SENATE BILL No. 1

AM000103 has been incorporated into introduced printing.

Synopsis: Human services matters.

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

SENATE BILL No. 1

A BILL FOR AN ACT to amend the Indiana Code concerning human services and to make an appropriation.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-14-30-4, AS ADDED BY P.L.207-2017, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 4. (a) The division shall notify the United States Department of Agriculture and take any other action necessary for the state to

~~(1) elect to participate in; and~~

~~(2) implement, beginning January 1, 2018;~~

terminate the state's participation in the use of expanded categorical eligibility within SNAP **unless required by federal law.**

(b) The division: ~~shall implement for the expanded categorical eligibility a countable asset limitation for resources that does not exceed five thousand dollars ($5,000). In determining whether an individual meets the resource requirement of this subsection, an individual's funeral and burial resources, including both revocable and irrevocable resources, may not be counted.~~

(1) may not apply gross income standards higher than the standards specified in 7 U.S.C. 2014(c);

(2) may not allow countable financial resources that are higher than the standards specified in 7 U.S.C. 2014(g)(1) other than the financial resources described in 7 U.S.C. 2014(g)(2)(D); and

(3) may apply alternate vehicle allowance standards authorized by 7 U.S.C. 2014(g)(2)(D).

(c) The division may adopt rules under IC 4-22-2 necessary to implement this section.

~~(d) Before November 1, 2018, the division shall submit a report in an electronic format under IC 5-14-6 to the legislative council concerning the projected total amounts that individuals receiving SNAP benefits would be required to repay over the period beginning January 1, 2018, and ending December 31, 2019, due to positive errors, in which individuals are approved for an amount in error and then are required to repay the amount. The projected total amounts must be based on the amounts that individuals receiving SNAP benefits have been required to repay over the period beginning January 1, 2018, and ending September 30, 2018, due to positive errors.~~

SECTION 2. IC 12-14-30-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 9. (a) An individual is not eligible to receive SNAP benefits unless the individual is a resident of the United States who meets at least one (1) of the following:**

(1) Is a citizen or national of the United States.

(2) Is an alien lawfully admitted for permanent residence (as defined in 8 U.S.C. 1101(a)(20) as an immigrant (as defined in 8 U.S.C. 1101(a)(15)), not including the following:

(A) An alien visitor.

(B) A tourist.

(C) A diplomat.

(D) A student.

(E) Any other individual admitted temporarily without intent to abandon the individual's residence in a foreign country.

(3) Is an alien who has been granted the status of Cuban or Haitian entrant, as set forth in Section 501(e) of the Refugee Education Assistance Act of 1980.

(4) Is an individual lawfully residing in the United States in accordance with a Compact of Free Association under 8 U.S.C. 1612(b)(2)(G).

(b) The division shall verify that an individual is eligible for SNAP benefits under subsection (a) and 7 U.S.C. 2015(f) during

enrollment and eligibility recertification by verifying citizenship or eligible alien status using the Systematic Alien Verification for Entitlements (SAVE) online service.

(c) If the division is unable to verify eligibility under subsection (b), the division shall verify citizenship through an acceptable form of proof of citizenship or eligible alien status. An acceptable form of proof includes the following:

(1) A certified birth certificate.

(2) United States passport.

(3) United States Customs and Immigration Service documentation.

The individual shall submit the documentation to the division required for verification under this subsection.

(d) The division shall submit to the United States Department of Agriculture information concerning any household member for whom the division is unable to verify eligible citizenship or immigration status, regardless of whether the household member is applying to participate in SNAP as a member of the household.

(e) Notwithstanding any option set forth in 7 CFR 273.11(c)(3), the division:

(1) shall consider the entire income and financial resources of any individual determined to be ineligible to participate in SNAP under subsection (a) or 7 U.S.C. 2015(f) when determining the eligibility and benefit allotment of the household of which the individual is a member; and

(2) may not prorate or exclude the income or financial resources of the ineligible individual.

SECTION 3. IC 12-14-32 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 32. Summer Cash Supplement Food Program

Sec. 1. As used in this chapter, "program" means a summer cash supplement food program for eligible school age children established under section 3 of this chapter.

Sec. 2. As used in this chapter, "SUN Bucks program" means the federal summer electronic benefit transfer program known as SUN Bucks administered by the United States Department of Agriculture.

Sec. 3. (a) The office of the secretary shall establish and administer a statewide summer cash supplement food program for eligible school age children for the summer of 2026.

(b) The program shall be modeled on the federal SUN Bucks

program using the same:

(1) eligibility criteria for benefits;

(2) benefit amount per eligible school age child; and

(3) food purchase authorizations;

as set forth under the SUN Bucks program.

