



February 13, 2026

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# ENGROSSED HOUSE BILL No. 1271

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DIGEST OF HB 1271 (Updated February 11, 2026 11:02 am - 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 make a reasonable effort 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  
(Continued next page)

**Effective:** July 1, 2026.

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

(SENATE SPONSORS — BROWN L, CRIDER, JOHNSON T)

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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.

January 30, 2026, engrossed.

February 2, 2026, read third time, passed. Yeas 85, nays 0.

SENATE ACTION

February 5, 2026, read first time and referred to Committee on Health and Provider Services.

February 12, 2026, amended, reported favorably — Do Pass. Reassigned to Committee on Appropriations pursuant to Rule 68(b).

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EH 1271—LS 7085/DI 141



## Digest Continued

organization, and a third party contractor from using downcoding in a specified manner. Prohibits a provider from using an automated process, system, or tool to submit a health benefits claim without the review of a provider or other person involved in the development of the claim for submission. Prohibits an insurer and a health maintenance organization from retroactively reducing the reimbursement rate for any CPT code. Sets forth limitations on the time frame in which an insurer and a health maintenance organization: (1) may request repayment of an overpayment, adjust a subsequent claim, recoup or refund a paid claim, or retroactively audit a paid claim; and (2) is required to correct a payment error to a provider. Provides that if an insurer or a health maintenance organization recoups payment from a provider due to an error in coordination of benefits, the provider may submit a claim for the same services to the appropriate insurer or health maintenance organization.



February 13, 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.

## ENGROSSED HOUSE BILL No. 1271

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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 for medical debt, by a hospital or any organization that**  
29 **has a financial 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 one (1) of the following times:**

- 39 (1) **During registration or intake for inpatient or outpatient**  
40 **services.**  
41 (2) **At discharge.**  
42 (3) **With the initial billing statement for the provided services.**



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

- 3 (1) A description of available payment assistance programs.
- 4 (2) Eligibility criteria.
- 5 (3) Application instructions.
- 6 (4) Contact information for a hospital representative when
- 7 assistance is needed to complete the application.

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

- 10 (1) in a writing delivered to the patient or the patient's
- 11 representative;
- 12 (2) by electronic mail; or
- 13 (3) through a mobile application or another Internet based
- 14 method, if available;

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

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

- 20 (1) Registration areas.
- 21 (2) Emergency departments.

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

25 Sec. 6. Before beginning a collection action, a hospital shall  
26 make a reasonable effort to notify the individual of available  
27 payment assistance programs and provide the individual with an  
28 application form.

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

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

34 Sec. 9. The state department may assess a hospital a civil  
35 penalty of not more than one thousand dollars (\$1,000) per  
36 violation for failure to comply with this chapter. A penalty  
37 collected under this section shall be deposited into the state general  
38 fund.

39 SECTION 6. IC 27-1-52 IS ADDED TO THE INDIANA CODE AS  
40 A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY  
41 1, 2026]:

42 Chapter 52. Downcoding of Health Benefits Claims



1           **Sec. 0.5.** As used in this chapter, "CARC" refers to the claim  
 2 adjustment reason codes that provide the reason for a financial  
 3 adjustment specified to a particular claim or service, as referenced  
 4 in the transmitted Accredited Standards Committee (ASC) X12  
 5 835 standard transaction adopted by the Department of Health and  
 6 Human Services under 45 CFR 162.1602.

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

9           **Sec. 2.** As used in this chapter, "downcode" or "downcoding"  
 10 means the unilateral alteration by an insurer of the:

11           (1) payment for an evaluation and management service code  
 12 or other service code; or

13           (2) level of evaluation and management service code or other  
 14 service code submitted on a claim that results in a lower  
 15 payment.

