PROPOSED AMENDMENT
HB 1271 # 5

DIGEST

Payment of claims. Requires a hospital to provide written notice of the hospital's payment assistance program during registration or intake for inpatient or outpatient services, at discharge, or with the initial billing statement. Removes language requiring a hospital to: (1) post signage at financial counseling offices; and (2) make a reasonable effort to determine whether the individual is eligible for a payment assistance program before beginning a collection action. Prohibits an insurer from engaging in certain downcoding practices and sets forth conditions for downcoding a claim. 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. Deletes SECTIONS 10, 11, 16, and 17 from the bill. Changes the time frame to one year for: (1) an insurer and a health maintenance organization to request repayment of an overpayment, adjust a subsequent claim, or recoup or refund a paid claim; and (2) a provider to provide notice of payment error to an insurer. Changes the time frame in which an insurer and a health maintenance organization may retroactively audit a paid claim to three years after the claim was paid. Allows an insurer or a health maintenance organization and a provider to enter into a value based health care reimbursement agreement that provides for different time frames. 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.

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.

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