HOUSE BILL No. 1271

AM127101 has been incorporated into introduced printing.

Synopsis: Payment of health claims.

Introduced

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.

Merged

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, 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) Assistance programs offered as part of a nonprofit hospital's community benefits plan.

(4) 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 the following times:

(1) During registration or intake for inpatient or outpatient services.

(2) At discharge, either in a written format or electronically through a patient portal system.

(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) Financial counseling offices.

(3) 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 do the following:

(1) Determine whether the individual is eligible for a payment assistance program.

(2) 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 benefit 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 27-1-48.5-10, AS ADDED BY P.L.237-2025, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 10. **(a)** The department shall adopt rules under IC 4-22-2 to effectuate the provisions of this chapter.

(b) The department shall initiate rulemaking to effectuate the provisions of this chapter not later than July 1, 2026.

SECTION 7. 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. 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, "downcoding" means the adjustment of a health benefits claim by an insurer to a less complex or lower price service for reimbursement to a provider in an amount less than the amount noted in the fully executed provider contract. The term includes the use of remittance advice remark codes.

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

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 27-8-5.7-9.5 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 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 provider unless the recoupment or refund is for an overpayment that was caused by:

(1) fraud;

(2) an error in the coordination of benefits; or

(3) duplicate payments.

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) 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 insurer determines that the claim was submitted fraudulently; or

(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.

(b) The limitation on seeking recoupment or refund of a payment made to a health provider facility under subsection (a) 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.

(c) Any recoupment or refund attempted in violation of this section is void and unenforceable.

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.

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 27-13-36.2-7.5 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 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 10 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; or

(3) duplicate payments.

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) Subject to section 10 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 health maintenance organization determines that the claim was submitted fraudulently; or

(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.

(b) The limitation on seeking recoupment or refund of a payment made to a health provider facility under subsection (a) 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.

(c) Any recoupment or refund attempted in violation of this section is void and unenforceable.

SECTION 17. 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.

SECTION 18. **An emergency is declared for this act.**