-4.5-6;

on the state department's website.

Sec. 5. (a) The state department may assess a health care entity that violates section 3 of this chapter a fine of one thousand dollars ($1,000) per day for which the report is past due.

(b) A fine under this section shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.

(c) The state department may waive a fine assessed under this section.

(d) The state health commissioner may take action against an ambulatory outpatient surgical center or a birthing center under IC 16-21-3 for repeated violations of section 3 of this chapter.

Sec. 6. (a) In addition to other penalties provided under this chapter, the state department shall adopt rules under IC 4-22-2 that establish a schedule of civil penalties that may be levied upon a health care entity, other than an ambulatory outpatient surgical center or a birthing center, for repeated violations of section 3 of this chapter.

(b) A penalty included in the schedule of civil penalties adopted under this chapter may not exceed ten thousand dollars ($10,000).

(c) The state department may issue an order of compliance, impose a civil penalty included in the schedule of civil penalties adopted under subsection (a), or both, against a health care entity described in subsection (a) that:

(1) fails to comply with section 3 of this chapter or a rule adopted under this section; or

(2) interferes with or obstructs the state department or the state department's designated agent in the performance of duties under this chapter.

(d) An order of compliance may be issued under IC 4-21.5-3-6, IC 4-21.5-3-8, or IC 4-21.5-4. A civil penalty may be imposed only in a proceeding under IC 4-21.5-3-8.

(e) A proceeding commenced to impose a civil penalty may be consolidated with any other proceeding commenced to enforce this chapter or a rule adopted under this chapter.

Sec. 7. (a) Before December 1 of each year, the state department shall submit to the legislative council an annual report of the:

(1) violations assessed; and

(2) fines waived;

under section 5 of this chapter in the previous calendar year.

(b) A report described in this section must be submitted in an electronic format under IC 5-14-6.

Sec. 8. (a) The state department shall issue a notice or bulletin on at least two (2) occasions to notify health care entities of the reporting requirements set forth in this chapter.

(b) A notice or bulletin issued under this section must be posted on the state department's website in a manner that is easily accessible to health care entities.".

Delete page 3.

Page 4, delete line 1 through 4.

Page 7, line 40, delete "16-19-18-2," and insert "**16-19-16.5-3,**".

Page 7, line 42, delete "16-19-18-3." and insert "**16-19-16.5-4.**".

Page 10, line 19, delete "16-19-18-2," and insert "**16-19-16.5-3,**".

Page 10, line 21, delete "16-19-18-3." and insert "**16-19-16.5-4.**".

(Reference is to HB 1666 as printed February 4, 2025.)

MCGUIRE

HOUSE MOTION

Mr. Speaker: I move that House Bill 1666 be amended to read as follows:

Page 4, between lines 4 and 5, begin a new paragraph and insert:

"SECTION 4. IC 25-1-8.5-2, AS ADDED BY P.L.95-2024, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 2. (a) As used in this chapter, "health care entity" means any of the following:

(1) ~~Any~~ **Except as provided in subsection (b), an** organization or business that provides diagnostic, medical, surgical, dental treatment, or rehabilitative care.

(2) An insurer that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1), except for the following types of coverage:

(A) Accident only, credit, dental, vision, long term care, or disability income insurance.

(B) Coverage issued as a supplement to liability insurance.

(C) Automobile medical payment insurance.

(D) A specified disease policy.

(E) A policy that provides indemnity benefits not based on any expense incurred requirements, including a plan that provides

coverage for:

(i) hospital confinement, critical illness, or intensive care; or

(ii) gaps for deductibles or copayments.

(F) Worker's compensation or similar insurance.

(G) A student health plan.

(H) A supplemental plan that always pays in addition to other coverage.

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

(4) A pharmacy benefit manager (as defined in IC 27-1-24.5-12).

(5) An administrator (as defined in IC 27-1-25-1).

(6) A private equity partnership, regardless of where the private equity partnership is located, seeking to enter into a merger or acquisition with an entity described in subdivisions (1) through (5).

(b) The term does not include:

(1) a health care provider (as defined by IC 4-6-14-2) that is wholly owned by practitioners who:

(A) are licensed in Indiana; and

(B) routinely provide health care services in the practitioner owned practice;

(2) the Medicaid program; or

(3) the Medicare program.

SECTION 5. IC 25-1-8.5-3.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 3.7. (a) The office of the attorney general may at any time investigate the market concentration of a health care entity. The office of the attorney general may issue a civil investigative demand under IC 4-6-3 to a health care entity subject to an investigation conducted under this section.**

(b) The office of the attorney general shall keep confidential all nonpublic information obtained in the course of an investigation conducted under this section. Confidential information may not be released to the public.".

