
HOUSE BILL No. 1271

AM127103 has been incorporated into January 30, 2026 printing.

Synopsis: Payment of health claims.

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Reprinted
January 30, 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.

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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:

1 SECTION 1. IC 16-18-2-52.5, AS AMENDED BY P.L.188-2025,
2 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
3 JULY 1, 2026]: Sec. 52.5. (a) "Charity care", for purposes of
4 IC 16-21-6, IC 16-21-9, **IC 16-21-9.5**, and IC 16-40-6, means the
5 unreimbursed cost to a hospital of providing, funding, or otherwise
6 financially supporting health care services:
7 (1) to a person classified by the hospital as financially indigent
8 or medically indigent on an inpatient or outpatient basis; and
9 (2) to financially indigent patients through other nonprofit or
10 public outpatient clinics, hospitals, or health care organizations.
11 (b) As used in this section, "financially indigent" means an
12 uninsured or underinsured person who is accepted for care with no
13 obligation or a discounted obligation to pay for the services rendered
14 based on the hospital's financial criteria and procedure used to
15 determine if a patient is eligible for charity care. The criteria and
16 procedure must include income levels and means testing indexed to the
17 federal poverty guidelines. A hospital may determine that a person is

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

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

8 SECTION 2. IC 16-18-2-58.5 IS ADDED TO THE INDIANA
9 CODE AS A **NEW SECTION TO READ AS FOLLOWS**
10 **[EFFECTIVE JULY 1, 2026]: Sec. 58.5. "Collection action", for**
11 **purposes of IC 16-21-9.5, has the meaning set forth in**
12 **IC 16-21-9.5-1.**

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

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

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

25 **Chapter 9.5. Notice of Payment Assistance Programs**

26 **Sec. 1. As used in this chapter, "collection action" means the**
27 **sale or assignment of a bill to a collection agency, or the pursuit of**
28 **litigation, by a hospital or any organization that has a financial**
29 **relationship with the hospital.**

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

- 32 (1) **Charity care.**
- 33 (2) **Financial assistance.**
- 34 (3) **Any other payment plans made available to a patient by**
35 **a hospital.**

36 **Sec. 3. (a) A hospital shall provide written notice of the**
37 **hospital's payment assistance program to a patient or the patient's**
38 **representative at the following times:**

- 39 (1) **During registration or intake for inpatient or outpatient**
40 **services, unless the patient is incapable of reasonably**
41 **receiving the notice at that time.**
- 42 (2) **If the patient is incapable of reasonably receiving the**

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- 1 notice during registration or intake under subdivision (1), at
2 discharge.
- 3 (3) With the initial billing statement for the provided
4 services.
- 5 (b) The written notice required under subsection (a) must
6 include the following:
- 7 (1) A description of available payment assistance programs.
8 (2) Eligibility criteria.
9 (3) Application instructions.
10 (4) Contact information for a hospital representative when
11 assistance is needed to complete the application.
- 12 (c) A hospital may provide notice to a patient or the patient's
13 representative under subsection (a):
- 14 (1) in a writing delivered to the patient or the patient's
15 representative;
16 (2) by electronic mail; or
17 (3) through a mobile application or another Internet based
18 method, if available;
- 19 according to the preference for communication expressed by the
20 patient or patient's representative.
- 21 Sec. 4. A hospital shall post conspicuous signage notifying
22 patients of the availability of payment assistance programs in the
23 following locations:
- 24 (1) Registration areas.
25 (2) Financial counseling offices.
26 (3) Emergency departments.
- 27 Sec. 5. A hospital shall make payment assistance program
28 information available electronically through any patient portal
29 maintained by the hospital.
- 30 Sec. 6. Before beginning a collection action, a hospital shall do
31 the following:
- 32 (1) Make a reasonable effort to determine whether the
33 individual is eligible for a payment assistance program.
34 (2) Make a reasonable effort to notify the individual of
35 available payment assistance programs and provide the
36 individual with an application form.
- 37 Sec. 7. A nonprofit hospital shall annually report compliance
38 with this chapter as part of the nonprofit hospital's community
39 benefit plan report under IC 16-21-9-7.
- 40 Sec. 8. The state department may adopt rules under IC 4-22-2
41 to administer and enforce this chapter.
- 42 Sec. 9. The state department may assess a hospital a civil

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1 penalty of not more than one thousand dollars (\$1,000) per
 2 violation for failure to comply with this chapter. A penalty
 3 collected under this section shall be deposited into the state general
 4 fund.