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



- 1 contract (as defined in IC 27-13-1-21) or a group contract (as  
2 defined in IC 27-13-1-16).
- 3 (3) A third party contractor of an entity described in  
4 subdivision (1) or (2).
- 5 Sec. 7. As used in this chapter, "provider" means an individual  
6 or entity licensed or legally authorized to provide health care  
7 services.
- 8 Sec. 7.5. As used in this chapter, "RARC" refers to remittance  
9 advice remark codes that provide:
- 10 (1) supplemental information about a financial adjustment  
11 indicated by a CARC; or  
12 (2) information about remittance processing.
- 13 Sec. 8. Notwithstanding any other law or regulation to the  
14 contrary, an insurer may not use downcoding in a manner that  
15 prevents a provider from:
- 16 (1) submitting a health benefits claim for the actual health  
17 care service performed; and  
18 (2) collecting reimbursement from the insurer for the actual  
19 health care service performed.
- 20 Sec. 9. (a) An insurer may not use an automated:
- 21 (1) process;  
22 (2) system; or  
23 (3) tool, including artificial intelligence;  
24 as the sole basis to downcode a claim based on medical necessity  
25 without the review of the covered individual's medical record by an  
26 employee or contractor of the insurer.
- 27 (b) A provider may not use an automated:
- 28 (1) process;  
29 (2) system; or  
30 (3) tool, including artificial intelligence;  
31 to submit a health benefits claim without the review of a provider  
32 or other person involved in the development of the claim for  
33 submission.
- 34 (c) An insurer must disclose in an easily accessible and readable  
35 manner when artificial intelligence is used to:
- 36 (1) make an adverse determination on a prior authorization  
37 request; or  
38 (2) downcode a claim.
- 39 Sec. 10. An insurer may not downcode a claim based solely on  
40 the reported diagnosis code.
- 41 Sec. 11. If a claim is downcoded, the insurer shall:
- 42 (1) notify the provider using the appropriate CARC and



- 1 RARC to clearly indicate that the claim has been downcoded;  
 2 and  
 3 (2) provide:  
 4 (A) the specific reason for the downcoding, including  
 5 reference to the clinical criteria used to justify the  
 6 downcoding;  
 7 (B) the original and revised service codes and payment  
 8 amounts; and  
 9 (C) a notice of the right to appeal as described in section 12  
 10 of this chapter.

11 Sec. 12. (a) An insurer shall provide providers with a clear and  
 12 accessible process for appealing downcoded claims, including:

- 13 (1) a written or electronic notice detailing how to initiate an  
 14 appeal;  
 15 (2) contact information for the individual managing the  
 16 appeal; and  
 17 (3) a timeline for submission of an appeal that is not less than  
 18 one hundred eighty (180) days.

19 (b) An insurer shall allow a provider to appeal in batches of  
 20 similar claims involving substantially similar downcoding issues  
 21 without restriction.

22 Sec. 13. An insurer may not downcode in a targeted or  
 23 discriminatory manner against providers that routinely treat  
 24 patients with complex or chronic conditions.

25 Sec. 14. The department shall adopt rules under IC 4-22-2 to  
 26 carry out this chapter.

27 SECTION 7. IC 27-8-5.7-0.5 IS ADDED TO THE INDIANA  
 28 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 29 [EFFECTIVE JULY 1, 2026]: Sec. 0.5. Sections 6.7 and 11.5 of this  
 30 chapter, as added in the 2026 session of the general assembly, and  
 31 section 10 of this chapter, as amended in the 2026 session of the  
 32 general assembly, apply to an accident and sickness insurance  
 33 policy that:

- 34 (1) is issued, delivered, amended, or renewed after June 30,  
 35 2026; and  
 36 (2) provides coverage during a plan year beginning after  
 37 December 31, 2026.

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



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

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

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

8 **(2) posting on the insurer's website;**

9 **before prospectively implementing a rate reduction for any CPT**  
 10 **code.**

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

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

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

19 **(b) An insurer may not recoup or refund a paid claim more than**  
 20 **one (1) year after the date on which the claim was initially paid.**

21 **(c) An insurer may not retroactively audit a paid claim more**  
 22 **than three (3) years after the date on which the claim was initially**  
 23 **paid.**

24 ~~(b)~~ **(d) An insurer may not be required to correct a payment error to**  
 25 **a provider more than two (2) years after the date on which a payment**  
 26 **on a provider claim was made to the provider by the insurer. if notice**  
 27 **of the payment error is not provided within one (1) year after**  
 28 **payment for a fully adjudicated claim is received.**

29 ~~(c)~~ **(e) This section does Subsections (a), (b), and (d) do not apply**  
 30 **in cases of fraud by the provider, the insured, or the insurer with**  
 31 **respect to the health benefits claim on which the overpayment or**  
 32 **underpayment was made when a final determination of fraud has**  
 33 **been made by a court.**

