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 4, delete lines 27 through 29, begin a new line block indented and insert:

"**(1) A policy of accident and sickness insurance (as defined in IC 27-8-5-1).**".

Page 4, delete lines 36 through 39, begin a new line block indented and insert:

"**(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).**".

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.

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

and when so amended that said bill do pass.

Committee Vote: Yeas 11, Nays 1.

Mishler **Chairperson**