(c) The office of the secretary shall establish:

(1) the timing of monthly benefit distributions under the program; and

(2) the duration of the program for the summer, which shall begin approximately at the end of the school year and continue for at least one hundred twenty-two (122) days after that date.

Sec. 4. There is appropriated from the state general fund the total amount necessary to fully fund the program for the summer of 2026.

Sec. 5. Beginning after 2026, the office of the secretary shall apply to participate in the SUN Bucks program or any successor or similar program and fund a statewide program each summer.

SECTION 4. IC 12-15-1-24, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2026 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: Sec. 24. (a) Except as required under federal law, the office of the secretary may not accept self-attestation of any of the following in the administration of the Medicaid program without verification before enrollment:

(1) Income.

(2) Residency.

(3) Age.

(4) Household composition.

(5) Caretaker or relative status.

(6) Receipt of other coverage.

(b) The office of the secretary shall enter into a data matching agreement with:

(1) the state lottery commission; and

(2) the Indiana gaming commission;

to, on at least a monthly basis, identify individuals receiving Medicaid assistance with lottery and gambling winnings of at least three thousand dollars ($3,000). Upon verification of any winnings resulting in the individual no longer being eligible for Medicaid, the office of the secretary shall terminate the individual's enrollment.

(c) On at least a monthly basis, the office of the secretary shall review vital statistics information provided by the Indiana department

of health under IC 16-19-3-19 to determine removal of deceased individuals from Medicaid enrollment.

(d) On at least a quarterly basis, the office of the secretary shall receive and review information from the department of state revenue and the department of workforce development concerning Medicaid recipients that indicates a change in circumstances that may affect eligibility, including changes to employment or wages.

(e) On at least an annual basis, the office of the secretary shall receive and review information from the department of state revenue concerning Medicaid recipients, including:

(1) adjusted gross income; and

(2) family composition;

that indicates a change in circumstances that may affect Medicaid eligibility.

(f) On at least a monthly basis, the office of the secretary shall review information concerning Medicaid recipients who also receive SNAP **benefits** to determine whether there has been any change in circumstances that may affect Medicaid eligibility, including a change in residency as may be identified through electronic benefit transfer program transactions.

(g) On at least a monthly basis, the office of the secretary shall receive and review information from the department of correction concerning Medicaid recipients that may indicate a change in circumstances that may affect Medicaid eligibility.

(h) Upon receiving information concerning a Medicaid recipient that indicates a change in circumstances that may affect Medicaid eligibility, the office of the secretary shall promptly conduct an eligibility redetermination for the recipient.

(i) Unless prohibited by federal law, the office of the secretary shall conduct a Medicaid eligibility redetermination for a recipient as follows:

(1) At least one (1) time every six (6) months for a nonelderly adult Medicaid recipient whose eligibility is determined based upon a modified adjusted gross income standard under 42 CFR 435.603, including adults eligible under 42 U.S.C. 1396u-1.

(2) At least one (1) time every twelve (12) months for any other Medicaid recipient.

SECTION 5. IC 12-15-1-25, AS ADDED BY P.L.126-2025, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 25. (a) Unless prohibited by federal law and on at least a monthly basis, the office of the secretary shall review the

following to assess continuous eligibility of Medicaid recipients:

(1) The following information maintained by the United States Social Security Administration:

(A) Earned income information.

(B) Death register information.

(C) Incarceration records.

(D) Supplemental security income information.

(E) Beneficiary records.

(F) Earnings information.

(G) Pension information.

(2) The following information maintained by the United States Department of Health and Human Services:

(A) Income and employment information maintained in the national directory of new hires data base.

(B) Child support enforcement data.

(3) Change of address **or mail forwarding address** information maintained by the United States Postal Service.

(4) Payment and earnings information maintained by the United States Department of Housing and Urban Development.

(5) National fleeing felon information maintained by the United States Federal Bureau of Investigation.

(6) Tax filing information maintained by the United States Department of the Treasury.

(b) The office of the secretary may contract with an independent third party for additional data base searches that may contain information that indicates a change in circumstances that may affect Medicaid applicant or recipient eligibility.

(c) At least one (1) time per month, the office of the secretary shall transmit information to the United States Department of Health and Human Services required by 42 U.S.C. 1396a(uu) to prevent Medicaid enrollment in more than one (1) state.

SECTION 6. IC 12-15-2-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: Sec. 2. The county office shall determine eligibility and shall certify to the office at the time and in the manner required by the office a list of individuals who have been found eligible to receive Medicaid and the effective date for the payment of assistance under this chapter. The date must be:

(1) not earlier than one (1) month before the first day of the month in which the application or request is made **for individuals eligible under IC 12-15-44.5; and**

(2) not earlier than two (2) months before the first day of the month in which an application or request is made for any

other individual not described in subdivision (1).

