February 20, 2026

ENGROSSED
HOUSE BILL No. 1271

DIGEST OF HB 1271 (Updated February 19, 2026 6:56 pm - DI 129)

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. Excludes the Medicaid program from provisions limiting downcoding of health claims. 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.

McGuire, Goss-Reaves, Carbaugh, Garcia Wilburn

(SENATE SPONSORS — BROWN L, CRIDER, JOHNSON T, RANDOLPH LONNIE M)

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).
February 19, 2026, amended, reported favorably — Do Pass. Reassigned to Committee on Rules and Legislative Procedure pursuant to Rule 68(b). Committee report: Rules Committee Report; adopted voice vote.

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 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. Provides that an insurer and a health maintenance organization may not be required to correct a payment error to a provider if notice of the payment error is not provided within 180 days.

February 20, 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

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

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

SECTION 1. IC 16-18-2-52.5, AS AMENDED BY P.L.188-2025, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 52.5. (a) "Charity care", for purposes of IC 16-21-6, IC 16-21-9, **IC 16-21-9.5,** and IC 16-40-6, means the unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services:

(1) to a person classified by the hospital as financially indigent or medically indigent on an inpatient or outpatient basis; and

(2) to financially indigent patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

(b) As used in this section, "financially indigent" means an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's financial criteria and procedure used to determine if a patient is eligible for charity care. The criteria and procedure must include income levels and means testing indexed to the federal poverty guidelines. A hospital may determine that a person is

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

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

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.**

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

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

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

Chapter 9.5. Notice of Payment Assistance Programs

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 for medical debt, by a hospital or any organization that has a financial relationship with the hospital.

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

(1) Charity care.

(2) Financial assistance.

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

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.

(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) 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 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 benefits 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 violation for failure to comply with this chapter. A penalty collected under this section shall be deposited into the state general fund.

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

Chapter 52. Downcoding of Health Benefits Claims

Sec. 0.3. This chapter does not apply to the Medicaid program or a managed care organization (as defined in IC 12-7-2-126.9) that provides services to a Medicaid recipient.

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.

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

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.

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

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

(1) human illness;

(2) physical disability; or

(3) injury.

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

(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1), but not including the coverages described in IC 27-8-5-2.5(a).

(2) An individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16) with a health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4).

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

(1) An insurer (as defined in IC 27-1-2-3(x)) that issues a policy of accident and sickness insurance (as defined in IC 27-8-5-1), but not including the coverages described in IC 27-8-5-2.5(a).

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

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. (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.

Sec. 14. 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 and 11.5 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 claims submitted under 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 27-8-5.7-10, 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 hundred eighty (180) days** 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 a paid claim more than one hundred eighty (180) days 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 hundred eighty (180) days 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 hospital licensed under IC 16-21 may enter into a separate written agreement that provides for different time frames than those specified in this section.

SECTION 11. 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.

SECTION 12. 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 and 9.5 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 claims submitted under 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 13. 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 14. 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;

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

SECTION 15. 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 hundred eighty (180) days** 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 a paid claim more than one hundred eighty (180) days 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 hundred eighty (180) days 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 hospital licensed under IC 16-21 may enter into a separate written agreement that provides for different time frames than those specified in this section.

SECTION 16. 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.

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:**

(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

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.

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.

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

CORRECTED
COMMITTEE REPORT

Mr. President: The Senate Committee on Appropriations, to which was referred Engrossed 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 3, line 31, delete "benefit" and insert "**benefits**".

Page 3, after line 42, begin a new paragraph and insert:

"**Sec. 0.3. This chapter does not apply to the Medicaid program or a managed care organization (as defined in IC 12-7-2-126.9) that provides services to a Medicaid recipient.**".

Page 6, line 32, after "to" insert "**claims submitted under**".

Page 7, delete lines 11 through 37, begin a new paragraph and insert:

"SECTION 10. 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 hundred eighty (180) days** 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 a paid claim more than one hundred eighty (180) days 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 hundred eighty (180) days 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 hospital licensed under IC 16-21 may enter into a separate

written agreement that provides for different time frames than those specified in this section.".

Page 8, line 21, after "to" insert "**claims submitted under**".

Page 9, delete lines 1 through 31, begin a new paragraph and insert:

"SECTION 15. 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 hundred eighty (180) days** 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 a paid claim more than one hundred eighty (180) days 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 hundred eighty (180) days 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 hospital licensed under IC 16-21 may enter into a separate written agreement that provides for different time frames than those specified in this section.".

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to EHB 1271 as printed February 13, 2026.)

MISHLER, Chairperson

Committee Vote: Yeas 11, Nays 1.

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 19, 2026, House Bill 1271 was reassigned to the Committee on Rules and Legislative Procedure to be corrected as follows:

The Senate Committee on Appropriations vote sheet be corrected to record the adoption of Amendments #7 and #9 by consent and the committee report be corrected to incorporate Amendments #7 and #9 as adopted and remove the incorrect reference on the vote sheet and incorporation in the committee report of Amendment #8 which was not adopted by the committee.

BRAY

COMMITTEE REPORT

Mr. President: The Senate Committee on Rules and Legislative Procedure, to which was referred House Bill 1271 to be corrected as directed in the Senate Rule 68(b) Report of the President Pro Tempore, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said correction be adopted.

BRAY, Chair