STATE OF INDIANA

MIKE BRAUN, GOVERNOR

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January 21, 2026

The Honorable Michael K. Braun
Office of the Governor
200 W. Washington Street
Room 206
Indianapolis, IN 46204

Re: Response to Executive Order 25-21 Increasing Freedom and Opportunity for Hoosiers by Improving Price Transparency in Healthcare

Dear Governor Braun:

This document serves as the formal response of the Indiana Department of Insurance and Secretary of Health and Family Services to the directives set forth in Executive Order 25-21 issued on January 21, 2025. Executive Order 25-21 states, in relevant part:

> The Indiana Department of Insurance ("IDOI") and the Family and Social Services Administration ("FSSA"), in consultation with the Secretary of Health and Family Services ("HFS"), shall conduct an assessment and provide recommendations to ensure that healthcare coverage providers and insurance companies comply with federal and state healthcare price transparency statutes and other relevant state rules, regulations and policies. The review shall be completed by October 31, 2025, with a written report provided to the Governor and the Legislative Council by November 30, 2025.
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> IDOI, FSSA, and the Secretary of HFS shall develop recommendations for penalties for healthcare coverage providers found to be non-compliant with health care price transparency statutes, state rules, regulations and policies. These recommendations shall be included in the written report provided to the Governor and the Legislative Council by November 30, 2025.

The IDOI, in consultation with the Secretary of HFS, has conducted a thorough review, and the attached document details our findings and recommendations to meet the objectives of Executive Order 25-21.

Sincerely,

Secretary Gloria Sachdev
Health and Family Services

Commissioner Holly W. Lambert
Indiana Department of Insurance

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On January 21, 2025, Governor Braun signed Executive Order 25-21, titled Increasing Freedom and Opportunity for Hoosiers by Increasing Price Transparency in Healthcare. Executive Order 25-21 states, in relevant part:

> The Indiana Department of Insurance ("IDOI") and the Family and Social Services Administration ("FSSA"), in consultation with the Secretary of Health and Family Services ("HFS"), shall conduct an assessment and provide recommendations to ensure that healthcare coverage providers and insurance companies comply with federal and state healthcare price transparency statutes and other relevant state rules, regulations and policies. The review shall be completed by October 31, 2025, with a written report provided to the Governor and the Legislative Council by November 30, 2025.
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> IDOI, FSSA, and the Secretary of HFS shall develop recommendations for penalties for healthcare coverage providers found to be non-compliant with health care price transparency statutes, state rules, regulations and policies. These recommendations shall be included in the written report provided to the Governor and the Legislative Council by November 30, 2025.

Executive Summary

In furtherance of the requirements detailed in Executive Order 25-21, the IDOI engaged the Seattle office of Milliman, Inc. ("Milliman Seattle") to support this order, including performing an analysis assessing the current quality of payer published Transparency in Coverage Machine readable Files ("TiC data") within Indiana. Milliman Seattle deployed a multidisciplinary team of actuaries, data scientists, and analysts to perform a comprehensive review and analysis to support the Secretary of HFS and the IDOI's

ability to make recommendations. Some key results of Milliman Seattle's three part review are outlined below:

