



Reprinted
January 30, 2026

HOUSE BILL No. 1271

DIGEST OF HB 1271 (Updated January 29, 2026 3:29 pm - DI 141)

Citations Affected: IC 16-18; IC 16-21; IC 27-1; IC 27-8; IC 27-13.

Synopsis: Payment of health claims. Requires a hospital to: (1) disclose information concerning payment assistance programs; (2) post signs concerning the programs in specified locations of the hospital; and (3) make information concerning the programs available to individuals through the hospital's patient portal system. Requires a hospital to notify individuals of available payment assistance programs before beginning a collection action against the individual. Prohibits an insurer that issues a policy of accident and sickness insurance (insurer), a health maintenance organization, and a third party contractor from using downcoding in a specified manner. Prohibits an insurer and a health maintenance organization from retroactively reducing the reimbursement rate for any CPT code. Sets forth limitations on an insurer and a health maintenance organization retroactively auditing a paid claim or seeking recoupment or a refund of a paid claim.

Effective: July 1, 2026.

**McGuire, Goss-Reaves, Carbaugh,
Garcia Wilburn**

January 6, 2026, read first time and referred to Committee on Insurance.
January 20, 2026, amended, reported — Do Pass.
January 29, 2026, read second time, amended, ordered engrossed.

HB 1271—LS 7085/DI 141



Reprinted
January 30, 2026

Second Regular Session of the 124th General Assembly (2026)

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 2025 Regular Session of the General Assembly.

HOUSE BILL No. 1271

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

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

1 SECTION 1. IC 16-18-2-52.5, AS AMENDED BY P.L.188-2025,
2 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2026]: Sec. 52.5. (a) "Charity care", for purposes of
4 IC 16-21-6, IC 16-21-9, **IC 16-21-9.5**, and IC 16-40-6, means the
5 unreimbursed cost to a hospital of providing, funding, or otherwise
6 financially supporting health care services:
7 (1) to a person classified by the hospital as financially indigent or
8 medically indigent on an inpatient or outpatient basis; and
9 (2) to financially indigent patients through other nonprofit or
10 public outpatient clinics, hospitals, or health care organizations.
11 (b) As used in this section, "financially indigent" means an
12 uninsured or underinsured person who is accepted for care with no
13 obligation or a discounted obligation to pay for the services rendered
14 based on the hospital's financial criteria and procedure used to
15 determine if a patient is eligible for charity care. The criteria and
16 procedure must include income levels and means testing indexed to the
17 federal poverty guidelines. A hospital may determine that a person is

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1 financially or medically indigent under the hospital's eligibility system
2 after health care services are provided.

3 (c) As used in this section, "medically indigent" means a person
4 whose medical or hospital bills after payment by third party payors
5 exceed a specified percentage of the patient's annual gross income as
6 determined in accordance with the hospital's eligibility system, and
7 who is financially unable to pay the remaining bill.

8 SECTION 2. IC 16-18-2-58.5 IS ADDED TO THE INDIANA
9 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
10 [EFFECTIVE JULY 1, 2026]: **Sec. 58.5. "Collection action", for**
11 **purposes of IC 16-21-9.5, has the meaning set forth in**
12 **IC 16-21-9.5-1.**

13 SECTION 3. IC 16-18-2-251 IS AMENDED TO READ AS
14 FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 251. "Nonprofit
15 hospital", for purposes of IC 16-21-9 and **IC 16-21-9.5**, has the
16 meaning set forth in IC 16-21-9-3.

17 SECTION 4. IC 16-18-2-272.4 IS ADDED TO THE INDIANA
18 CODE AS A **NEW** SECTION TO READ AS FOLLOWS
19 [EFFECTIVE JULY 1, 2026]: **Sec. 272.4. "Payment assistance**
20 **program", for purposes of IC 16-21-9.5, has the meaning set forth**
21 **in IC 16-21-9.5-2.**

22 SECTION 5. IC 16-21-9.5 IS ADDED TO THE INDIANA CODE
23 AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE
24 JULY 1, 2026]:

25 **Chapter 9.5. Notice of Payment Assistance Programs**

26 **Sec. 1. As used in this chapter, "collection action" means the**
27 **sale or assignment of a bill to a collection agency, or the pursuit of**
28 **litigation, by a hospital or any organization that has a financial**
29 **relationship with the hospital.**

30 **Sec. 2. As used in this chapter, "payment assistance program"**
31 **refers to any of the following:**

32 **(1) Charity care.**

33 **(2) Financial assistance.**

34 **(3) Any other payment plans made available to a patient by a**
35 **hospital.**

36 **Sec. 3. (a) A hospital shall provide written notice of the**
37 **hospital's payment assistance program to a patient or the patient's**
38 **representative at the following times:**

39 **(1) During registration or intake for inpatient or outpatient**
40 **services, unless the patient is incapable of reasonably**
41 **receiving the notice at that time.**

42 **(2) If the patient is incapable of reasonably receiving the**



notice during registration or intake under subdivision (1), at discharge.