SECTION 7. IC 12-15-2-17.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 17.2. (a) This section is effective October 1, 2026.**

(b) Except as otherwise provided by federal law, the office of the secretary shall count any income of a household member who is ineligible due to the household member's immigration status when calculating and determining an individual's financial eligibility for Medicaid.

(c) The office of the secretary shall apply for any Medicaid state plan amendment necessary to implement this section.

SECTION 8. IC 12-15-2.5-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE OCTOBER 1, 2026]: Sec. 1. **(a) This section does not apply to any alien for whom federal financial participation is unavailable under 42 U.S.C. 1396b(v)(5) or any alien who has not satisfied the requirements of 8 U.S.C. 1613.**

(b) A person who:

(1) is ~~classified as a refugee (as defined in 8 U.S.C. 1101)~~ **lawfully admitted for permanent residence (as defined in 8 U.S.C. 1101(a)(20);**

(2) has been granted the status of Cuban or Haitian entrant under Section 501(e) of the Refugee Education Assistance Act of 1980; or

(3) lawfully resides in the United States in accordance with a Compact of Free Association under 8 U.S.C. 1612(b)(2)(G);

is eligible for all services under this article as if the person were classified as a citizen of the United States.

SECTION 9. IC 12-15-2.5-3, AS AMENDED BY P.L.1-2007, SECTION 121, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE OCTOBER 1, 2026]: Sec. 3. A person who is in the United States ~~without permission of the United States Citizenship and Immigration Services~~ **and who does not meet the requirements of 42 U.S.C. 1396b(v)(5)** is not entitled to receive assistance under this article.

SECTION 10. IC 12-15-2.5-3.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 3.5. (a) This section is effective October 1, 2026.**

(b) The office of the secretary shall do the following:

(1) Verify citizenship or satisfactory immigration status for each applicant, recipient, or identified household member of

an applicant or recipient.

(2) Either:

(A) after a reasonable opportunity period to verify citizenship or satisfactory immigration status where the status could not be verified; or

(B) upon receipt of verification that indicates that the applicant, recipient, or household member is not a United States citizen or lacks satisfactory immigration status and has entered the United Status without inspection or admission, or has remained beyond the expiration of an authorized period of stay;

promptly refer the applicant, recipient, or household member of an applicant or recipient to the United States Department of Homeland Security or any other appropriate federal authority for further investigation and enforcement.

SECTION 11. IC 12-15-4-1.3 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 1.3. (a) This section is effective October 1, 2026.**

(b) The office shall include a field concerning an applicant's immigration status on any Medicaid presumptive eligibility application used for the Medicaid program.

(c) A hospital, clinic, or other qualified entity conducting a presumptive eligibility determination shall collect and transmit the required information concerning the applicant's immigration status as part of the individual's presumptive eligibility application.

(d) A presumptive eligibility application may not be approved unless the applicant's immigration status has been verified to meet the requirements set forth in IC 12-15-2.5-1.

SECTION 12. IC 12-15-44.5-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 1.5. As used in this chapter, "office" refers to the office of the secretary.**

SECTION 13. IC 12-15-44.5-3, AS AMENDED BY P.L.126-2025, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 3. (a) The healthy Indiana plan is established. **The secretary shall oversee the plan and has the authority to set policy for the plan in compliance with this chapter.**

(b) The office, **under the direction of the secretary,** shall administer the plan.

(c) The adult group described in 42 CFR 435.119 may be eligible for the plan if the conditions in section 4 of this chapter are met and if

the individual meets at least one (1) of the following:

(1) Is working at least ~~twenty (20)~~ **eighty (80)** hours per ~~week on a monthly average.~~ **month.**

(2) Is participating in and complying with the requirements of a work program for at least ~~twenty (20)~~ **eighty (80)** hours per ~~week, as determined by the office.~~ **month.**

(3) Is volunteering **or performing community service** at least ~~twenty (20)~~ **eighty (80)** hours per ~~week, as determined by the office.~~ **month.**

(4) Undertakes a combination of the activities described in subdivision (1), (2), or (3) for a combined total of at least ~~twenty (20)~~ **eighty (80)** hours per ~~week, as determined by the office.~~ **month.**

(5) Participates in and complies with the **work** requirements of ~~a workfare program, as determined by the office.~~ **the TANF program or SNAP.**

(6) ~~Receives unemployment compensation and complies with federal and state work requirements under the unemployment compensation system.~~ **Has:**

(A) a monthly income of at least the applicable minimum wage requirement under 29 U.S.C. 206, multiplied by eighty (80) hours; or

(B) an average monthly income in the preceding six (6) months that is not less than the applicable minimum wage requirements under 29 U.S.C. 206, multiplied by eighty (80) hours and is a seasonal worker as defined under 26 U.S.C. 45R(d)(5)(B).