1. Review of TiC enforcement policies from other states and federal regulators:
    a. Most states have not implemented any significant payer price transparency policies.
        i. Texas has enacted federal requirements into state law but has no history of penalizing payers.
        ii. Colorado has implemented requirements that payers must submit TiC data directly to the state web portal twice a year; however, there is no penalty framework or history of penalizing payers.
        iii. Michigan requires confirmation of posted TiC data within regulatory filings but has no history of penalizing payers.
        iv. Washington state requires an attestation regarding TiC data compliance through a separate channel but has no history of penalizing payers.
2. Review of Indiana TiC data and identification of areas where data can be improved:
    a. This analysis reviewed $4.6 billion in commercial claims from the Indiana All Payer Claims Database (APCD) and in that analysis, $964 million of claims (approximately 21% by allowed amount) matched exactly with the TiC file rates.
    b. TiC file schema 2.0 was finalized by the Centers for Medicare and Medicaid Services (CMS) on October 1, 2025, with an enforcement date of February 2, 2026. This new schema will significantly improve the quality of the TiC data.
    c. The lack of identification of networks was a significant hurdle in this assessment. It is vital that networks are clearly and consistently identified in the TiC data, APCD data, and to consumers.
3. Policy development support, scenario modeling and penalty phases
    a. One of the primary goals of this analysis is to identify areas where payers need to improve their TiC data so it can be used to help Hoosiers effectively shop for healthcare. There are two framework options for the penalty phase for payers:
        i. *Framework A: Rubric Approach with Data Review*. Allows the state to target specific data issues that payers must correct by attaching higher penalties to key issues.
        ii. *Framework B: APCD Rate Matching Review.* Focus entirely on whether or not the TiC data adequately explains the historical APCD claims data, without considering other data issues.

The following analysis explores ways to empower Hoosiers through price transparency and to assist them in making informed healthcare decisions. The report reviews current practices and provides recommendations for future actions that can help Hoosiers better estimate and manage their healthcare expenses.

The Federal Transparency in Coverage Final Rule ("TiC Rule") requires insurance companies ("payers") to post their in-network prices for "all covered items and services" in a machine-readable file. While there are several other files payers are required to post under the TiC Rule, the in-network file of the TiC data is the most important and was the focus of the assessment. In theory, this TiC data would be a complete, clear, and definitive list of all prices for in-network care and could be used to help consumers shop for healthcare. However, this assessment shows that the TiC data currently posted is unfit for this purpose because it is far too incomplete and ambiguous.

This review shows that all payers need to make improvements to the quality and completeness of their in-network TiC files. The primary result is that only 21% or $964 million of the claims (by allowed amount) exactly matched the posted rates. Easing the standard to approximate matches within +/- 5%, payers still only achieved match rates from 12.1% to 37%. These match rates will need to be much higher before the TiC data is useful to consumers.

This assessment also identifies issues within the TiC files themselves, apart from any comparison with claims data. Examples include a high prevalence of unnecessary duplication, multiple rate schedules for the same provider, multiple rates for the same services, missing or incorrect data, and invalid/non-standard codes. These issues introduce ambiguity and must be addressed before the TiC data is complete and reliable enough to be utilized.

In addition, Milliman Seattle's report shows that enforcement of healthcare price transparency in the state of Indiana is possible. Establishing and enforcing penalties while requiring complete and accurate data are prerequisites before Hoosiers can benefit from this data and meaningfully shop for healthcare. With appropriate regulation and enforced financial accountability, the goal of true price transparency is within reach.

The Secretary of HFS and the IDOI recommends a 3-phased approach to enforcing transparency.

Phase 1: Focused In-Depth Review of Special Contracting Provisions, Drafting of Standard Provisions, and APCD Enhancements

Consistent with existing Indiana law and the Affordable Care Act-conformity provisions in IC 27-8-5 and IC 27-8-15, the IDOI can incorporate TiC requirements into targeted market conduct examinations, when appropriate, and require corrective action plans contemplate TiC requirements for fully insured issuers. This enforcement would proceed parallel with the longer-term analytical and legislative work described below[1].

With only 21% of paid claims (by allowed amount) having matching rates in the TiC data, there is a large gap between the price lists in the TiC files and the actual prices being paid on claims. Some of these differences are due to incomplete or improper completion of the TiC files and hence are eligible for federal penalties. Other differences come from cases where payment logic is required for correct application of the TiC rates. There is a need for clarity regarding the pricing adjustments that apply in these more complicated situations. However, regulatory review cannot happen at scale without standardization.

