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## SENATE BILL No. 1

Proposed Changes to January 16, 2026 printing by AM000110

### DIGEST OF PROPOSED AMENDMENT

Work requirement exemption. Exempts an individual who is receiving inpatient hospital services from the Medicaid work requirements.

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:*

- 1 SECTION 1. IC 4-12-1-18, AS AMENDED BY P.L.174-2022,
- 2 SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE
- 3 JANUARY 1, 2026 (RETROACTIVE)]: Sec. 18. Except for allotment
- 4 stipulations provided in IC 4-12-18 and IC 12-8-15, federal funds
- 5 received by an instrumentality are appropriated for purposes specified
- 6 by the federal government and the general assembly, if that body elects
- 7 to appropriate federal funds, subject to allotment by the budget agency.
- 8 The provisions of this chapter and other laws concerning the
- 9 acceptance, disbursement, review, and approval of grants, loans, and
- 10 gifts made by the federal government or any other source to the state
- 11 or its agencies apply to instrumentalities.
- 12 SECTION 2. IC 12-7-2-24.3 IS ADDED TO THE INDIANA
- 13 CODE AS A NEW SECTION TO READ AS FOLLOWS
- 14 [EFFECTIVE JULY 1, 2026]: Sec. 24.3. "Candy", for purposes of
- 15 IC 12-14-30-10, has the meaning set forth in IC 12-14-30-10(a).
- 16 SECTION 3. IC 12-7-2-179.5 IS ADDED TO THE INDIANA
- 17 CODE AS A NEW SECTION TO READ AS FOLLOWS
- 18 [EFFECTIVE JULY 1, 2026]: Sec. 179.5. "Soft drink", for purposes
- 19 of IC 12-14-30-10, has the meaning set forth in IC 12-14-30-10(b).
- 20 SECTION 4. IC 12-8-15 IS ADDED TO THE INDIANA CODE

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AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE  
JANUARY 1, 2026 (RETROACTIVE)]:

**Chapter 15. Indiana Rural Health Transformation Fund**

**Sec. 1. (a)** The Indiana rural health transformation fund is established as a dedicated fund for the purpose of implementing the Indiana rural health transformation program authorized by federal law under Section 71401 of Public Law 119-21 (42 U.S.C. 1397ee), and based on Indiana's federally approved application. The fund shall be administered by the office of the secretary.

**(b)** Money in the fund is continuously appropriated. The fund consists of federal funds received from the federal government under Section 71401 of Public Law 119-21.

**(c)** The expenses of administering the fund shall be paid from money in the fund to the extent allowable by federal law under Section 71401 of Public Law 119-21.

**(d)** The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

**(e)** Money in the fund at the end of a state fiscal year does not revert to the state general fund.

**(f)** The secretary may make recommendations concerning expenditures from the fund to the budget committee, and allotments and expenditures from the fund are subject to budget committee review before the allotment and expenditure may occur.

**(g)** This section expires December 31, 2032.

**Sec. 2. (a)** Before June 1 and December 1 of each year, the office of the secretary shall submit a written report for review to the budget committee concerning the following:

**(1)** An itemization of each of the expenditures of money from the fund since the last report to the budget committee.

**(2)** The aggregate amount of expenditures of money from the fund since the last report to the budget committee.

**(3)** Anticipated expenditures for the subsequent six (6) months.

**(4)** Whether the office of the secretary is meeting the benchmarks set forth in the state federally approved application for the federal funds.

**(5)** Whether the office of the secretary believes the state is meeting the federally approved application requirements necessary to continue to receive federal funds for operation of the Indiana rural health transformation program.

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**(b) This section expires December 31, 2033.**

SECTION 5. 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 6. 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.**

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(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

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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 7. IC 12-14-30-10 IS ADDED TO THE INDIANA  
 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 [EFFECTIVE JULY 1, 2026]: Sec. 10. (a) As used in this section,  
 "candy" means a preparation of sugar, honey, or other natural or  
 artificial sweeteners in combination with chocolate, fruits, nuts, or  
 other ingredients or flavorings in the form of bars, drops, or pieces.  
 The term does not include any preparation requiring refrigeration.

(b) As used in this section, "soft drink" means nonalcoholic  
 beverages that contain natural or artificial sweeteners. The term  
 does not include beverages that contain milk or milk products, soy,  
 rice, or similar milk substitutes, or are exclusively naturally  
 sweetened using natural vegetable or fruit juice.

(c) A SNAP recipient may not use SNAP benefits to purchase  
 candy or soft drinks.

(d) If the office of the secretary determines that a waiver or  
 authorization by a federal agency is needed to implement this  
 section, the office of the secretary shall request the necessary  
 waiver or authorization.

SECTION 8. 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

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1 secretary shall terminate the individual's enrollment.