34 **(f) Notwithstanding subsections (a) through (d), an insurer and**  
 35 **a provider may enter into a value based health care reimbursement**  
 36 **agreement (as defined in IC 27-1-37.6-15) that provides for**  
 37 **different time frames than those specified in this section.**

38 SECTION 11. IC 27-8-5.7-11.5 IS ADDED TO THE INDIANA  
 39 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 40 [EFFECTIVE JULY 1, 2026]: **Sec. 11.5. (a) If an insurer or a health**  
 41 **maintenance organization (as defined in IC 27-13-36.2-2) recoups**  
 42 **payment from a provider due to an error in coordination of**



1 benefits, the provider may submit a claim for the same services to  
2 the appropriate insurer.

3 (b) Except as provided in subsection (d) and notwithstanding  
4 any other provision of law, a provider may submit a claim to the  
5 appropriate insurer not later than ninety (90) days after the date  
6 the recoupment is made.

7 (c) A provider that submits a claim under this section shall  
8 provide documentation to the insurer demonstrating:

9 (1) the original submission of the claim to the initial insurer or  
10 health maintenance organization; and

11 (2) the recoupment of payment by the initial insurer or health  
12 maintenance organization due to an error in coordination of  
13 benefits.

14 (d) Nothing in this section prevents an insurer from allowing a  
15 provider more time to submit a claim.

16 SECTION 12. IC 27-13-36.2-0.5 IS ADDED TO THE INDIANA  
17 CODE AS A NEW SECTION TO READ AS FOLLOWS  
18 [EFFECTIVE JULY 1, 2026]: **Sec. 0.5. Sections 4.7 and 9.5 of this**  
19 **chapter, as added in the 2026 session of the general assembly, and**  
20 **section 8 of this chapter, as amended in the 2026 session of the**  
21 **general assembly, apply to an individual contract and a group**  
22 **contract that:**

23 (1) is entered into, delivered, amended, or renewed after June  
24 30, 2026; and

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

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

32 SECTION 14. IC 27-13-36.2-4.7 IS ADDED TO THE INDIANA  
33 CODE AS A NEW SECTION TO READ AS FOLLOWS  
34 [EFFECTIVE JULY 1, 2026]: **Sec. 4.7. (a) A health maintenance**  
35 **organization may not retroactively reduce the reimbursement rate**  
36 **for any CPT code (as defined in IC 27-1-37.5-3).**

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

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

40 (2) posting on the health maintenance organization's website;  
41 before prospectively reducing the reimbursement rate for any CPT  
42 code (as defined in IC 27-1-37.5-3).



1 SECTION 15. 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~~ **one (1) year** after the date on which an  
 5 overpayment on a provider claim was made to the provider by the  
 6 health maintenance 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 **(b) A health maintenance organization may not recoup or**  
 11 **refund a paid claim more than one (1) year after the date on which**  
 12 **the claim was initially paid.**

13 **(c) A health maintenance organization may not retroactively**  
 14 **audit a paid claim more than three (3) years after the date on**  
 15 **which the claim was initially paid.**

16 ~~(b)~~ **(d) A health maintenance organization may not be required to**  
 17 **correct a payment error to a provider more than two (2) years after the**  
 18 **date on which a payment on a provider claim was made to the provider**  
 19 **by the health maintenance organization: if notice of the payment**  
 20 **error is not provided within one (1) year after payment for a fully**  
 21 **adjudicated claim is received.**

22 ~~(c)~~ **(e) This section does Subsections (a), (b), and (d) do not apply**  
 23 **in cases of fraud by the provider, the enrollee, or the health**  
 24 **maintenance organization with respect to the health benefits claim on**  
 25 **which the overpayment or underpayment was made when a final**  
 26 **determination of fraud has been made by a court.**

27 **(f) Notwithstanding subsections (a) through (d), a health**  
 28 **maintenance organization and a provider may enter into a value**  
 29 **based health care reimbursement agreement (as defined in**  
 30 **IC 27-1-37.6-15) that provides for different time frames than those**  
 31 **specified in this section.**

