PROPOSED AMENDMENT
HB 1271 # 1

DIGEST

Payment of health claims. Adds a definition of "collection action" and amends the definition of "payment assistance program" for purposes of the chapter regarding notice of payment assistance programs. Removes language requiring signs concerning payment assistance programs to be printed in at least the five most used languages spoken in the county. Amends the definition of "insurer" for purposes of the chapter regarding downcoding of health benefits claims. Removes applicability sections for the provisions relating to insurers and health maintenance organizations recouping or refunding paid claims. Provides that an insurer and a health maintenance organization may not retroactively audit or seek recoupment or a refund of a paid claim more than 180 days after the date on which the claim was initially paid. (Under the introduced version of the bill, an insurer and a health maintenance organization may not retroactively audit or seek recoupment or a refund of a paid claim more than 180 days after the date on which the claim was initially paid or the same number of days that a provider is required to submit a claim to the health maintenance organization, whichever occurs first.) 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 after payment for a fully adjudicated claim is received.

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.

(Reference is to HB 1271 as introduced.)