2 (c) On at least a monthly basis, the office of the secretary shall  
3 review vital statistics information provided by the Indiana department  
4 of health under IC 16-19-3-19 to determine removal of deceased  
5 individuals from Medicaid enrollment.

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

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

14 (1) adjusted gross income; and

15 (2) family composition;

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

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

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

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

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

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

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

42 SECTION 9. IC 12-15-1-25, AS ADDED BY P.L.126-2025,

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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 10. 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**

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1 individuals eligible under IC 12-15-44.5; and  
 2 (2) not earlier than two (2) months before the first day of the  
 3 month in which an application or request is made for any  
 4 other individual not described in subdivision (1).

5 SECTION 11. IC 12-15-2-17.2 IS ADDED TO THE INDIANA  
 6 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 7 [EFFECTIVE JULY 1, 2026]: Sec. 17.2. (a) This section is effective  
 8 October 1, 2026.

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

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

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

21 (b) A person who:

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

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

28 (3) lawfully resides in the United States in accordance with  
 29 a Compact of Free Association under 8 U.S.C. 1612(b)(2)(G);  
 30 is eligible for all services under this article as if the person were  
 31 classified as a citizen of the United States.

32 SECTION 13. IC 12-15-2.5-3, AS AMENDED BY P.L.1-2007,  
 33 SECTION 121, IS AMENDED TO READ AS FOLLOWS  
 34 [EFFECTIVE OCTOBER 1, 2026]: Sec. 3. A person who is in the  
 35 United States ~~without permission of the United States Citizenship and~~  
 36 ~~Immigration Services and who does not meet the requirements of 42~~  
 37 ~~U.S.C. 1396b(v)(5)~~ is not entitled to receive assistance under this  
 38 article.

39 SECTION 14. IC 12-15-2.5-3.5 IS ADDED TO THE INDIANA  
 40 CODE AS A NEW SECTION TO READ AS FOLLOWS  
 41 [EFFECTIVE JULY 1, 2026]: Sec. 3.5. (a) This section is effective  
 42 October 1, 2026.

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(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 States 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 15. 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 16. 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 17. 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

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1 administer the plan.

2 (c) The adult group described in 42 CFR 435.119 may be eligible  
3 for the plan if the conditions in section 4 of this chapter are met and if  
4 the individual meets at least one (1) of the following:

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

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

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

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

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

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

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

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

31 (7) Participates in a ~~substance use drug addiction or alcoholic~~  
32 ~~treatment and rehabilitation program, as defined in 7 U.S.C.~~  
33 **2012(h).**

34 (8) Is medically certified as ~~physically or mentally unfit for~~  
35 ~~employment.~~ **medically frail (as defined in 42 CFR**  
36 **440.315(f)).**

37 (9) Is:

38 (A) pregnant;

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

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

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- 1           (14)    years of age.
- 2           (10) Is a ~~parent, spouse, or caretaker~~ **family caregiver under**
- 3           **Section 2 of the RAISE Family Caregivers Act** personally
- 4           providing the care for an individual with a serious medical
- 5           condition or a disability.
- 6           (11) Is an individual who ~~has been released from incarceration~~
- 7           ~~for less than ninety (90) days.~~ **is an inmate of a public**
- 8           **institution.**
- 9           (12) Is an Indiana resident enrolled in and attending an
- 10          accredited educational program ~~full~~ **at least half** time.
- 11          (13) **Is, as set forth in the Indian Health Care Improvement**
- 12          **Act:**
- 13                (A) **an Indian;**
- 14                (B) **an urban Indian; or**
- 15                (C) **a California Indian;**
- 16          **or has otherwise been determined eligible as an Indian by the**
- 17          **federal Indian Health Service.**
- 18          (14) **Is eligible for medical assistance under 42 U.S.C.**
- 19          **1396a(a)(10)(A)(i)(IX).**
- 20          (15) **Is a veteran with a disability rated as total under 38**
- 21          **U.S.C. 1155.**
- 22          [ (16) Is receiving inpatient hospital services, nursing facility
- 23               services, services in an intermediate care facility for
- 24               individuals with intellectual disabilities, inpatient psychiatric
- 25               care, or other services of similar acuity, including outpatient
- 26               care, as set forth in 42 U.S.C. 1396a(xx)(3)(b)(ii)(I) and as
- 27               determined by the Secretary of the United States Department
- 28               of Health and Human Services.
- 29          ]An individual must meet the Medicaid residency requirements under
- 30          IC 12-15-4-4 and this article to be eligible for the plan.
- 31          (d) The following individuals are not eligible for the plan:
- 32                (1) An individual who participates in the federal Medicare
- 33                program (42 U.S.C. 1395 et seq.).
- 34                (2) An individual who is otherwise eligible and enrolled for
- 35                medical assistance.
- 36          (e) The department of insurance and the office of the secretary
- 37          shall provide oversight of the marketing practices of the plan.
- 38          (f) The office shall promote the plan and provide information to
- 39          potential eligible individuals who live in medically underserved rural
- 40          areas of Indiana.
- 41          (g) The office shall, to the extent possible, ensure that enrollment
- 42          in the plan is distributed throughout Indiana in proportion to the

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1 number of individuals throughout Indiana who are eligible for  
2 participation in the plan.