32 SECTION 16. IC 27-13-36.2-9.5 IS ADDED TO THE INDIANA  
 33 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 34 [EFFECTIVE JULY 1, 2026]: Sec. 9.5. (a) **If an insurer (as defined**  
 35 **in IC 27-8-5.7-3) or a health maintenance organization recoups**  
 36 **payment from a provider due to an error in coordination of**  
 37 **benefits, the provider may submit a claim for the same services to**  
 38 **the appropriate health maintenance organization.**

39 **(b) Except as provided in subsection (d) and notwithstanding**  
 40 **any other provision of law, a provider may submit a claim to the**  
 41 **appropriate health maintenance organization not later than ninety**  
 42 **(90) days after the date the recoupment is made.**



1           (c) A provider that submits a claim under this section shall  
2 provide documentation to the health maintenance organization  
3 demonstrating:  
4           (1) the original submission of the claim to the initial insurer or  
5 health maintenance organization; and  
6           (2) the recoupment of payment by the initial insurer or health  
7 maintenance organization due to an error in coordination of  
8 benefits.  
9           (d) Nothing in this section prevents a health maintenance  
10 organization from allowing a provider more time to submit a  
11 claim.



## 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.

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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

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COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred House Bill No. 1271, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 2, line 28, delete "litigation," and insert "**litigation for medical debt**,"

Page 2, delete lines 36 through 42.

Page 3, delete lines 1 through 3, begin a new paragraph and insert:

**"Sec. 3. (a) A hospital shall provide written notice of the hospital's payment assistance program to a patient or the patient's representative at one (1) of the following times:**

- (1) During registration or intake for inpatient or outpatient services.
- (2) At discharge.
- (3) With the initial billing statement for the provided services."

Page 3, delete line 24.

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Page 3, line 25, delete "(3)" and insert "(2)".

Page 3, delete lines 29 through 35, begin a new paragraph and insert:

**"Sec. 6. Before beginning a collection action, a hospital shall make a reasonable effort to notify the individual of available payment assistance programs and provide the individual with an application form."**

Page 4, between lines 7 and 8, begin a new paragraph and insert:

**"Sec. 0.5. As used in this chapter, "CARC" refers to the claim adjustment reason codes that provide the reason for a financial adjustment specified to a particular claim or service, as referenced in the transmitted Accredited Standards Committee (ASC) X12 835 standard transaction adopted by the Department of Health and Human Services under 45 CFR 162.1602."**

Page 4, delete lines 10 through 15, begin a new paragraph and insert:

**"Sec. 2. As used in this chapter, "downcode" or "downcoding" means the unilateral alteration by an insurer of the:**

- (1) payment for an evaluation and management service code or other service code; or**
- (2) level of evaluation and management service code or other service code submitted on a claim that results in a lower payment."**

Page 5, between lines 7 and 8, begin a new paragraph and insert:

**"Sec. 7.5. As used in this chapter, "RARC" refers to remittance advice remark codes that provide:**

- (1) supplemental information about a financial adjustment indicated by a CARC; or**
- (2) information about remittance processing."**

Page 5, between lines 14 and 15, begin a new paragraph and insert:

**"Sec. 9. (a) An insurer may not use an automated:**

- (1) process;**
- (2) system; or**
- (3) tool, including artificial intelligence;**

**as the sole basis to downcode a claim based on medical necessity without the review of the covered individual's medical record by an employee or contractor of the insurer.**

**(b) A provider may not use an automated:**

- (1) process;**
- (2) system; or**
- (3) tool, including artificial intelligence;**

**to submit a health benefits claim without the review of a provider**



or other person involved in the development of the claim for submission.

(c) An insurer must disclose in an easily accessible and readable manner when artificial intelligence is used to:

- (1) make an adverse determination on a prior authorization request; or
- (2) downcode a claim.

Sec. 10. An insurer may not downcode a claim based solely on the reported diagnosis code.

Sec. 11. If a claim is downcoded, the insurer shall:

- (1) notify the provider using the appropriate CARC and RARC to clearly indicate that the claim has been downcoded; and
- (2) provide:
  - (A) the specific reason for the downcoding, including reference to the clinical criteria used to justify the downcoding;
  - (B) the original and revised service codes and payment amounts; and
  - (C) a notice of the right to appeal as described in section 12 of this chapter.