(7) Participates in a ~~substance use~~ **drug addiction or alcoholic** treatment and rehabilitation program, **as defined in 7 U.S.C. 2012(h).**

(8) Is medically certified as ~~physically or mentally unfit for employment.~~ **medically frail (as defined in 42 CFR 440.315(f)).**

(9) Is:

(A) pregnant;

(B) entitled to postpartum medical assistance under 42 U.S.C. 1396a(e)(5) or 42 U.S.C. 1396a(e)(16); or ~~is~~

(C) a parent, **guardian,** or caretaker **relative** responsible for the care of a dependent child less than ~~six (6)~~ **fourteen (14)** years of age.

(10) Is a ~~parent, spouse, or caretaker~~ **family caregiver under Section 2 of the RAISE Family Caregivers Act** personally

providing the care for an individual with a serious medical condition or a disability.

(11) Is an individual who ~~has been released from incarceration for less than ninety (90) days.~~ **is an inmate of a public institution.**

(12) Is an Indiana resident enrolled in and attending an accredited educational program ~~full~~ **at least half** time.

(13) Is, as set forth in the Indian Health Care Improvement Act:

(A) an Indian;

(B) an urban Indian; or

(C) a California Indian;

or has otherwise been determined eligible as an Indian by the federal Indian Health Service.

(14) Is eligible for medical assistance under 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

(15) Is a veteran with a disability rated as total under 38 U.S.C. 1155.

An individual must meet the Medicaid residency requirements under IC 12-15-4-4 and this article to be eligible for the plan.

(d) The following individuals are not eligible for the plan:

(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.).

(2) An individual who is otherwise eligible and enrolled for medical assistance.

(e) The department of insurance and the office of the secretary shall provide oversight of the marketing practices of the plan.

(f) The office shall promote the plan and provide information to potential eligible individuals who live in medically underserved rural areas of Indiana.

(g) The office shall, to the extent possible, ensure that enrollment in the plan is distributed throughout Indiana in proportion to the number of individuals throughout Indiana who are eligible for participation in the plan.

(h) The office shall establish standards for consumer protection, including the following:

(1) Quality of care standards.

(2) A uniform process for participant grievances and appeals.

(3) Standardized reporting concerning provider performance, consumer experience, and cost.

(i) A health care provider that provides care to an individual who receives health coverage under the plan shall also participate in the

Medicaid program under this article.

(j) The following do not apply to the plan:

(1) IC 12-15-12.

(2) IC 12-15-13.

(3) IC 12-15-14.

(4) IC 12-15-15.

(5) IC 12-15-21.

(6) IC 12-15-26.

(7) IC 12-15-31.1.

(8) IC 12-15-34.

(9) IC 12-15-35.

(10) IC 16-42-22-10.

SECTION 14. IC 12-15-44.5-3.5, AS AMENDED BY P.L.180-2022(ss), SECTION 16, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3.5. (a) The plan must include the following in a manner and to the extent determined by the ~~office.~~ **secretary:**

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage, including coverage of a long acting, nonaddictive medication assistance treatment drug if the drug is being prescribed for the treatment of substance abuse.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Comprehensive disease management.

(9) Home health services, including case management.

(10) Urgent care center services.

(11) Preventative care services.

(12) Family planning services:

(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and

(B) not including abortion or abortifacients.

(13) Hospice services.

(14) Substance abuse services.

(15) Donated breast milk that meets requirements developed by the office of Medicaid policy and planning.

(16) A service determined by the secretary to be required by federal law as a benchmark service under the federal Patient Protection and Affordable Care Act.

(b) The plan may not permit treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(c) The plan may provide vision services and dental services only to individuals who regularly make the required monthly contributions for the plan as set forth in section 4.7(c) of this chapter.

(d) The benefit package offered in the plan:

(1) must be benchmarked to a commercial health plan described in 45 CFR 155.100(a)(1) or 45 CFR 155.100(a)(4); and

(2) may not include a benefit that is not present in at least one (1) of these commercial benchmark options.

(e) The office shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The office shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

(f) The plan shall, at no cost to the individual, provide payment of preventative care services described in 42 U.S.C. 300gg-13 for an individual who participates in the plan.

(g) The plan shall, at no cost to the individual, provide payments of not more than five hundred dollars ($500) per year for preventative care services not described in subsection (f). Any additional preventative care services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan.

