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HOUSE BILL No. 1271

Proposed Changes to January 30, 2026 printing by AM127103

DIGEST OF PROPOSED AMENDMENT

Medicaid exemption. Excludes the Medicaid program from the definition of "insurer" and "health maintenance organization".

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
- 18 financially or medically indigent under the hospital's eligibility system
- 19 after health care services are provided.
- 20 (c) As used in this section, "medically indigent" means a person

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HB 1271—LS 7085/DI 141



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1 whose medical or hospital bills after payment by third party payors
 2 exceed a specified percentage of the patient's annual gross income as
 3 determined in accordance with the hospital's eligibility system, and
 4 who is financially unable to pay the remaining bill.

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

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

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

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

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

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

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

- 29 (1) Charity care.
 30 (2) Financial assistance.
 31 (3) Any other payment plans made available to a patient by
 32 a hospital.

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

- 36 (1) During registration or intake for inpatient or outpatient
 37 services, unless the patient is incapable of reasonably
 38 receiving the notice at that time.
 39 (2) If the patient is incapable of reasonably receiving the
 40 notice during registration or intake under subdivision (1), at
 41 discharge.
 42 (3) With the initial billing statement for the provided

HB 1271—LS 7085/DI 141



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1 services.

2 (b) The written notice required under subsection (a) must

3 include the following:

4 (1) A description of available payment assistance programs.

5 (2) Eligibility criteria.

6 (3) Application instructions.

7 (4) Contact information for a hospital representative when

8 assistance is needed to complete the application.

9 (c) A hospital may provide notice to a patient or the patient's

10 representative under subsection (a):

11 (1) in a writing delivered to the patient or the patient's

12 representative;

13 (2) by electronic mail; or

14 (3) through a mobile application or another Internet based

15 method, if available;

16 according to the preference for communication expressed by the

17 patient or patient's representative.

18 Sec. 4. A hospital shall post conspicuous signage notifying

19 patients of the availability of payment assistance programs in the

20 following locations:

21 (1) Registration areas.

22 (2) Financial counseling offices.

23 (3) Emergency departments.

24 Sec. 5. A hospital shall make payment assistance program

25 information available electronically through any patient portal

26 maintained by the hospital.

27 Sec. 6. Before beginning a collection action, a hospital shall do

28 the following:

29 (1) Make a reasonable effort to determine whether the

30 individual is eligible for a payment assistance program.

31 (2) Make a reasonable effort to notify the individual of

32 available payment assistance programs and provide the

33 individual with an application form.

34 Sec. 7. A nonprofit hospital shall annually report compliance

35 with this chapter as part of the nonprofit hospital's community

36 benefit plan report under IC 16-21-9-7.

37 Sec. 8. The state department may adopt rules under IC 4-22-2

38 to administer and enforce this chapter.

39 Sec. 9. The state department may assess a hospital a civil

40 penalty of not more than one thousand dollars (\$1,000) per

41 violation for failure to comply with this chapter. A penalty

42 collected under this section shall be deposited into the state general

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1 **fund.**

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

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

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

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

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

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

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

- 23 (1) human illness;
24 (2) physical disability; or
25 (3) injury.

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

28 (1) A policy of accident and sickness insurance (as defined in
29 IC 27-8-5-1), but not including the coverages described in
30 IC 27-8-5-2.5(a).

31 (2) An individual contract (as defined in IC 27-13-1-21) or a
32 group contract (as defined in IC 27-13-1-16) with a health
33 maintenance organization (as defined in IC 27-13-1-19) that
34 provides coverage for basic health care services (as defined
35 in IC 27-13-1-4).

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

37 (1) An insurer (as defined in IC 27-1-2-3(x)) that issues a
38 policy of accident and sickness insurance (as defined in
39 IC 27-8-5-1), but not including the coverages described in
40 IC 27-8-5-2.5(a).

41 (2) A health maintenance organization (as defined in
42 IC 27-13-1-19) that provides coverage for basic health care

HB 1271—LS 7085/DI 141



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1 services (as defined in IC 27-13-1-4) under an individual
2 contract (as defined in IC 27-13-1-21) or a group contract (as
3 defined in IC 27-13-1-16).

4 (3) A third party contractor of an entity described in
5 subdivision (1) or (2).

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

9 Sec. 8. Notwithstanding any other law or regulation to the
10 contrary, an insurer may not use downcoding in a manner that
11 prevents a provider from:

12 (1) submitting a health benefits claim for the actual health
13 care service performed; and

14 (2) collecting reimbursement from the insurer for the actual
15 health care service performed.