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

8 **Chapter 52. Downcoding of Health Benefits Claims**

9 **Sec. 0.5.** This chapter does not apply to the Medicaid program
 10 or a managed care organization (as defined in IC 12-7-2-126.9) that
 11 provides services to a Medicaid recipient.

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

14 **Sec. 2.** As used in this chapter, "downcoding" means the
 15 adjustment of a health benefits claim by an insurer to a less
 16 complex or lower price service for reimbursement to a provider in
 17 an amount less than the amount noted in the fully executed
 18 provider contract. The term includes the use of remittance advice
 19 remark codes.

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

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

- 26 (1) human illness;
- 27 (2) physical disability; or
- 28 (3) injury.

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

- 31 (1) A policy of accident and sickness insurance (as defined in
 32 IC 27-8-5-1), but not including the coverages described in
 33 IC 27-8-5-2.5(a).
- 34 (2) An individual contract (as defined in IC 27-13-1-21) or a
 35 group contract (as defined in IC 27-13-1-16) with a health
 36 maintenance organization (as defined in IC 27-13-1-19) that
 37 provides coverage for basic health care services (as defined
 38 in IC 27-13-1-4).

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

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

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1 **IC 27-8-5-2.5(a).**
 2 **(2) A health maintenance organization (as defined in**
 3 **IC 27-13-1-19) that provides coverage for basic health care**
 4 **services (as defined in IC 27-13-1-4) under an individual**
 5 **contract (as defined in IC 27-13-1-21) or a group contract (as**
 6 **defined in IC 27-13-1-16).**

7 **(3) A third party contractor of an entity described in**
 8 **subdivision (1) or (2).**

9 **Sec. 7. As used in this chapter, "provider" means an individual**
 10 **or entity licensed or legally authorized to provide health care**
 11 **services.**

12 **Sec. 8. Notwithstanding any other law or regulation to the**
 13 **contrary, an insurer may not use downcoding in a manner that**
 14 **prevents a provider from:**

- 15 **(1) submitting a health benefits claim for the actual health**
 16 **care service performed; and**
- 17 **(2) collecting reimbursement from the insurer for the actual**
 18 **health care service performed.**

19 **Sec. 9. The department shall adopt rules under IC 4-22-2 to**
 20 **carry out this chapter.**

21 **SECTION 7. IC 27-8-5.7-0.5 IS ADDED TO THE INDIANA**
 22 **CODE AS A NEW SECTION TO READ AS FOLLOWS**
 23 **[EFFECTIVE JULY 1, 2026]: Sec. 0.5. Sections 6.7, 9.5, and 9.7 of**
 24 **this chapter, as added in the 2026 session of the general assembly,**
 25 **and section 10 of this chapter, as amended in the 2026 session of**
 26 **the general assembly, apply to an accident and sickness insurance**
 27 **policy that:**

- 28 **(1) is issued, delivered, amended, or renewed after June 30,**
 29 **2026; and**
- 30 **(2) provides coverage during a plan year beginning after**
 31 **December 31, 2026.**

32 **SECTION 8. IC 27-8-5.7-2.7 IS ADDED TO THE INDIANA**
 33 **CODE AS A NEW SECTION TO READ AS FOLLOWS**
 34 **[EFFECTIVE JULY 1, 2026]: Sec. 2.7. As used in this chapter,**
 35 **"health provider facility" has the meaning set forth in**
 36 **IC 27-1-37-3.2.**

37 **SECTION 9. IC 27-8-5.7-6.7 IS ADDED TO THE INDIANA**
 38 **CODE AS A NEW SECTION TO READ AS FOLLOWS**
 39 **[EFFECTIVE JULY 1, 2026]: Sec. 6.7. (a) An insurer may not**
 40 **retroactively reduce the reimbursement rate for any CPT code.**

41 **(b) An insurer shall provide at least sixty (60) days written**
 42 **notice by:**

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1 (1) mail or electronic mail to a provider; and
 2 (2) posting on the insurer's website;
 3 before prospectively implementing a rate reduction for any CPT
 4 code.