Prior to proposed state penalties being issued, the Secretary of HFS and the IDOI recommends a focused and in-depth study to:

1. Work with stakeholders to understand how often claims and TiC rates do not match due to improper completion of the TiC files versus how often the mismatch is due to legitimate and standard adjustments that the TiC files cannot adequately capture.
2. Create a Standard Provisions document that would include a limited set of standard options for common reimbursement logic such as inpatient outliers, inlier and transfers, carveouts and new technologies. It would also include a list of all rules that result in a change in the code-specific rate when a service is performed with other services. This document could also include interaction rules and coding edit rules.
3. Review the data collected by the APCD for the purpose of identifying any additional fields or improvements required to make full use of the claims data.

This study will help the IDOI identify the limits of the TiC schema help us to set and adjust compliance standards. Standardizing special provisions greatly simplifies the contracting, billing, and regulatory review process by handling special cases in a predictable way. Finally, reviewing the APCD for improvements helps to ensure that the data is actionable.

[1] This paragraph was added by the Secretary of Health and Family Services, with the consent of the Indiana Department of Insurance, after the required publication date of November 30, 2025.

Phase 2: Codify Standard Provisions, Begin Enforcement, Issue Penalties, and Develop Review Systems

The Secretary of HFS and the IDOI recommends that the Indiana General Assembly consider new legislation that requires the drafted Standard Provisions document in Phase 1 to be in all payer-provider contracts. This would allow for enforcement through financial penalties when the paid claims are not calculated according to the expected standard logic. Without this legislation, it would be much more challenging to distinguish between contract specific provisions and non-compliance.

Hoosiers can only shop for care if they are able to identify the prices that apply to their plan's network. The new TiC schema 2.0 has added "network name" as a required field and efforts are currently underway to do the same in the APCD. To better support Hoosiers and price transparency, the IDOI recommends new legislation to require health insurance cards to exhibit and clearly label the plan's network name as "Network Name: [plan's network name]".

Two distinct penalty frameworks are discussed in Milliman Seattle's report. Framework A is useful in assessing how close a submission is to being fully compliant. Framework B is useful in assessing how often the data reflected the prices that were charged. When developing the penalty framework to be used, the IDOI may also consider the difference between a claim's allowed amount, and the TiC files negotiated rate after any adjustments in the Standard Provisions document that are applicable.

Informed by the study conducted in Phase 1, the Secretary of HFS and the IDOI also recommends legislation that allows the IDOI to impose an initial State Selected Error Penalty Unit Fee between $25,000 - $250,000, develop and post a penalty framework, conduct an assessment, and issue fines in a manner consistent to one or more of the penalty frameworks described in Milliman Seattle's report. The IDOI may increase or decrease the State Selected Error Penalty Unit Fee for a given assessment period so long as the same unit fee applies to all payers. Penalties assessed shall be used to fund the review program and price transparency, including the development of a data submission portal, automated review systems, and APCD enhancements. Assessments shall be conducted, and any applicable penalties issued at least every 6 months.

Phase 3: State Specific TiC Files, Monthly Assessments, and Use of Data

Following Phase 2 and drawing from Colorado's continued efforts in price transparency, Indiana should require filtered and state specific TiC files for group and individual fully insured commercial plans to be submitted directly to the IDOI utilizing a portal designed for that purpose. Files would be submitted by network. The portal would perform basic validations before accepting a submission. Accepted data would then undergo automated reviews that compare the allowed amount for fully insured commercial claims to the calculated negotiated rate from the TiC file submission and under the logic specified in the Standard Provisions document. To ensure the usefulness of the state specific TiC file data for consumer shopping, all negotiated rates would need to be expressed as a dollar amount even when they were originally negotiated as a percentage of billed charges. The framework developed in Phase 2 would then be applied and the corresponding penalties would be issued.

Once the understandability, completeness, and accuracy of the State Specific TiC data improve sufficiently, it can be used on the Consumer Facing APCD website as real-time pricing information. Since the rates submitted in the TiC files can only be validated after claims have both occurred and been submitted to the APCD, there will be a period of time between when prices are posted and when they can be verified against claims data. Since consumers will be making financial decisions based on this data before it can be validated, the penalty framework needs to be flexible enough to ensure the rates posted are reliable.

The enclosed report and all exhibits referenced therein are hereby submitted in their entirety.