16 Sec. 9. The department shall adopt rules under IC 4-22-2 to
17 carry out this chapter.

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

25 (1) is issued, delivered, amended, or renewed after June 30,
26 2026; and

27 (2) provides coverage during a plan year beginning after
28 December 31, 2026.

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

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

38 (b) An insurer shall provide at least sixty (60) days written
39 notice by:

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

41 (2) posting on the insurer's website;

42 before prospectively implementing a rate reduction for any CPT

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1 **code.**

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

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

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

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

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

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

33 **(c) The limitation on seeking recoupment or refund of a**
34 **payment made to a health provider facility under subsection (b)**
35 **applies regardless of:**

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

41 SECTION 12. IC 27-8-5.7-10, AS ADDED BY P.L.55-2006,
42 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

HB 1271—LS 7085/DI 141



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1 JULY 1, 2026]: Sec. 10. (a) An insurer may not, more than two (2)
 2 years after the date on which an overpayment on a provider claim was
 3 made to the provider by the insurer:

4 (1) request that the provider repay the overpayment; or

5 (2) adjust a subsequent claim filed by the provider as a method
 6 of obtaining reimbursement of the overpayment from the
 7 provider.

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

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

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

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

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

29 (2) provides coverage during a plan year beginning after
 30 December 31, 2026.

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

36 SECTION 15. IC 27-13-36.2-4.7 IS ADDED TO THE INDIANA
 37 CODE AS A NEW SECTION TO READ AS FOLLOWS
 38 [EFFECTIVE JULY 1, 2026]: **Sec. 4.7. (a) A health maintenance**
 39 **organization may not retroactively reduce the reimbursement rate**
 40 **for any CPT code (as defined in IC 27-1-37.5-3).**

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

HB 1271—LS 7085/DI 141



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1 (1) mail or electronic mail to a provider; and
 2 (2) posting on the health maintenance organization's website;
 3 before prospectively reducing the reimbursement rate for any CPT
 4 code (as defined in IC 27-1-37.5-3).

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

10 (b) Subject to section 8 of this chapter, a health maintenance
 11 organization may not seek recoupment or a refund of a payment
 12 made to a provider unless the recoupment or refund is for an
 13 overpayment that was 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 17. IC 27-13-36.2-7.7 IS ADDED TO THE INDIANA
 19 CODE AS A NEW SECTION TO READ AS FOLLOWS
 20 [EFFECTIVE JULY 1, 2026]: Sec. 7.7. (a) This section only applies
 21 to the recoupment or refund of a payment made by a health
 22 maintenance organization to a health provider facility when an
 23 individual was transferred from one (1) health provider facility to
 24 another health provider facility.

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

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

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

- 40 (1) the reason for the transfer;
 41 (2) the type of facility receiving the individual; or
 42 (3) the acuity, age, or diagnosis of the individual.

HB 1271—LS 7085/DI 141



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1 **(d) Any recoupment or refund attempted in violation of this**
 2 **section is void and unenforceable.**
 3 SECTION 18. IC 27-13-36.2-8, AS ADDED BY P.L.55-2006,
 4 SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 5 JULY 1, 2026]: Sec. 8. (a) ~~A health maintenance organization may not,~~
 6 ~~more than two (2) years after the date on which an overpayment on a~~
 7 ~~provider claim was made to the provider by the health maintenance~~
 8 ~~organization:~~
 9 ~~(1) request that the provider repay the overpayment; or~~
 10 ~~(2) adjust a subsequent claim filed by the provider as a method~~
 11 ~~of obtaining reimbursement of the overpayment from the~~
 12 ~~provider.~~
 13 **(a) A health maintenance organization may not retroactively**
 14 **audit a paid claim or seek recoupment or a refund of a paid claim**
 15 **more than one hundred eighty (180) days after the date on which**
 16 **the claim was initially paid.**
 17 (b) A health maintenance organization may not be required to
 18 correct a payment error to a provider ~~more than two (2) years after the~~
 19 ~~date on which a payment on a provider claim was made to the provider~~
 20 ~~by the health maintenance organization. if notice of the payment~~
 21 ~~error is not provided within one hundred eighty (180) days after~~
 22 ~~payment for a fully adjudicated claim is received.~~
 23 (c) This section does not apply in cases of fraud by the provider,
 24 the enrollee, or the health maintenance organization with respect to the
 25 **health benefits** claim on which the overpayment or underpayment was
 26 made.
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HB 1271—LS 7085/DI 141



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