(3) With the initial billing statement for the provided services.

(b) The written notice required under subsection (a) must include the following:

(1) A description of available payment assistance programs.

(2) Eligibility criteria.

(3) Application instructions.

(4) Contact information for a hospital representative when assistance is needed to complete the application.

(c) A hospital may provide notice to a patient or the patient's representative under subsection (a):

(1) in a writing delivered to the patient or the patient's representative;

(2) by electronic mail; or

(3) through a mobile application or another Internet based method, if available;

according to the preference for communication expressed by the patient or patient's representative.

Sec. 4. A hospital shall post conspicuous signage notifying patients of the availability of payment assistance programs in the following locations:

(1) Registration areas.

(2) Financial counseling offices.

(3) Emergency departments.

Sec. 5. A hospital shall make payment assistance program information available electronically through any patient portal maintained by the hospital.

Sec. 6. Before beginning a collection action, a hospital shall do the following:

(1) Make a reasonable effort to determine whether the individual is eligible for a payment assistance program.

(2) Make a reasonable effort to notify the individual of available payment assistance programs and provide the individual with an application form.

Sec. 7. A nonprofit hospital shall annually report compliance with this chapter as part of the nonprofit hospital's community benefit plan report under IC 16-21-9-7.

Sec. 8. The state department may adopt rules under IC 4-22-2 to administer and enforce this chapter.

Sec. 9. The state department may assess a hospital a civil penalty of not more than one thousand dollars (\$1,000) per



1 violation for failure to comply with this chapter. A penalty
2 collected under this section shall be deposited into the state general
3 fund.

4 SECTION 6. IC 27-1-52 IS ADDED TO THE INDIANA CODE AS
5 A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY
6 1, 2026]:

7 **Chapter 52. Downcoding of Health Benefits Claims**

8 **Sec. 1.** As used in this chapter, "covered individual" means an
9 individual who is entitled to coverage under a health plan.

10 **Sec. 2.** As used in this chapter, "downcoding" means the
11 adjustment of a health benefits claim by an insurer to a less
12 complex or lower price service for reimbursement to a provider in
13 an amount less than the amount noted in the fully executed
14 provider contract. The term includes the use of remittance advice
15 remark codes.

16 **Sec. 3.** As used in this chapter, "health benefits claim" means a
17 claim submitted by a provider for payment under a health plan for
18 health care services provided to a covered individual.

19 **Sec. 4.** As used in this chapter, "health care service" means a
20 service or good furnished for the purpose of preventing,
21 alleviating, curing, or healing:

- 22 (1) human illness;
- 23 (2) physical disability; or
- 24 (3) injury.

25 **Sec. 5.** As used in this chapter, "health plan" means the
26 following:

- 27 (1) A policy of accident and sickness insurance (as defined in
28 IC 27-8-5-1), but not including the coverages described in
29 IC 27-8-5-2.5(a).
- 30 (2) An individual contract (as defined in IC 27-13-1-21) or a
31 group contract (as defined in IC 27-13-1-16) with a health
32 maintenance organization (as defined in IC 27-13-1-19) that
33 provides coverage for basic health care services (as defined in
34 IC 27-13-1-4).

35 **Sec. 6.** As used in this chapter, "insurer" means the following:

- 36 (1) An insurer (as defined in IC 27-1-2-3(x)) that issues a
37 policy of accident and sickness insurance (as defined in
38 IC 27-8-5-1), but not including the coverages described in
39 IC 27-8-5-2.5(a).
- 40 (2) A health maintenance organization (as defined in
41 IC 27-13-1-19) that provides coverage for basic health care
42 services (as defined in IC 27-13-1-4) under an individual



contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16).

(3) A third party contractor of an entity described in subdivision (1) or (2).

Sec. 7. As used in this chapter, "provider" means an individual or entity licensed or legally authorized to provide health care services.