5 SECTION 10. IC 27-8-5.7-9.5 IS ADDED TO THE INDIANA
 6 CODE AS A NEW SECTION TO READ AS FOLLOWS
 7 [EFFECTIVE JULY 1, 2026]: Sec. 9.5. (a) This section does not
 8 apply to the recoupment or refund of a payment that is subject to
 9 section 9.7 of this chapter.

10 (b) Subject to section 10 of this chapter, an insurer may not
 11 seek recoupment or a refund of a payment made to a provider
 12 unless the recoupment or refund is for an overpayment that was
 13 caused by:

- 14 (1) fraud;
 15 (2) an error in the coordination of benefits;
 16 (3) duplicate payments; or
 17 (4) a bill submitted in violation of IC 16-51-1-11.

18 SECTION 11. IC 27-8-5.7-9.7 IS ADDED TO THE INDIANA
 19 CODE AS A NEW SECTION TO READ AS FOLLOWS
 20 [EFFECTIVE JULY 1, 2026]: Sec. 9.7. (a) This section only applies
 21 to the recoupment or refund of a payment made by an insurer to
 22 a health provider facility when an individual was transferred from
 23 one (1) health provider facility to another health provider facility.

24 (b) Subject to section 10 of this chapter, an insurer may not
 25 seek recoupment or a refund of a payment made to a health
 26 provider facility that provided initial health care services to an
 27 individual who was subsequently transferred to another health
 28 provider facility unless:

- 29 (1) the claim was submitted fraudulently;
 30 (2) the:
 31 (A) individual was not entitled to coverage; or
 32 (B) health care services provided to the individual were
 33 not covered;
 34 at the time the health care services were rendered; or
 35 (3) the bill was submitted in violation of IC 16-51-1-11.

36 (c) The limitation on seeking recoupment or refund of a
 37 payment made to a health provider facility under subsection (b)
 38 applies regardless of:

- 39 (1) the reason for the transfer;
 40 (2) the type of facility receiving the individual; or
 41 (3) the acuity, age, or diagnosis of the individual.
 42 (d) Any recoupment or refund attempted in violation of this

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1 **section is void and unenforceable.**

2 SECTION 12. IC 27-8-5.7-10, AS ADDED BY P.L.55-2006,
3 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
4 JULY 1, 2026]: Sec. 10. (a) ~~An insurer may not, more than two (2)~~
5 ~~years after the date on which an overpayment on a provider claim was~~
6 ~~made to the provider by the insurer:~~

7 (1) request that the provider repay the overpayment; or
8 (2) adjust a subsequent claim filed by the provider as a method
9 of obtaining reimbursement of the overpayment from the
10 provider.

11 **(a) An insurer may not retroactively audit a paid claim or seek**
12 **recoupment or a refund of a paid claim more than one hundred**
13 **eighty (180) days after the date on which the claim was initially**
14 **paid.**

15 (b) An insurer may not be required to correct a payment error to
16 a provider ~~more than two (2) years after the date on which a payment~~
17 ~~on a provider claim was made to the provider by the insurer. if notice~~
18 ~~of the payment error is not provided within one hundred eighty~~
19 ~~(180) days after payment for a fully adjudicated claim is received.~~

20 (c) This section does not apply in cases of fraud by the provider,
21 the insured, or the insurer with respect to the **health benefits** claim on
22 which the overpayment or underpayment was made.

23 SECTION 13. IC 27-13-36.2-0.5 IS ADDED TO THE INDIANA
24 CODE AS A NEW SECTION TO READ AS FOLLOWS
25 [EFFECTIVE JULY 1, 2026]: **Sec. 0.5. Sections 4.7, 7.5, and 7.7 of**
26 **this chapter, as added in the 2026 session of the general assembly,**
27 **and section 8 of this chapter, as amended in the 2026 session of the**
28 **general assembly, apply to an individual contract and a group**
29 **contract that:**

30 (1) **is entered into, delivered, amended, or renewed after**
31 **June 30, 2026; and**

32 (2) **provides coverage during a plan year beginning after**
33 **December 31, 2026.**

34 SECTION 14. IC 27-13-36.2-2.3 IS ADDED TO THE INDIANA
35 CODE AS A NEW SECTION TO READ AS FOLLOWS
36 [EFFECTIVE JULY 1, 2026]: **Sec. 2.3. As used in this chapter,**
37 **"health provider facility" has the meaning set forth in**
38 **IC 27-1-37-3.2.**

39 SECTION 15. IC 27-13-36.2-4.7 IS ADDED TO THE INDIANA
40 CODE AS A NEW SECTION TO READ AS FOLLOWS
41 [EFFECTIVE JULY 1, 2026]: **Sec. 4.7. (a) A health maintenance**
42 **organization may not retroactively reduce the reimbursement rate**

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1 for any CPT code (as defined in IC 27-1-37.5-3).

