
**ENGROSSED
HOUSE BILL No. 1271**

AM127108 has been incorporated into February 13, 2026 printing.

Synopsis: Payment of health claims.

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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:

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 for medical debt, by a hospital or any organization that**
29 **has a financial 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 one (1) of the following times:**

- 39 (1) **During registration or intake for inpatient or outpatient**
40 **services.**
41 (2) **At discharge.**
42 (3) **With the initial billing statement for the provided**

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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) Emergency departments.

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

24 information available electronically through any patient portal

25 maintained by the hospital.

26 Sec. 6. Before beginning a collection action, a hospital shall

27 make a reasonable effort to notify the individual of available

28 payment assistance programs and provide the individual with an

29 application form.

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

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

32 benefits plan report under IC 16-21-9-7.

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

34 to administer and enforce this chapter.

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

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

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

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

39 fund.

40 SECTION 6. IC 27-1-52 IS ADDED TO THE INDIANA CODE

41 AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE

42 JULY 1, 2026]:

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

2 **Sec. 0.5.** As used in this chapter, "CARC" refers to the claim
3 **adjustment reason codes that provide the reason for a financial**
4 **adjustment specified to a particular claim or service, as referenced**
5 **in the transmitted Accredited Standards Committee (ASC) X12**
6 **835 standard transaction adopted by the Department of Health and**
7 **Human Services under 45 CFR 162.1602.**

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

10 **Sec. 2.** As used in this chapter, "downcode" or "downcoding"
11 **means the unilateral alteration by an insurer of the:**

12 (1) **payment for an evaluation and management service code**
13 **or other service code; or**

14 (2) **level of evaluation and management service code or other**
15 **service code submitted on a claim that results in a lower**
16 **payment.**

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).**

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

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

36 (1) **An insurer (as defined in IC 27-1-2-3(x)) that issues a**
37 **policy of accident and sickness insurance (as defined in**
38 **IC 27-8-5-1).**

39 (2) **A health maintenance organization (as defined in**
40 **IC 27-13-1-19) that provides coverage for basic health care**
41 **services (as defined in IC 27-13-1-4) under an individual**
42 **contract (as defined in IC 27-13-1-21) or a group contract (as**

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1 **defined in IC 27-13-1-16).**
2 **(3) A third party contractor of an entity described in**
3 **subdivision (1) or (2).**
4 **Sec. 7. As used in this chapter, "provider" means an individual**
5 **or entity licensed or legally authorized to provide health care**
6 **services.**
7 **Sec. 7.5. As used in this chapter, "RARC" refers to remittance**
8 **advice remark codes that provide:**
9 **(1) supplemental information about a financial adjustment**
10 **indicated by a CARC; or**
11 **(2) information about remittance processing.**
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. (a) An insurer may not use an automated:**
20 **(1) process;**
21 **(2) system; or**
22 **(3) tool, including artificial intelligence;**
23 **as the sole basis to downcode a claim based on medical necessity**
24 **without the review of the covered individual's medical record by an**
25 **employee or contractor of the insurer.**
26 **(b) A provider may not use an automated:**
27 **(1) process;**
28 **(2) system; or**
29 **(3) tool, including artificial intelligence;**
30 **to submit a health benefits claim without the review of a provider**
31 **or other person involved in the development of the claim for**
32 **submission.**
33 **(c) An insurer must disclose in an easily accessible and**
34 **readable manner when artificial intelligence is used to:**
35 **(1) make an adverse determination on a prior authorization**
36 **request; or**
37 **(2) downcode a claim.**
38 **Sec. 10. An insurer may not downcode a claim based solely on**
39 **the reported diagnosis code.**
40 **Sec. 11. If a claim is downcoded, the insurer shall:**
41 **(1) notify the provider using the appropriate CARC and**
42 **RARC to clearly indicate that the claim has been**