Sec. 8. Notwithstanding any other law or regulation to the contrary, an insurer may not use downcoding in a manner that prevents a provider from:

(1) submitting a health benefits claim for the actual health care service performed; and

(2) collecting reimbursement from the insurer for the actual health care service performed.

Sec. 9. The department shall adopt rules under IC 4-22-2 to carry out this chapter.

SECTION 7. IC 27-8-5.7-0.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 0.5. Sections 6.7, 9.5, and 9.7 of this chapter, as added in the 2026 session of the general assembly, and section 10 of this chapter, as amended in the 2026 session of the general assembly, apply to an accident and sickness insurance policy that:

(1) is issued, delivered, amended, or renewed after June 30, 2026; and

(2) provides coverage during a plan year beginning after December 31, 2026.

SECTION 8. IC 27-8-5.7-2.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 2.7. As used in this chapter, "health provider facility" has the meaning set forth in IC 27-1-37-3.2.

SECTION 9. IC 27-8-5.7-6.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 6.7. (a) An insurer may not retroactively reduce the reimbursement rate for any CPT code.

(b) An insurer shall provide at least sixty (60) days written notice by:

(1) mail or electronic mail to a provider; and

(2) posting on the insurer's website;

before prospectively implementing a rate reduction for any CPT code.



SECTION 10. IC 27-8-5.7-9.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 9.5. (a) This section does not apply to the recoupment or refund of a payment that is subject to section 9.7 of this chapter.**

(b) Subject to section 10 of this chapter, an insurer may not seek recoupment or a refund of a payment made to a provider unless the recoupment or refund is for an overpayment that was caused by:

- (1) fraud;**
- (2) an error in the coordination of benefits;**
- (3) duplicate payments; or**
- (4) a bill submitted in violation of IC 16-51-1-11.**

SECTION 11. IC 27-8-5.7-9.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 9.7. (a) This section only applies to the recoupment or refund of a payment made by an insurer to a health provider facility when an individual was transferred from one (1) health provider facility to another health provider facility.**

(b) Subject to section 10 of this chapter, an insurer may not seek recoupment or a refund of a payment made to a health provider facility that provided initial health care services to an individual who was subsequently transferred to another health provider facility unless:

- (1) the claim was submitted fraudulently;**
- (2) the:**
 - (A) individual was not entitled to coverage; or**
 - (B) health care services provided to the individual were not covered;**
- at the time the health care services were rendered; or**
- (3) the bill was submitted in violation of IC 16-51-1-11.**

(c) The limitation on seeking recoupment or refund of a payment made to a health provider facility under subsection (b) applies regardless of:

- (1) the reason for the transfer;**
- (2) the type of facility receiving the individual; or**
- (3) the acuity, age, or diagnosis of the individual.**

(d) Any recoupment or refund attempted in violation of this section is void and unenforceable.

SECTION 12. IC 27-8-5.7-10, AS ADDED BY P.L.55-2006, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 10. (a) An insurer may not, more than two (2)**



years after the date on which an overpayment on a provider claim was made to the provider by the insurer:

- (1) request that the provider repay the overpayment; or
- (2) adjust a subsequent claim filed by the provider as a method of obtaining reimbursement of the overpayment from the provider.

(a) An insurer may not retroactively audit a paid claim or seek recoupment or a refund of a paid claim more than one hundred eighty (180) days after the date on which the claim was initially paid.

(b) An insurer may not be required to correct a payment error to a provider more than two (2) years after the date on which a payment on a provider claim was made to the provider by the insurer: if notice of the payment error is not provided within one hundred eighty (180) days after payment for a fully adjudicated claim is received.

(c) This section does not apply in cases of fraud by the provider, the insured, or the insurer with respect to the health benefits claim on which the overpayment or underpayment was made.

SECTION 13. IC 27-13-36.2-0.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 0.5. Sections 4.7, 7.5, and 7.7 of this chapter, as added in the 2026 session of the general assembly, and section 8 of this chapter, as amended in the 2026 session of the general assembly, apply to an individual contract and a group contract that:**

- (1) is entered into, delivered, amended, or renewed after June 30, 2026; and
- (2) provides coverage during a plan year beginning after December 31, 2026.