2 (b) A health maintenance organization shall provide at least
3 sixty (60) days notice by:

4 (1) mail or electronic mail to a provider; and

5 (2) posting on the health maintenance organization's website;
6 before prospectively reducing the reimbursement rate for any CPT
7 code (as defined in IC 27-1-37.5-3).

8 SECTION 16. IC 27-13-36.2-7.5 IS ADDED TO THE INDIANA
9 CODE AS A NEW SECTION TO READ AS FOLLOWS
10 [EFFECTIVE JULY 1, 2026]: Sec. 7.5. (a) This section does not
11 apply to the recoupment or refund of a payment that is subject to
12 section 7.7 of this chapter.

13 (b) Subject to section 8 of this chapter, a health maintenance
14 organization may not seek recoupment or a refund of a payment
15 made to a provider unless the recoupment or refund is for an
16 overpayment that was caused by:

17 (1) fraud;

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

19 (3) duplicate payments; or

20 (4) a bill submitted in violation of IC 16-51-1-11.

21 SECTION 17. IC 27-13-36.2-7.7 IS ADDED TO THE INDIANA
22 CODE AS A NEW SECTION TO READ AS FOLLOWS
23 [EFFECTIVE JULY 1, 2026]: Sec. 7.7. (a) This section only applies
24 to the recoupment or refund of a payment made by a health
25 maintenance organization to a health provider facility when an
26 individual was transferred from one (1) health provider facility to
27 another health provider facility.

28 (b) Subject to section 8 of this chapter, a health maintenance
29 organization may not seek recoupment or a refund of a payment
30 made to a health provider facility that provided initial health care
31 services to an individual who was subsequently transferred to
32 another health provider facility unless:

33 (1) the claim was submitted fraudulently;

34 (2) the:

35 (A) individual was not entitled to coverage; or

36 (B) health care services provided to the individual were
37 not covered;

38 at the time the health care services were rendered; or

39 (3) the bill was submitted in violation of IC 16-51-1-11.

40 (c) The limitation on seeking recoupment or refund of a
41 payment made to a health provider facility under subsection (b)
42 applies regardless of:

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- 1 **(1) the reason for the transfer;**
- 2 **(2) the type of facility receiving the individual; or**
- 3 **(3) the acuity, age, or diagnosis of the individual.**
- 4 **(d) Any recoupment or refund attempted in violation of this**
- 5 **section is void and unenforceable.**

6 SECTION 18. IC 27-13-36.2-8, AS ADDED BY P.L.55-2006,
 7 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 8 JULY 1, 2026]: Sec. 8. (a) A health maintenance organization may not,
 9 more than two (2) years after the date on which an overpayment on a
 10 provider claim was made to the provider by the health maintenance
 11 organization:

- 12 (1) request that the provider repay the overpayment; or
- 13 (2) adjust a subsequent claim filed by the provider as a method
 14 of obtaining reimbursement of the overpayment from the
 15 provider:

16 **(a) A health maintenance organization may not retroactively**
 17 **audit a paid claim or seek recoupment or a refund of a paid claim**
 18 **more than one hundred eighty (180) days after the date on which**
 19 **the claim was initially paid.**

20 (b) A health maintenance organization may not be required to
 21 correct a payment error to a provider more than two (2) years after the
 22 date on which a payment on a provider claim was made to the provider
 23 by the health maintenance organization. **if notice of the payment**
 24 **error is not provided within one hundred eighty (180) days after**
 25 **payment for a fully adjudicated claim is received.**

26 (c) This section does not apply in cases of fraud by the provider,
 27 the enrollee, or the health maintenance organization with respect to the
 28 **health benefits** claim on which the overpayment or underpayment was
 29 made.

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