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- 1 downcoded; and
 2 (2) provide:
 3 (A) the specific reason for the downcoding, including
 4 reference to the clinical criteria used to justify the
 5 downcoding;
 6 (B) the original and revised service codes and payment
 7 amounts; and
 8 (C) a notice of the right to appeal as described in section
 9 12 of this chapter.
- 10 **Sec. 12. (a) An insurer shall provide providers with a clear and**
 11 **accessible process for appealing downcoded claims, including:**
 12 (1) a written or electronic notice detailing how to initiate an
 13 appeal;
 14 (2) contact information for the individual managing the
 15 appeal; and
 16 (3) a timeline for submission of an appeal that is not less than
 17 one hundred eighty (180) days.
- 18 **(b) An insurer shall allow a provider to appeal in batches of**
 19 **similar claims involving substantially similar downcoding issues**
 20 **without restriction.**
- 21 **Sec. 13. An insurer may not downcode in a targeted or**
 22 **discriminatory manner against providers that routinely treat**
 23 **patients with complex or chronic conditions.**
- 24 **Sec. 14. The department shall adopt rules under IC 4-22-2 to**
 25 **carry out this chapter.**
- 26 SECTION 7. IC 27-8-5.7-0.5 IS ADDED TO THE INDIANA
 27 CODE AS A NEW SECTION TO READ AS FOLLOWS
 28 [EFFECTIVE JULY 1, 2026]: **Sec. 0.5. Sections 6.7 and 11.5 of this**
 29 **chapter, as added in the 2026 session of the general assembly, and**
 30 **section 10 of this chapter, as amended in the 2026 session of the**
 31 **general assembly, apply to claims submitted under an accident and**
 32 **sickness insurance policy that:**
 33 (1) is issued, delivered, amended, or renewed after June 30,
 34 2026; and
 35 (2) provides coverage during a plan year beginning after
 36 December 31, 2026.
- 37 SECTION 8. IC 27-8-5.7-2.7 IS ADDED TO THE INDIANA
 38 CODE AS A NEW SECTION TO READ AS FOLLOWS
 39 [EFFECTIVE JULY 1, 2026]: **Sec. 2.7. As used in this chapter,**
 40 **"health provider facility" has the meaning set forth in**
 41 **IC 27-1-37-3.2.**
- 42 SECTION 9. IC 27-8-5.7-6.7 IS ADDED TO THE INDIANA

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1 CODE AS A NEW SECTION TO READ AS FOLLOWS
 2 [EFFECTIVE JULY 1, 2026]: **Sec. 6.7. (a) An insurer may not**
 3 **retroactively reduce the reimbursement rate for any CPT code.**

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

6 **(1) mail or electronic mail to a provider; and**

7 **(2) posting on the insurer's website;**

8 **before prospectively implementing a rate reduction for any CPT**
 9 **code.**

10 SECTION 10. IC 27-8-5.7-10, AS ADDED BY P.L.55-2006,
 11 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
 12 JULY 1, 2026]: **Sec. 10. (a) An insurer may not, more than ~~two (2)~~**
 13 **years **one hundred eighty (180) days** after the date on which an**
 14 **overpayment on a provider claim was made to the provider by the**
 15 **insurer:**

16 **(1) request that the provider repay the overpayment; or**

17 **(2) adjust a subsequent claim filed by the provider as a method**
 18 **of obtaining reimbursement of the overpayment from the**
 19 **provider.**

20 **(b) An insurer may not recoup a paid claim more than one**
 21 **hundred eighty (180) days after the date on which the claim was**
 22 **initially paid.**

23 **(c) An insurer may not retroactively audit a paid claim more**
 24 **than three (3) years after the date on which the claim was initially**
 25 **paid.**

26 ~~(b)~~ **(d) An insurer may not be required to correct a payment error**
 27 **to a provider more than two (2) years after the date on which a payment**
 28 **on a provider claim was made to the provider by the insurer. if notice**
 29 **of the payment error is not provided within one hundred eighty**
 30 **(180) days after payment for a fully adjudicated claim is received.**

31 ~~(c)~~ **(e) This section does Subsections (a), (b), and (d) do not**
 32 **apply in cases of fraud by the provider, the insured, or the insurer with**
 33 **respect to the **health benefits** claim on which the overpayment or**
 34 **underpayment was made **when a final determination of fraud has****
 35 **been made by a court.**