~~(h) The office shall apply to the United States Department of Health and Human Services for any amendment to the waiver necessary to implement the providing of the services or supplies described in subsection (a)(15). This subsection expires July 1, 2024.~~

SECTION 15. IC 12-15-44.5-4, AS AMENDED BY P.L.216-2025, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. (a) The plan:

(1) is not an entitlement program;

(2) serves as an alternative to health care coverage under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.);

(3) except as provided in section 4.2(a) of this chapter, must not grant eligibility under the state Medicaid plan for medical assistance under 42 U.S.C. 1396a; and

(4) must grant eligibility for the plan through an approved

demonstration project under 42 U.S.C. 1315.

(b) If any of the following occurs, the ~~office~~ **secretary** shall terminate the plan in accordance with section 6(b) of this chapter:

(1) The:

(A) percentages of federal medical assistance available to the plan for coverage of plan participants described in Section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act are less than the percentages provided for in Section 2001(a)(3)(B) of the federal Patient Protection and Affordable Care Act; and

(B) office, after considering the modification and the reduction in available funding, does not alter:

(i) the formula established under IC 16-21-10-13.3(b)(1) to cover the amount of the reduction in federal medical assistance; or

(ii) if applicable, the fee formula used to fund the reimbursement for inpatient and outpatient hospital services under IC 16-21-10-8.5 to cover the amount of the reduction in federal medical assistance.

For purposes of this subdivision, "coverage of plan participants" includes reimbursement, payments, contributions, and amounts referred to in IC 16-21-10-13.3(b)(1)(A), IC 16-21-10-13.3(b)(1)(C), and IC 16-21-10-13.3(b)(1)(D), including reimbursement, payments, contributions, and amounts incurred before termination of the plan.

(2) The:

(A) methodology of calculating the incremental fee set forth in IC 16-21-10-13.3 is modified in any way that results in a reduction in available funding;

(B) office, after considering the modification and reduction in available funding, does not alter:

(i) the formula established under IC 16-21-10-13.3(b)(1) to cover the amount of the reduction in fees; or

(ii) if applicable, the fee formula used to fund the reimbursement for inpatient and outpatient hospital services under IC 16-21-10-8.5 to cover the amount of the reduction in fees; and

(C) office does not use alternative financial support to cover the amount of the reduction in fees.

(3) The Medicaid waiver approving the plan is revoked, rescinded, vacated, or otherwise altered in a manner that the

state cannot comply with the requirements of this chapter.

(c) If federal financial participation for recipients covered under the plan is less than ninety percent (90%), the ~~office~~ **secretary** may terminate the plan in accordance with section 6(b) of this chapter.

(d) If the plan is terminated under subsection (b), the secretary may implement a plan for coverage of the affected population in a manner consistent with the healthy Indiana plan (IC 12-15-44.2 (before its repeal)) in effect on January 1, 2014:

(1) subject to prior approval of the United States Department of Health and Human Services; and

(2) using funding from the incremental fee set forth in IC 16-21-10-13.3.

(e) The ~~office~~ **secretary** may not operate the plan in a manner that would obligate the state to financial participation beyond the level of state appropriations or funding otherwise authorized for the plan.

(f) The office of the secretary shall submit annually to the budget committee an actuarial analysis of the plan that reflects a determination that sufficient funding is reasonably estimated to be available to operate the plan.

SECTION 16. IC 12-15-44.5-4.2, AS ADDED BY P.L.126-2025, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4.2. (a) Notwithstanding section 3 of this chapter, the ~~office of the~~ secretary shall amend the Medicaid state plan to not include individuals described in 42 CFR 435.119. The ~~office of the~~ secretary shall delay the effective date of the amendment to not later than upon the completion of negotiations with the United States Department of Health and Human Services for a 3.0 plan waiver and an approved implementation of the waiver.

(b) The ~~office of the~~ secretary shall continue to operate the plan, as in effect on January 1, 2025, until the effective date of a 3.0 plan waiver authorized by the United States Department of Health and Human Services or the expiration, termination, or vacatur of the waiver authorizing the plan. **However, the following statutes shall be implemented before the following dates:**

(1) Section 3(c) of this chapter, before January 1, 2027.

(2) Section 5.7 of this chapter, before October 2, 2028.

SECTION 17. IC 12-15-44.5-4.5, AS ADDED BY P.L.30-2016, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4.5. (a) An individual who participates in the plan must have a health care account to which payments may be made for the individual's participation in the plan.

(b) An individual's health care account must be used to pay the

individual's deductible for health care services under the plan.