SECTION 14. IC 27-13-36.2-2.3 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 2.3. As used in this chapter, "health provider facility" has the meaning set forth in IC 27-1-37-3.2.**

SECTION 15. IC 27-13-36.2-4.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 4.7. (a) A health maintenance organization may not retroactively reduce the reimbursement rate for any CPT code (as defined in IC 27-1-37.5-3).**

(b) A health maintenance organization shall provide at least sixty (60) days notice by:

- (1) mail or electronic mail to a provider; and
- (2) posting on the health maintenance organization's website;



1 before prospectively reducing the reimbursement rate for any CPT
2 code (as defined in IC 27-1-37.5-3).

3 SECTION 16. IC 27-13-36.2-7.5 IS ADDED TO THE INDIANA
4 CODE AS A NEW SECTION TO READ AS FOLLOWS
5 [EFFECTIVE JULY 1, 2026]: Sec. 7.5. (a) This section does not
6 apply to the recoupment or refund of a payment that is subject to
7 section 7.7 of this chapter.

8 (b) Subject to section 8 of this chapter, a health maintenance
9 organization may not seek recoupment or a refund of a payment
10 made to a provider unless the recoupment or refund is for an
11 overpayment that was caused by:

- 12 (1) fraud;
- 13 (2) an error in the coordination of benefits;
- 14 (3) duplicate payments; or
- 15 (4) a bill submitted in violation of IC 16-51-1-11.

16 SECTION 17. IC 27-13-36.2-7.7 IS ADDED TO THE INDIANA
17 CODE AS A NEW SECTION TO READ AS FOLLOWS
18 [EFFECTIVE JULY 1, 2026]: Sec. 7.7. (a) This section only applies
19 to the recoupment or refund of a payment made by a health
20 maintenance organization to a health provider facility when an
21 individual was transferred from one (1) health provider facility to
22 another health provider facility.

23 (b) Subject to section 8 of this chapter, a health maintenance
24 organization may not seek recoupment or a refund of a payment
25 made to a health provider facility that provided initial health care
26 services to an individual who was subsequently transferred to
27 another health provider facility unless:

- 28 (1) the claim was submitted fraudulently;
- 29 (2) the:
 - 30 (A) individual was not entitled to coverage; or
 - 31 (B) health care services provided to the individual were not
 - 32 covered;
 - 33 at the time the health care services were rendered; or
 - 34 (3) the bill was submitted in violation of IC 16-51-1-11.

35 (c) The limitation on seeking recoupment or refund of a
36 payment made to a health provider facility under subsection (b)
37 applies regardless of:

- 38 (1) the reason for the transfer;
- 39 (2) the type of facility receiving the individual; or
- 40 (3) the acuity, age, or diagnosis of the individual.

41 (d) Any recoupment or refund attempted in violation of this
42 section is void and unenforceable.



1 SECTION 18. IC 27-13-36.2-8, AS ADDED BY P.L.55-2006,
2 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2026]: Sec. 8. (a) ~~A health maintenance organization may not,~~
4 ~~more than two (2) years after the date on which an overpayment on a~~
5 ~~provider claim was made to the provider by the health maintenance~~
6 ~~organization:~~

7 (1) ~~request that the provider repay the overpayment; or~~

8 (2) ~~adjust a subsequent claim filed by the provider as a method of~~
9 ~~obtaining reimbursement of the overpayment from the provider.~~

10 **(a) A health maintenance organization may not retroactively**
11 **audit a paid claim or seek recoupment or a refund of a paid claim**
12 **more than one hundred eighty (180) days after the date on which**
13 **the claim was initially paid.**

14 (b) A health maintenance organization may not be required to
15 correct a payment error to a provider ~~more than two (2) years after the~~
16 ~~date on which a payment on a provider claim was made to the provider~~
17 ~~by the health maintenance organization: if notice of the payment~~
18 ~~error is not provided within one hundred eighty (180) days after~~
19 ~~payment for a fully adjudicated claim is received.~~

20 (c) This section does not apply in cases of fraud by the provider, the
21 enrollee, or the health maintenance organization with respect to the
22 **health benefits** claim on which the overpayment or underpayment was
23 made.



COMMITTEE REPORT

Mr. Speaker: Your Committee on Insurance, to which was referred House Bill 1271, 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 2, between lines 7 and 8, begin a new paragraph and insert:

"SECTION 2. IC 16-18-2-58.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 58.5. "Collection action", for purposes of IC 16-21-9.5, has the meaning set forth in IC 16-21-9.5-1.**"

Page 2, line 16, delete "IC 16-21-9.5-1." and insert "**IC 16-21-9.5-2.**".