Sec. 12. (a) An insurer shall provide providers with a clear and accessible process for appealing downcoded claims, including:

- (1) a written or electronic notice detailing how to initiate an appeal;
- (2) contact information for the individual managing the appeal; and
- (3) a timeline for submission of an appeal that is not less than one hundred eighty (180) days.

(b) An insurer shall allow a provider to appeal in batches of similar claims involving substantially similar downcoding issues without restriction.

Sec. 13. An insurer may not downcode in a targeted or discriminatory manner against providers that routinely treat patients with complex or chronic conditions."

Page 5, line 15, delete "9." and insert "14."

Page 5, line 19, delete "Sections 6.7, 9.5, and 9.7" and insert "Sections 6.7 and 11.5".

Delete page 6.

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 one (1) year** 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.

**(b) An insurer may not recoup or refund a paid claim more than one (1) year after the date on which the claim was initially paid.**

**(c) An insurer may not retroactively audit a paid claim more than three (3) years after the date on which the claim was initially paid.**

~~(b)~~ **(d) 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 (1) year after payment for a fully adjudicated claim is received.**

~~(c)~~ **(e) This section does Subsections (a), (b), and (d) do 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 when a final determination of fraud has been made by a court.**

**(f) Notwithstanding subsections (a) through (d), an insurer and a provider may enter into a value based health care reimbursement agreement (as defined in IC 27-1-37.6-15) that provides for different time frames than those specified in this section.**

SECTION 13. IC 27-8-5.7-11.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 11.5. (a) If an insurer or a health maintenance organization (as defined in IC 27-13-36.2-2) recoups payment from a provider due to an error in coordination of benefits, the provider may submit a claim for the same services to the appropriate insurer.**

**(b) Except as provided in subsection (d) and notwithstanding any other provision of law, a provider may submit a claim to the appropriate insurer not later than ninety (90) days after the date the recoupment is made.**

**(c) A provider that submits a claim under this section shall provide documentation to the insurer demonstrating:**

- (1) the original submission of the claim to the initial insurer or health maintenance organization; and**
- (2) the recoupment of payment by the initial insurer or health maintenance organization due to an error in coordination of**



**benefits.**

**(d) Nothing in this section prevents an insurer from allowing a provider more time to submit a claim."**

Page 7, line 20, delete "Sections 4.7, 7.5, and 7.7" and insert "**Sections 4.7 and 9.5**".

Page 8, delete lines 3 through 42, 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 one (1) year** 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.

**(b) A health maintenance organization may not recoup or refund a paid claim more than one (1) year after the date on which the claim was initially paid.**

**(c) A health maintenance organization may not retroactively audit a paid claim more than three (3) years after the date on which the claim was initially paid.**

~~(b)~~ **(d) 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 (1) year after payment for a fully adjudicated claim is received.**

~~(c)~~ **(e) This section does Subsections (a), (b), and (d) do 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 when a final determination of fraud has been made by a court.**

**(f) Notwithstanding subsections (a) through (d), a health maintenance organization and a provider may enter into a value based health care reimbursement agreement (as defined in IC 27-1-37.6-15) that provides for different time frames than those specified in this section.**

SECTION 19. IC 27-13-36.2-9.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 9.5. (a) If an insurer (as defined in IC 27-8-5.7-3) or a health maintenance organization recoups payment from a provider due to an error in coordination of**



benefits, the provider may submit a claim for the same services to the appropriate health maintenance organization.

(b) Except as provided in subsection (d) and notwithstanding any other provision of law, a provider may submit a claim to the appropriate health maintenance organization not later than ninety (90) days after the date the recoupment is made.

(c) A provider that submits a claim under this section shall provide documentation to the health maintenance organization demonstrating:

(1) the original submission of the claim to the initial insurer or health maintenance organization; and

(2) the recoupment of payment by the initial insurer or health maintenance organization due to an error in coordination of benefits.

(d) Nothing in this section prevents a health maintenance organization from allowing a provider more time to submit a claim."

Delete page 9.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to HB 1271 as reprinted January 30, 2026.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 12, Nays 0.

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REPORT OF THE PRESIDENT  
PRO TEMPORE

Mr. President: Pursuant to Senate Rule 68(b), I hereby report that, subsequent to the adoption of the Committee Report on February 12, 2026, House Bill 1271 was reassigned to the Committee on Appropriations.

BRAY