Page 5, line 4, delete "entity unless" and insert "**entity, or a health care provider described in section 2(b) of this chapter, unless**".

Page 5, line 19, delete "shall" and insert "**may**".

Page 5, line 20, delete "acquisition if the following criteria are met:" and insert "**acquisition. The office of the attorney general shall apply the following criteria in determining whether to approve a proposed merger or acquisition:**".

Renumber all SECTIONS consecutively.

(Reference is to HB 1666 as printed February 4, 2025.)

MCGUIRE

HOUSE MOTION

Mr. Speaker: I move that House Bill 1666 be amended to read as follows:

Page 4, between lines 4 and 5, begin a new paragraph and insert:

"SECTION 4. IC 25-1-8.5-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.5. As used in this chapter, "approval board" refers to the health care entity merger approval board established by section 3.5 of this chapter.**

SECTION 5. IC 25-1-8.5-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 3.5. (a) The health care entity merger approval board is established to:**

(1) evaluate; and

(2) approve or deny;

proposed mergers and acquisitions of health care entities under section 4.5 of this chapter.

(b) The approval board is comprised of the following members:

(1) The attorney general or the attorney general's designee.

(2) The secretary of health and family or an individual designated by the governor.

(3) The secretary of business affairs or an individual designated by the governor.

(4) Two (2) members appointed by the governor after considering individuals recommended for appointment by the legislative council under subsection (c).

(c) Before July 1, 2025, the legislative council shall recommend at least (2) individuals to the governor for appointment to the approval board under subsection (b)(4). Individuals recommended by the legislative council may not be members of the general assembly.

(d) The office of the attorney general shall provide staff support to the approval board.

(e) The members of the approval board shall annually elect a chair and vice chair from the membership of the board. Before

August 1, 2025, the attorney general shall schedule a meeting of the approval board to elect the chair and vice chair. Thereafter, the approval board shall meet at the call of the chair. The chair elected under this subsection shall serve until a successor is elected in the following calendar year.

(f) A member of the approval board serves a four (4) year term that expires June 30 of an odd-numbered year.

(g) A member of the approval board serves at the pleasure of the appointing authority and may be reappointed to successive terms.

(h) A vacancy on the approval board shall be filled by the appropriate appointing authority. An individual appointed to fill a vacancy serves for the unexpired term of the individual's predecessor.

(i) Each member of the approval board who is not a state employee is entitled to reimbursement for mileage, traveling expenses as provided under IC 4-13-1-4, and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(j) Each member of the approval board who is a state employee is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(k) Expenses paid under subsections (i) and (j) shall be paid from appropriations made to the office of the attorney general.".

Page 5, line 5, delete "office of the attorney general" and insert "**approval board**".

Page 5, line 8, delete "office of the attorney general" and insert "**approval board**".

Page 5, line 10, delete "office of the attorney general" and insert "**approval board**".

Page 5, line 16, delete "office of the attorney general" and insert "**approval board**".

Page 5, line 19, delete "office of the attorney general" and insert "**approval board**".

Page 6, line 15, delete "office of the attorney general" and insert "**approval board**".

Page 11, after line 12, begin a new paragraph and insert:

"SECTION 9. **An emergency is declared for this act.**".

Renumber all SECTIONS consecutively.

(Reference is to HB 1666 as printed February 4, 2025.)

MCGUIRE

HOUSE MOTION

Mr. Speaker: I move that House Bill 1666 be amended to read as follows:

Page 2, line 11, delete "IC 16-19-18," and insert "**IC 16-21-6**,".

Page 2, line 11, delete "IC 16-19-18-1." and insert "**IC 16-21-6-0.3.**".

Page 2, delete lines 12 through 42, begin a new paragraph and insert:

"SECTION 3. IC 16-19-3-35 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 35. (a) The state department shall cooperate with the Indiana professional licensing agency and the department of insurance to develop and implement a plan to:**

(1) collect the information described in IC 16-21-6-3(a)(14) through IC 16-21-6-3(a)(17), IC 25-22.5-18-3, and IC 27-1-4.5-5; and

(2) make the information publicly available as set forth in this section.

(b) Before December 1 of each year, the state department shall publicly post the information:

(1) collected under IC 16-21-6-3(a)(14) through IC 16-21-6-3(a)(17); and

(2) received from the:

(A) Indiana professional licensing agency under IC 25-22.5-18-4; or

(B) department of insurance under IC 27-1-4.5-6;

on the state department's website.".

Delete page 3.