(c) An individual's deductible must be at least two thousand five hundred dollars ($2,500) per year.

(d) An individual may make payments to the individual's health care account as follows:

(1) An employer withholding or causing to be withheld from an employee's wages or salary, after taxes are deducted from the wages or salary, the individual's contribution under this chapter and distributed equally throughout the calendar year.

(2) Submission of the individual's contribution under this chapter to the office to deposit in the individual's health care account in a manner prescribed by the ~~office.~~ **secretary.**

(3) Another method determined by the ~~office.~~ **secretary.**

SECTION 18. IC 12-15-44.5-4.7, AS AMENDED BY P.L.126-2025, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 4.7. (a) To participate in the plan, an individual must:

(1) apply for the plan on a form prescribed by the ~~office;~~ **secretary;**

(2) comply with the requirements of section 3(c) of this chapter for the three (3) consecutive months immediately preceding the month the individual applies to the plan; and

(3) provide documentary evidence of compliance with subdivision (2).

The secretary may not accept self-attestation by the applicant as evidence of compliance. The ~~office~~ **secretary** may develop and allow a joint application for a household.

(b) A pregnant woman is not subject to the cost sharing provisions of the plan. Subsections (c) through (g) do not apply to a pregnant woman participating in the plan.

(c) An applicant who is approved to participate in the plan does not begin benefits under the plan until a payment of at least:

(1) one-twelfth (1/12) of the annual income contribution amount; or

(2) ten dollars ($10);

is made to the individual's health care account established under section 4.5 of this chapter for the individual's participation in the plan. To continue to participate in the plan, an individual must contribute to the individual's health care account at least two percent (2%) of the individual's annual household income per year or an amount determined by the secretary that is based on the individual's annual household income per year, but not less than one dollar ($1) per month.

The amount determined by the secretary under this subsection must be approved by the United States Department of Health and Human Services and must be budget neutral to the state as determined by the state budget agency.

(d) If an applicant who is approved to participate in the plan fails to make the initial payment into the individual's health care account, at least the following must occur:

(1) If the individual has an annual income that is at or below one hundred percent (100%) of the federal poverty income level, the individual's benefits are reduced as specified in subsection (e)(1).

(2) If the individual has an annual income of more than one hundred percent (100%) of the federal poverty income level, the individual is not enrolled in the plan.

(e) If an enrolled individual's required monthly payment to the plan is not made within sixty (60) days after the required payment date, the following, at a minimum, occur:

(1) For an individual who has an annual income that is at or below one hundred percent (100%) of the federal income poverty level, the individual is:

(A) transferred to a plan that has a material reduction in benefits, including the elimination of benefits for vision and dental services; and

(B) required to make copayments for the provision of services that may not be paid from the individual's health care account.

(2) For an individual who has an annual income of more than one hundred percent (100%) of the federal poverty income level, the individual shall be terminated from the plan and may not reenroll in the plan for at least six (6) months.

(f) The state shall contribute to the individual's health care account the difference between the individual's payment required under this section and the plan deductible set forth in section 4.5(c) of this chapter.

(g) A member shall remain enrolled with the same managed care organization during the member's benefit period. A member may change managed care organizations as follows:

(1) Without cause:

(A) before making a contribution or before finalizing enrollment in accordance with subsection (d)(1); or

(B) during the annual plan renewal process.

(2) For cause, as determined by the office **under the direction**

of the secretary.

(h) The office may reimburse medical providers at the appropriate Medicaid fee schedule rate for certified medical claims incurred prior to the beginning of benefits under subsection (c) provided that the claims:

(1) were incurred not more than thirty (30) days prior to the individual's application; and

(2) are on behalf of an individual who:

(A) is approved to participate in the plan;

(B) is enrolled in the plan subject to the provisions in subsection (d); and

(C) was eligible for the plan at the time care and services were furnished.

(i) An enrolled individual in the plan must be in compliance with section 3(c) of this chapter in each month in order to remain enrolled in the plan.

SECTION 19. IC 12-15-44.5-4.9, AS AMENDED BY P.L.114-2018, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: Sec. 4.9. (a) An individual who is approved to participate in the plan is eligible ~~for a twelve (12) month plan period~~ if the individual continues to meet the plan requirements specified in this chapter.

(b) If an individual chooses to renew participation in the plan, the individual is subject to ~~an annual~~ **a semiannual** renewal process ~~at the end of the benefit period~~ to determine continued eligibility for participating in the plan. ~~If the individual does not complete the renewal process, the individual may not reenroll in the plan for at least six (6) months.~~

(c) This subsection applies to participants who consistently made the required payments in the individual's health care account. If the individual receives the qualified preventative services recommended to the individual during the year, the individual is eligible to have the individual's unused share of the individual's health care account at the end of the plan period, determined by the office, matched by the state and carried over to the subsequent plan period to reduce the individual's required payments. If the individual did not, during the plan period, receive all qualified preventative services recommended to the individual, only the nonstate contribution to the health care account may be used to reduce the individual's payments for the subsequent plan period.