Page 2, between lines 20 and 21, begin a new paragraph and insert:

"Sec. 1. As used in this chapter, "collection action" means the sale or assignment of a bill to a collection agency, or the pursuit of litigation, by a hospital or any organization that has a financial relationship with the hospital."

Page 2, line 21, delete "1." and insert "**2.**".

Page 2, delete line 25.

Page 2, line 26, delete "(4)" and insert "**(3)**".

Page 2, between lines 27 and 28, begin a new line block indented and insert:

"(4) Any other payment plans made available to a patient by a hospital."

Page 2, line 28, delete "2." and insert "**3.**".

Page 3, line 10, delete "3." and insert "**4.**".

Page 3, line 13, delete "Inpatient and outpatient registration" and insert "**Registration**".

Page 3, delete lines 16 through 18.

Page 3, line 19, delete "4." and insert "**5.**".

Page 3, line 22, delete "5." and insert "**6.**".

Page 3, line 29, delete "6." and insert "**7.**".

Page 3, line 32, delete "7." and insert "**8.**".

Page 3, line 34, delete "8." and insert "**9.**".

Page 5, between lines 1 and 2, begin a new line block indented and insert:

"(3) A third party contractor of an entity described in subdivision (1) or (2)."

Page 5, delete lines 14 through 21.

Page 5, line 35, after "before" insert "**prospectively**".



Page 6, delete lines 30 through 42.

Page 7, delete lines 1 through 17, begin a new paragraph and insert:

"SECTION 12. IC 27-8-5.7-10, AS ADDED BY P.L.55-2006, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 10. (a) ~~An insurer may not, more than two (2) years after the date on which an overpayment on a provider claim was made to the provider by the insurer:~~

(1) request that the provider repay the overpayment; or

(2) adjust a subsequent claim filed by the provider as a method of obtaining reimbursement of the overpayment from the provider.

(a) An insurer may not retroactively audit a paid claim or seek recoupment or a refund of a paid claim more than one hundred eighty (180) days after the date on which the claim was initially paid.

(b) An insurer may not be required to correct a payment error to a provider ~~more than two (2) years after the date on which a payment on a provider claim was made to the provider by the insurer:~~ **if notice of the payment error is not provided within one hundred eighty (180) days after payment for a fully adjudicated claim is received.**

(c) This section does not apply in cases of fraud by the provider, the insured, or the insurer with respect to the **health benefits** claim on which the overpayment or underpayment was made."

Page 7, line 32, after "before" insert "**prospectively**".

Page 8, delete lines 29 through 42.

Page 9, delete lines 1 through 12, begin a new paragraph and insert:

"SECTION 18. IC 27-13-36.2-8, AS ADDED BY P.L.55-2006, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 8. (a) ~~A health maintenance organization may not, more than two (2) years after the date on which an overpayment on a provider claim was made to the provider by the health maintenance organization:~~

(1) request that the provider repay the overpayment; or

(2) adjust a subsequent claim filed by the provider as a method of obtaining reimbursement of the overpayment from the provider.

(a) A health maintenance organization may not retroactively audit a paid claim or seek recoupment or a refund of a paid claim more than one hundred eighty (180) days after the date on which the claim was initially paid.

(b) A health maintenance organization may not be required to correct a payment error to a provider ~~more than two (2) years after the date on which a payment on a provider claim was made to the provider by the health maintenance organization:~~ **if notice of the payment**



error is not provided within one hundred eighty (180) days after payment for a fully adjudicated claim is received.

(c) This section does not apply in cases of fraud by the provider, the enrollee, or the health maintenance organization with respect to the **health benefits** claim on which the overpayment or underpayment was made."

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1271 as introduced.)

CARBAUGH

Committee Vote: yeas 11, nays 1.

HOUSE MOTION

Mr. Speaker: I move that House Bill 1271 be amended to read as follows:

Page 2, delete lines 34 through 35.

Page 2, line 36, delete "(4)" and insert "(3)".

Page 2, delete lines 41 through 42.

Page 3, delete lines 1 through 2, begin a new line block indented and insert:

"(1) During registration or intake for inpatient or outpatient services, unless the patient is incapable of reasonably receiving the notice at that time.

(2) If the patient is incapable of reasonably receiving the notice during registration or intake under subdivision (1), at discharge."

Page 3, line 31, delete "Determine" and insert "**Make a reasonable effort to determine**".

Page 4, delete lines 4 through 9.

