ENGROSSED
HOUSE BILL No. 1271

AM127107 has been incorporated into February 13, 2026 printing.

Synopsis: Payment of health claims.

Merged

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February 13, 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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ENGROSSED
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

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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 for medical debt, 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) 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 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

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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) 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 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 27-1-52 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]:

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Chapter 52. Downcoding of Health Benefits Claims

Sec. 0.3. This chapter does not apply to the Medicaid program or a managed care organization (as defined in IC 12-7-2-126.9) that provides services to a Medicaid recipient.

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.

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, "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.

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

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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. 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.

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. (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.

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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.

Sec. 14. The department shall adopt rules under IC 4-22-2 to carry out this chapter.

SECTION 7. IC 27-8-5.7-0.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 0.5. Sections 6.7 and 11.5 of this chapter, as added in the 2026 session of the general assembly, and section 10 of this chapter, as amended in the 2026 session of the general assembly, apply to an accident and sickness insurance policy that:**

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

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

SECTION 8. IC 27-8-5.7-2.7 IS ADDED TO THE INDIANA

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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 27-8-5.7-10, 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

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different time frames than those specified in this section.

SECTION 11. 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.

SECTION 12. IC 27-13-36.2-0.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 0.5. Sections 4.7 and 9.5 of this chapter, as added in the 2026 session of the general assembly, and section 8 of this chapter, as amended in the 2026 session of the general assembly, apply to an individual contract and a group contract that:**

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

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

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).**

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(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 27-13-36.2-8, 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 16. 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**

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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.

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