36 **(f) Notwithstanding subsections (a) through (d), an insurer and**
 37 **a hospital licensed under IC 16-21 may enter into a separate**
 38 **written agreement that provides for different time frames than**
 39 **those specified in this section.**

40 SECTION 11. IC 27-8-5.7-11.5 IS ADDED TO THE INDIANA
 41 CODE AS A NEW SECTION TO READ AS FOLLOWS
 42 [EFFECTIVE JULY 1, 2026]: **Sec. 11.5. (a) If an insurer or a health**

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1 maintenance organization (as defined in IC 27-13-36.2-2) recoups
 2 payment from a provider due to an error in coordination of
 3 benefits, the provider may submit a claim for the same services to
 4 the appropriate insurer.

5 (b) Except as provided in subsection (d) and notwithstanding
 6 any other provision of law, a provider may submit a claim to the
 7 appropriate insurer not later than ninety (90) days after the date
 8 the recoupment is made.

9 (c) A provider that submits a claim under this section shall
 10 provide documentation to the insurer demonstrating:

11 (1) the original submission of the claim to the initial insurer
 12 or health maintenance organization; and

13 (2) the recoupment of payment by the initial insurer or
 14 health maintenance organization due to an error in
 15 coordination of benefits.

16 (d) Nothing in this section prevents an insurer from allowing
 17 a provider more time to submit a claim.

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

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

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

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

34 SECTION 14. IC 27-13-36.2-4.7 IS ADDED TO THE INDIANA
 35 CODE AS A NEW SECTION TO READ AS FOLLOWS
 36 [EFFECTIVE JULY 1, 2026]: **Sec. 4.7. (a) A health maintenance**
 37 **organization may not retroactively reduce the reimbursement rate**
 38 **for any CPT code (as defined in IC 27-1-37.5-3).**

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

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

42 (2) posting on the health maintenance organization's website;

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1 **before prospectively reducing the reimbursement rate for any CPT**
 2 **code (as defined in IC 27-1-37.5-3).**

3 SECTION 15. 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~~ **one hundred eighty (180) days** after the date
 7 on which an overpayment on a provider claim was made to the provider
 8 by the health maintenance 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 **(b) A health maintenance organization may not recoup a paid**
 14 **claim more than one hundred eighty (180) days after the date on**
 15 **which the claim was initially paid.**

16 **(c) A health maintenance organization may not retroactively**
 17 **audit a paid claim more than three (3) years after the date on**
 18 **which the claim was initially paid.**

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

25 ~~(c)~~ **(e) This section does Subsections (a), (b), and (d) do not**
 26 **apply in cases of fraud by the provider, the enrollee, or the health**
 27 **maintenance organization with respect to the health benefits claim on**
 28 **which the overpayment or underpayment was made when a final**
 29 **determination of fraud has been made by a court.**

30 **(f) Notwithstanding subsections (a) through (d), a health**
 31 **maintenance organization and a hospital licensed under IC 16-21**
 32 **may enter into a separate written agreement that provides for**
 33 **different time frames than those specified in this section.**

34 SECTION 16. IC 27-13-36.2-9.5 IS ADDED TO THE INDIANA
 35 CODE AS A NEW SECTION TO READ AS FOLLOWS
 36 [EFFECTIVE JULY 1, 2026]: Sec. 9.5. (a) **If an insurer (as defined**
 37 **in IC 27-8-5.7-3) or a health maintenance organization recoups**
 38 **payment from a provider due to an error in coordination of**
 39 **benefits, the provider may submit a claim for the same services to**
 40 **the appropriate health maintenance organization.**

41 **(b) Except as provided in subsection (d) and notwithstanding**
 42 **any other provision of law, a provider may submit a claim to the**

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1 appropriate health maintenance organization not later than ninety
2 (90) days after the date the recoupment is made.
3 (c) A provider that submits a claim under this section shall
4 provide documentation to the health maintenance organization
5 demonstrating:
6 (1) the original submission of the claim to the initial insurer
7 or health maintenance organization; and
8 (2) the recoupment of payment by the initial insurer or
9 health maintenance organization due to an error in
10 coordination of benefits.
11 (d) Nothing in this section prevents a health maintenance
12 organization from allowing a provider more time to submit a
13 claim.

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