2026 Indiana Health Care Affordability Snapshot

The Health Care Value Hub ("the Hub") is proud to launch the 2026 Health Care Affordability Policy Snapshot ("Affordability Snapshot"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other interested parties a tool to compare their state's health policies across other states. The categories examined in this resource explore a variety of policy options that impact health care affordability. Policies were examined for whether they were active, implemented to a limited degree, or not active as of May 15, 2026. Sources for this information can be found in the downloadable ***Data and Source Document*** **available on the** Dashboard **page. Definitions and descriptions for each policy category can be found in the** ***Glossary*****.**

The Hub offers support dedicated to understanding health care policy and connecting advocates and other interested parties together to help build a patient-centered, high-value health care system. As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

Health Care Spending Benchmark	**Authority to Enforce Health Care Spending Benchmarks**	**Hospital or Primary Care Spending Oversight Entity**	**All-Payer Claims Database**	**Price Transparency Tool**	**Prescription Drug Price Transparency Reporting Requirements**
Ownership Transparency	**Cost Oversight Office or Commission**	**Health Care Financing Taskforce**	**Consolidation Transaction Notification Requirements**	**Authority to Modify or Reject Consolidation Transactions**	**Affordability Criteria Included in Transaction Review**
Restricts All-or-Nothing Contract Provisions	**Restricts Anti-Tiering or Anti-Steering Contract Provisions**	**Restricts Most-Favored Nation Contract Provisions**	**Restricts Price Secrecy and Gag Clause Contract Provisions**		

Key:

- State has passed legislation to implement these policies
- State has passed not legislation to implement these policies

Improve Transparency and Market Oversight

Health Care Spending Oversight

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Health Care Spending Benchmark	✖	State has not established a health care spending benchmark for providers, insurance carriers, or both	
Authority to Enforce Health Care Spending Benchmark	✖	State has not established a health care spending benchmark, with or without enforcement mechanisms	
Hospital or Primary Care Spending Oversight Entity	✖	State does not monitor and report hospital spending, primary care spending, or both	

Improve Transparency and Market Oversight

Health Care Spending Oversight

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
All-Payer Claims Database Established		State has a(n) all-payer or multi-payer claims database	
Price Transparency Tool(s)		State has a public-facing price transparency tool that reports negotiated rates	The Indiana All-Payer Claims Database operates a consumer-facing health care price transparency tool called Indiana Health Prices. The tool allows users to explore the average price to insurance, including the out-of-pocket costs, of various common services across payers and facilities.
Prescription Drug Price Transparency Reporting Requirement(s)		Organizations are not required to report prescription drug price information to a state entity	

Improve Transparency and Market Oversight

Health Care Spending Oversight

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Ownership Transparency		State requires providers and facilities to report ownership data annually	Indiana House Bill 1666, enacted in 2025, requires certain entities in the health care sector to report ownership information to state agencies. Under the law, hospitals report to the Indiana Department of Health, certain health care entities report to the secretary of state, and insurers, third-party administrators, and pharmacy benefit managers report to the Department of Insurance. The Indiana Department of Health must then publish an annual report on this ownership information.
Cost Oversight Office or Commission		State does not have a cost oversight office or commission	
Health Care Financing Taskforce		State does not have a health care financing task force*	

Improve Transparency and Market Oversight

Consolidation Oversight

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Transaction Notification Required		Requires health systems or providers to notify the state of consolidation transactions.	Indiana requires health care entities to notify the Attorney General of mergers and acquisitions with a value of at least $10 million 90 days prior to the merger or acquisitions. As of 7/1/2025, health care providers that are majority owned by licensed Indiana practitioners that routinely provide health care services in the practice are excluded from this requirement.
Authority to Modify or Reject Consolidation Transactions		Does not have authority to approve, set conditions, or disapprove consolidation transactions	The Attorney General does not have approval authority, and instead reviews information submitted and analyzes any antitrust concerns with the transaction and may issue a civil investigative demand.
Affordability Criteria Included in Transaction Review		Does not include consumer affordability or price growth in review criteria, approval conditions, or both	

Improve Transparency and Market Oversight

Anti-Competitive Contract Provisions

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2025	Summary
Restricts All-or-Nothing Contract Provisions		Law restricts All-or-Nothing contract provisions	Indiana legislators passed a law in 2025 that prohibits contracts between health care providers and insurance carriers, including pharmacy benefit managers, from requiring all-or-nothing inclusion of facilities in a select network plan.
Restricts Anti-Tiering and Anti-Steering Contract Provisions		Law restricts Anti-Tiering or Anti-Steering contract provisions	Indiana passed legislation in 2025 prohibiting anti-steering and anti-tiering clauses in contracts involving health care providers.
Restricts Most Favored Nation Contract Provisions		Law restricts Most Favored Nation contract provisions	Indiana prohibits Most Favored Nation clauses in insurer-provider contracts, barring provisions that guarantee an insurer the lowest rates or require the provider to disclose reimbursement rates under contracts with other insurers.
Restricts Price Secrecy and Gag Clause Contract Provisions		State law prohibits price secrecy or gag clause restrictions in contracts between health insurance carriers and health care providers	Indiana prohibits gag clauses in health provider contracts through two statutes. IC 27-1-37-7 (effective July 1, 2020) bars contracts from restricting the disclosure of claims data to employers providing coverage. IC 27-1-37-8 (effective July 1, 2021) further prohibits contracts from limiting the disclosure of allowed amounts, fees, or out-of-pocket costs to insureds, enrollees, or their treating providers, with any violating provision deemed severable and void.