Page 5, between lines 22 and 23, begin a new paragraph and insert:

"SECTION 7. IC 27-8-5.7-0.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 0.5. Sections 6.7, 9.5, and 9.7 of this chapter, as added in the 2026 session of the general assembly, and section 10 of this chapter, as amended in the 2026 session of the general assembly, apply to an accident and sickness insurance policy that:

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(1) is issued, delivered, amended, or renewed after June 30, 2026; and

(2) provides coverage during a plan year beginning after December 31, 2026."

Page 5, delete lines 38 through 42.

Page 6, delete lines 1 through 31, begin a new paragraph and insert:

"SECTION 10. IC 27-8-5.7-9.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 9.5. (a) This section does not apply to the recoupment or refund of a payment that is subject to section 9.7 of this chapter.**

(b) Subject to section 10 of this chapter, an insurer may not seek recoupment or a refund of a payment made to a provider unless the recoupment or refund is for an overpayment that was caused by:

- (1) fraud;**
- (2) an error in the coordination of benefits;**
- (3) duplicate payments; or**
- (4) a bill submitted in violation of IC 16-51-1-11.**

SECTION 11. IC 27-8-5.7-9.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 9.7. (a) This section only applies to the recoupment or refund of a payment made by an insurer to a health provider facility when an individual was transferred from one (1) health provider facility to another health provider facility.**

(b) Subject to section 10 of this chapter, an insurer may not seek recoupment or a refund of a payment made to a health provider facility that provided initial health care services to an individual who was subsequently transferred to another health provider facility unless:

- (1) the claim was submitted fraudulently;**
- (2) the:**
 - (A) individual was not entitled to coverage; or**
 - (B) health care services provided to the individual were not covered;**
- at the time the health care services were rendered; or**
- (3) the bill was submitted in violation of IC 16-51-1-11.**

(c) The limitation on seeking recoupment or refund of a payment made to a health provider facility under subsection (b) applies regardless of:

- (1) the reason for the transfer;**
- (2) the type of facility receiving the individual; or**



(3) the acuity, age, or diagnosis of the individual.

(d) Any recoupment or refund attempted in violation of this section is void and unenforceable."

Page 7, between lines 9 and 10, begin a new paragraph and insert:

"SECTION 13. IC 27-13-36.2-0.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 0.5. Sections 4.7, 7.5, and 7.7 of this chapter, as added in the 2026 session of the general assembly, and section 8 of this chapter, as amended in the 2026 session of the general assembly, apply to an individual contract and a group contract that:

(1) is entered into, delivered, amended, or renewed after June 30, 2026; and

(2) provides coverage during a plan year beginning after December 31, 2026."

Page 7, delete lines 26 through 42.

Page 8, delete lines 1 through 20, begin a new paragraph and insert:

"SECTION 15. IC 27-13-36.2-7.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 7.5. (a) This section does not apply to the recoupment or refund of a payment that is subject to section 7.7 of this chapter.

(b) Subject to section 8 of this chapter, a health maintenance organization may not seek recoupment or a refund of a payment made to a provider unless the recoupment or refund is for an overpayment that was caused by:

(1) fraud;

(2) an error in the coordination of benefits;

(3) duplicate payments; or

(4) a bill submitted in violation of IC 16-51-1-11.

SECTION 16. IC 27-13-36.2-7.7 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 7.7. (a) This section only applies to the recoupment or refund of a payment made by a health maintenance organization to a health provider facility when an individual was transferred from one (1) health provider facility to another health provider facility.

(b) Subject to section 8 of this chapter, a health maintenance organization may not seek recoupment or a refund of a payment made to a health provider facility that provided initial health care services to an individual who was subsequently transferred to another health provider facility unless:



- (1) the claim was submitted fraudulently;**
- (2) the:**
 - (A) individual was not entitled to coverage; or**
 - (B) health care services provided to the individual were not covered;**
- at the time the health care services were rendered; or**
- (3) the bill was submitted in violation of IC 16-51-1-11.**
- (c) The limitation on seeking recoupment or refund of a payment made to a health provider facility under subsection (b) applies regardless of:**
 - (1) the reason for the transfer;**
 - (2) the type of facility receiving the individual; or**
 - (3) the acuity, age, or diagnosis of the individual.**
- (d) Any recoupment or refund attempted in violation of this section is void and unenforceable."**

Page 9, delete line 2.

Renumber all SECTIONS consecutively.

(Reference is to HB 1271 as printed January 20, 2026.)

MCGUIRE