(d) For individuals participating in the plan who, in the past, did not make consistent payments into the individual's health care account

while participating in the plan, but:

(1) had a balance remaining in the individual's health care account; and

(2) received all of the required preventative care services;

the ~~office~~ **secretary** may elect to offer a discount on the individual's required payments to the individual's health care account for the subsequent benefit year. The amount of the discount under this subsection must be related to the percentage of the health care account balance at the end of the plan year but not to exceed a fifty percent (50%) discount of the required contribution.

(e) If an individual is no longer eligible for the plan, does not renew participation in the plan at the end of the plan period, or is terminated from the plan for nonpayment of a required payment, the office shall, not more than one hundred twenty (120) days after the last date of the plan benefit period, refund to the individual the amount determined under subsection (f) of any funds remaining in the individual's health care account as follows:

(1) An individual who is no longer eligible for the plan or does not renew participation in the plan at the end of the plan period shall receive the amount determined under STEP FOUR of subsection (f).

(2) An individual who is terminated from the plan due to nonpayment of a required payment shall receive the amount determined under STEP SIX of subsection (f).

The office may charge a penalty for any voluntary withdrawals from the health care account by the individual before the end of the plan benefit year. The individual may receive the amount determined under STEP SIX of subsection (f).

(f) The office, **under the direction of the secretary,** shall determine the amount payable to an individual described in subsection (e) as follows:

STEP ONE: Determine the total amount paid into the individual's health care account under this chapter.

STEP TWO: Determine the total amount paid into the individual's health care account from all sources.

STEP THREE: Divide STEP ONE by STEP TWO.

STEP FOUR: Multiply the ratio determined in STEP THREE by the total amount remaining in the individual's health care account.

STEP FIVE: Subtract any nonpayments of a required payment.

STEP SIX: Multiply the amount determined under STEP FIVE by at least seventy-five hundredths (0.75).

(g) The office of the secretary shall conduct an eligibility redetermination for each plan participant at least one (1) time every six (6) months.

SECTION 20. IC 12-15-44.5-5, AS AMENDED BY P.L.201-2023, SECTION 136, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5. (a) A managed care organization that contracts with the office to provide health coverage, dental coverage, or vision coverage to an individual who participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall reimburse providers at a rate that is not less than the rate established by the secretary; and

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan.

(b) A managed care organization that contracts with the office to provide health coverage under the plan must incorporate cultural competency standards established by the ~~office.~~ **secretary.** The standards must include standards for non-English speaking, minority, and disabled populations.

SECTION 21. IC 12-15-44.5-5.5, AS ADDED BY P.L.30-2016, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 5.5. The office, **under the direction of the secretary,** shall refer any member of the plan who:

(1) is employed for less than twenty (20) hours per week; and

(2) is not a full-time student;

to a workforce training and job search program.

SECTION 22. IC 12-15-44.5-5.7, AS AMENDED BY P.L.114-2018, SECTION 7, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 5.7. **(a)** Subject to appeal to the office **and except as provided in subsection (b),** an individual ~~may~~ **shall** be held responsible under the plan for receiving nonemergency services in an emergency room setting, including prohibiting the individual from using funds in the individual's health care account to pay for the nonemergency services and paying a copayment for the services of at least:

(1) eight dollars ($8) **for an individual who has an income of one hundred percent (100%) or less of the federal poverty level; or**

(2) thirty-five dollars ($35) for an individual who has an income of more than one hundred percent (100%) of the federal poverty level;

for the nonemergency use of a hospital emergency department.

(b) ~~However,~~ An individual may not be prohibited from using funds in the individual's health care account to pay for nonemergency services provided in an emergency room setting for a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

(1) place an individual's health in serious jeopardy;

(2) result in serious impairment to the individual's bodily functions; or

(3) result in serious dysfunction of a bodily organ or part of the individual.

(c) In addition to the copayments described in subsection (a), the office of the secretary shall require a plan participant who has an income above one hundred percent (100%) of the federal poverty level to pay additional cost sharing requirements established by the office of the secretary in the amount of at least one dollar ($1) and not more than thirty-five dollars ($35).

(d) Unless otherwise allowed by federal law, the total aggregate amount of cost sharing charges imposed on a quarterly basis for a plan participant under this chapter may not exceed five percent (5%) of the plan participant's family income.