Glossary

Health Care Spending Benchmarks

Health care spending benchmarks aim to limit annual health care spending growth by establishing a maximum limit, or “benchmark.” Benchmarks may examine overall spending or spending for specific hospitals or insurers. Of note, as of 2026 there is pending litigation against health care cost growth benchmarks in some states which may affect the status of these policies.

Authority to Enforce Health Care Spending Benchmarks

Some states grant oversight entities the authority to enforce health care spending benchmarks. In these states, if the benchmark is surpassed, the overseeing state entity will often collaborate with providers to curtail spending, and some states authorize the entity to mandate performance improvement plans or impose penalties. This section examines whether a state has established a benchmark, and if so, whether the state has statutory authority to enforce the benchmark.

Hospital or Primary Care Spending Oversight Entity

Health spending oversight entities monitor and track health care spending systematically, offering data and research support to ensure efficient resource use. While many states set population health priorities, few have established oversight entities with enforcement powers. This section examines whether a state has a health spending oversight entity reviewing primary care, hospital spending, or both.

All-Payer Claims Database

All-payer claims databases (APCDs) compile diverse health care data that may include health, dental, and pharmacy claims from private insurers, state employee health programs, Medicare, and Medicaid. In instances where a database includes only some of these payers, it is referred to as a multi-payer claims database. Typically created through legislation, APCDs are often subject to state oversight and regulation. However, some claims databases have been voluntarily developed by independent entities, limiting oversight.

Price Transparency Tool

A website that displays price information on healthcare services, allowing consumers to “shop” for the best price and budget for expected services. To be credited, the tool must show negotiated prices for various services and be accessible without fees, IRB approval, or legislative restrictions. Additionally, this section reviews whether a state requires prescription drug price data to be reported to a state entity and if a state has another form of price transparency regulation.

Prescription Drug Price Transparency Reporting Requirement

Prescription Drug Price Transparency Reporting Requirements enforce policies for drug manufacturers, insurers, and pharmacy benefit managers to report detailed information about how prescription drug prices are set and increased over time. They are set to promote accountability, reduce hidden costs, and give insight into rising drug costs.

Ownership Transparency

States, policymakers, and the public frequently have no clear picture of who actually owns and controls the providers delivering care to their residents. Requiring annual ownership reporting addresses this transparency gap. When states have accurate, up-to-date ownership data, they can identify consolidation trends before they become entrenched, enforce antitrust and corporate practice of medicine rules more effectively, and hold entities accountable when ownership changes lead to price increases or quality declines.

Glossary

Cost Oversight Office or Commission
To address health care affordability concerns across state populations, some states have established Cost Oversight Offices or Commissions focused on analyzing drivers of high health care costs, working with stakeholders, and creating recommendations for administrative or regulatory solutions. These groups provide broad cost oversight of entire health care systems within a state, from hospitals to insurance practices.

Health Care Financing Taskforce
In an effort to assess health care spending, some states have launched Health Care Financing Taskforces and other entities to evaluate Medicaid financing mechanisms, evaluate Medicaid spending growth, and reduce duplicative spending and inefficiencies in Medicaid program administration while maintaining access to and quality in health care.

Consolidation Transaction Notification Required
Health care consolidation refers to health care entities (i.e. doctor's offices or hospitals) joining together under a common owner through a merger or acquisition. Some states require health care systems and/or providers to notify the state of consolidation transactions.

Authority to Modify or Reject Consolidation Transactions
During health care consolidation transactions, some states have the authority to approve, modify, or deny the transactions based on their own reviews.

Affordability Criteria Included in Transaction Review
When health care entities consolidate, some states require that affordability criteria like consumer affordability or price growth be considered in approval conditions, review criteria, or both.

Restricts All-or-Nothing Contract Provisions
Anti-competitive contracting is a pattern of contracting between health care providers and insurers where one party gains unfair advantages over potential competitors. States can enact regulations that limit dominant health systems from abusing their market power in ways that increase prices. For example, All-or-Nothing contract provisions are typically applied by health systems to require plans to contract with all providers in their system or none of them, even if those providers are low-value or high-cost.

Restricts Anti-Tiering or Anti-Steering Contract Provisions
These contract provisions require insurers to place certain providers in higher tiers regardless of cost or quality (anti-tiering) and restrict directing patients to higher value care from competitors (anti-steering).

Restricts Most Favored Nation Contract Provisions
In health care, Most-Favored Nation clauses are contract terms in which a health insurance company requires a provider or health system to guarantee that no other health plan will receive the same prices at a lower price. This restriction prevents providers or health systems from offering better pricing to competitors and can lead to higher overall prices when insurers and providers work together to maintain these rates.

Restricts Price Secrecy and Gag Clause Contract Provisions
Gag clauses are contractual provisions that prevent providers and insurers from disclosing prices, including negotiated rates, to patients, employers, or plan sponsors. These provisions can limit price transparency and make it harder for patients, self-funded employers, and policymakers to identify where health care markets are not functioning effectively. Congress passed the Consolidated Appropriations Act of 2020, which prohibits most gag clauses in health insurance contracts.