Page 4, delete lines 1 through 4, begin a new paragraph and insert:

"SECTION 5. IC 16-21-6-0.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: **Sec. 0.3. As used in this chapter, "controlling" has the meaning set forth in IC 23-1-43-8**

SECTION 6. IC 16-21-6-3, AS AMENDED BY P.L.152-2024, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2025]: Sec. 3. (a) Each hospital shall file with the state department a report for the preceding fiscal year within one hundred twenty (120) days after the end of the hospital's fiscal year. For the filing of a report, the state department may grant an extension of the time to file the report if the hospital shows good cause for the extension. The report must contain the following:

(1) A copy of the hospital's balance sheet, including a statement describing the hospital's total assets and total liabilities.

(2) A copy of the hospital's income statement.

(3) A statement of changes in financial position.

(4) A statement of changes in fund balance.

(5) Accountant notes pertaining to the report.

(6) A copy of the hospital's report required to be filed annually under 42 U.S.C. 1395g, and other appropriate utilization and financial reports required to be filed under federal statutory law.

(7) Net patient revenue and total number of paid claims, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient

revenue for services provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(8) Net patient revenue and total number of paid claims from facility fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including inpatient services from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including outpatient services from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims from facility fees for:

(i) Medicare;

(ii) Medicaid;

(iii) commercial insurance, including the total net patient revenue from facility fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;

(iv) self-pay; and

(v) any other category of payer.

(9) Net patient revenue and total number of paid claims from professional fees, including providing the information as follows:

(A) The net patient revenue and total number of paid claims for inpatient services from professional fees for:

(i) Medicare;

(ii) Medicaid;
(iii) commercial insurance, including inpatient services from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.

(B) The net patient revenue and total number of paid claims for outpatient services from professional fees for:
(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including outpatient services from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.

(C) The total net patient revenue and total number of paid claims from professional fees for:
(i) Medicare;
(ii) Medicaid;
(iii) commercial insurance, including the total net patient revenue from professional fees provided to patients participating in a fully-funded health insurance plan or a self-funded health insurance plan;
(iv) self-pay; and
(v) any other category of payer.

(10) A statement including:
(A) Medicare gross revenue;
(B) Medicaid gross revenue;
(C) other revenue from state programs;
(D) revenue from local government programs;
(E) local tax support;
(F) charitable contributions;
(G) other third party payments;
(H) gross inpatient revenue;
(I) gross outpatient revenue;
(J) contractual allowance;
(K) any other deductions from revenue;
(L) charity care provided;
(M) itemization of bad debt expense; and
(N) an estimation of the unreimbursed cost of subsidized

health services.

(11) A statement itemizing donations.

(12) A statement describing the total cost of reimbursed and unreimbursed research.

(13) A statement describing the total cost of reimbursed and unreimbursed education separated into the following categories:

(A) Education of physicians, nurses, technicians, and other medical professionals and health care providers.

(B) Scholarships and funding to medical schools, and other postsecondary educational institutions for health professions education.

(C) Education of patients concerning diseases and home care in response to community needs.

(D) Community health education through informational programs, publications, and outreach activities in response to community needs.

(E) Other educational services resulting in education related costs.

(14) The name of each person or entity that has:

(A) an ownership interest of at least five percent (5%);

(B) a controlling interest; or

(C) an interest as a private equity partner;

in the hospital.

(15) The business address of each person or entity identified under subdivision (14). The business address must include a:

(A) building number;

(B) street name;

(C) city name;

(D) ZIP code; and

(E) country name.

The business address may not include a post office box number.

(16) The business website, if applicable, of each person or entity identified under subdivision (14).

(17) Any of the following identification numbers, if applicable, for a person or entity identified under subdivision (14):

(A) National provider identifier (NPI).

(B) Taxpayer identification number (TIN).

(C) Employer identification number (EIN).

(D) CMS certification number (CCN).

(E) National Association of Insurance Commissioners (NAIC) identification number.

(F) A personal identification number associated with a license issued by the department of insurance.

A hospital may not include the Social Security number of any individual.

(b) The information in the report filed under subsection (a) must be provided from reports or audits certified by an independent certified public accountant or by the state board of accounts.

(c) A hospital that fails to file the report required under subsection (a) by the date required shall pay to the state department a fine of one thousand dollars ($1,000) per day for which the report is past due. A fine under this subsection shall be deposited into the payer affordability penalty fund established by IC 12-15-1-18.5.".

Page 7, line 40, delete "chapter, IC 16-19-18-2," and insert "**chapter, IC 16-21-6-3(a)(14) through IC 16-21-6-3(a)(17),**".

Page 7, line 42, delete "IC 16-19-18-3." and insert "**IC 16-19-3-35.**".

Page 10, line 19, delete "IC 16-19-18-2," and insert "**IC 16-21-6-3(a)(14) through IC 16-21-6-3(a)(17),**".

Page 10, line 21, delete "IC 16-19-18-3." and insert "**IC 16-19-3-35.**".

Renumber all SECTIONS consecutively.

(Reference is to HB 1666 as printed February 4, 2025.)

BARRETT