SECTION 23. IC 12-15-44.5-6, AS AMENDED BY P.L.216-2025, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 6. (a) For a state fiscal year beginning July 1, 2018, and before July 1, 2024, the office, after review by the state budget committee, may determine that no incremental fees collected under IC 16-21-10-13.3 are required to be deposited into the phase out trust fund established under section 7 of this chapter. This subsection expires July 1, 2024.

(b) If the plan is to be terminated for any reason, the ~~office~~ **secretary** shall, if required, provide notice of termination of the plan to the United States Department of Health and Human Services and begin the process of phasing out the plan.

(c) Before submitting:

(1) an extension of; or

(2) a material amendment to;

the plan to the United States Department of Health and Human Services, the ~~office~~ **secretary** shall inform the Indiana Hospital Association of the extension or material amendment to the plan.

SECTION 24. IC 12-15-44.5-8, AS AMENDED BY

P.L.152-2017, SECTION 35, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. The following requirements apply to funds appropriated by the general assembly to the plan and the incremental fee used for purposes of IC 16-21-10-13.3:

(1) At least eighty-seven percent (87%) of the funds must be used to fund payment for health care services.

(2) An amount determined by the ~~office of the~~ secretary to fund:

(A) administrative costs of; and

(B) any profit made by;

a managed care organization under a contract with the office to provide health coverage under the plan. The amount determined under this subdivision may not exceed thirteen percent (13%) of the funds.

SECTION 25. IC 12-15-44.5-9, AS AMENDED BY P.L.93-2024, SECTION 113, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 9. The ~~office~~ **secretary** may adopt rules under IC 4-22-2 necessary to implement:

(1) this chapter; or

(2) a Section 1115 Medicaid demonstration waiver concerning the plan that is approved by the United States Department of Health and Human Services.

SECTION 26. IC 12-15-44.5-10, AS AMENDED BY P.L.126-2025, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: Sec. 10. (a) The secretary has the authority to provide benefits to individuals eligible under the adult group described in 42 CFR 435.119 only in accordance with this chapter.

(b) The secretary shall limit enrollment in the plan to the number of individuals that ensures that financial participation does not exceed the level of state appropriations or other funding for the plan.

(c) The secretary may negotiate and make changes to the plan, except that the secretary may not negotiate or change the plan in a way that would do the following:

(1) Reduce the following:

(A) Contribution amounts below the minimum levels set forth in section 4.7 of this chapter.

(B) Deductible amounts below the minimum amount established in section 4.5(c) of this chapter.

(C) The number of hours required to satisfy the work requirements specified in section 3(c)(1) of this chapter unless expressly required by federal law.

(2) Remove or reduce the penalties for nonpayment set forth in

section 4.7 of this chapter.

(3) Revise the use of the health care account requirement set forth in section 4.5 of this chapter.

(4) Include noncommercial benefits or add additional plan benefits in a manner inconsistent with section 3.5 of this chapter.

(5) Allow services to begin:

(A) without the payment established or required by; or

(B) earlier than the time frames otherwise established by; section 4.7 of this chapter.

(6) Reduce financial penalties for the inappropriate use of the emergency room below the minimum levels set forth in section 5.7 of this chapter.

(7) Permit members to change health plans without cause in a manner inconsistent with section 4.7(g) of this chapter.

(8) Operate the plan in a manner that would obligate the state to financial participation beyond the level of state appropriations or funding otherwise authorized for the plan.

(d) The secretary may make changes to the plan under this chapter if the changes are required by federal law or regulation and the office provides a written report of the changes to the state budget committee.

(e) The secretary shall verify an individual's compliance with the requirements of section 3(c) of this chapter on an ongoing, and at least quarterly, basis. The secretary may not accept any of the following methods as being sufficient to verify compliance:

(1) A plan participant's self-attestation of compliance.

(2) Designations, approvals, or determinations of compliance by a managed care organization.

(f) The secretary may accept a medically frail status set forth in section 3(c)(8) of this chapter only if the individual has been medically certified as medically frail (as defined in 42 CFR 440.315(f)) by any of the following:

(1) A physician.

(2) A physician's assistant.

(3) An advanced practice registered nurse.

(4) A nurse.

(5) A designated representative of a physician's office, on behalf of an individual described in subdivisions (1) through (4).

(6) A psychologist.

(7) A social worker.

(g) The secretary may not do any of the following:

(1) Expand the definition of medically frail for purposes of

this chapter beyond the definition set forth in 42 CFR 440.315(f).

(2) Request the implementation of any additional exemptions other than the exemptions set forth in section 3 of this chapter.

SECTION 27. **An emergency is declared for this act.**