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

- 5 (1) Quality of care standards.
- 6 (2) A uniform process for participant grievances and appeals.
- 7 (3) Standardized reporting concerning provider performance,  
8 consumer experience, and cost.

9 (i) A health care provider that provides care to an individual who  
10 receives health coverage under the plan shall also participate in the  
11 Medicaid program under this article.

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

- 13 (1) IC 12-15-12.
- 14 (2) IC 12-15-13.
- 15 (3) IC 12-15-14.
- 16 (4) IC 12-15-15.
- 17 (5) IC 12-15-21.
- 18 (6) IC 12-15-26.
- 19 (7) IC 12-15-31.1.
- 20 (8) IC 12-15-34.
- 21 (9) IC 12-15-35.
- 22 (10) IC 16-42-22-10.

23 SECTION 18. IC 12-15-44.5-3.5, AS AMENDED BY  
24 P.L.180-2022(ss), SECTION 16, IS AMENDED TO READ AS  
25 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 3.5. (a) The plan  
26 must include the following in a manner and to the extent determined by  
27 the ~~office~~: **secretary**:

- 28 (1) Mental health care services.
- 29 (2) Inpatient hospital services.
- 30 (3) Prescription drug coverage, including coverage of a long  
31 acting, nonaddictive medication assistance treatment drug if the  
32 drug is being prescribed for the treatment of substance abuse.
- 33 (4) Emergency room services.
- 34 (5) Physician office services.
- 35 (6) Diagnostic services.
- 36 (7) Outpatient services, including therapy services.
- 37 (8) Comprehensive disease management.
- 38 (9) Home health services, including case management.
- 39 (10) Urgent care center services.
- 40 (11) Preventative care services.
- 41 (12) Family planning services:  
42 (A) including contraceptives and sexually transmitted

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- 1 disease testing, as described in federal Medicaid law (42  
 2 U.S.C. 1396 et seq.); and  
 3 (B) not including abortion or abortifacients.  
 4 (13) Hospice services.  
 5 (14) Substance abuse services.  
 6 (15) Donated breast milk that meets requirements developed by  
 7 the office of Medicaid policy and planning.  
 8 (16) A service determined by the secretary to be required by  
 9 federal law as a benchmark service under the federal Patient  
 10 Protection and Affordable Care Act.  
 11 (b) The plan may not permit treatment limitations or financial  
 12 requirements on the coverage of mental health care services or  
 13 substance abuse services if similar limitations or requirements are not  
 14 imposed on the coverage of services for other medical or surgical  
 15 conditions.  
 16 (c) The plan may provide vision services and dental services only  
 17 to individuals who regularly make the required monthly contributions  
 18 for the plan as set forth in section 4.7(c) of this chapter.  
 19 (d) The benefit package offered in the plan:  
 20 (1) must be benchmarked to a commercial health plan described  
 21 in 45 CFR 155.100(a)(1) or 45 CFR 155.100(a)(4); and  
 22 (2) may not include a benefit that is not present in at least one (1)  
 23 of these commercial benchmark options.  
 24 (e) The office shall provide to an individual who participates in the  
 25 plan a list of health care services that qualify as preventative care  
 26 services for the age, gender, and preexisting conditions of the  
 27 individual. The office shall consult with the federal Centers for Disease  
 28 Control and Prevention for a list of recommended preventative care  
 29 services.  
 30 (f) The plan shall, at no cost to the individual, provide payment of  
 31 preventative care services described in 42 U.S.C. 300gg-13 for an  
 32 individual who participates in the plan.  
 33 (g) The plan shall, at no cost to the individual, provide payments  
 34 of not more than five hundred dollars (\$500) per year for preventative  
 35 care services not described in subsection (f). Any additional  
 36 preventative care services covered under the plan and received by the  
 37 individual during the year are subject to the deductible and payment  
 38 requirements of the plan.  
 39 ~~(h) The office shall apply to the United States Department of~~  
 40 ~~Health and Human Services for any amendment to the waiver~~  
 41 ~~necessary to implement the providing of the services or supplies~~  
 42 ~~described in subsection (a)(15). This subsection expires July 1, 2024.~~

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SECTION 19. 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

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- 1 IC 16-21-10-13.3(b)(1) to cover the amount of the  
 2 reduction in fees; or  
 3 (ii) if applicable, the fee formula used to fund the  
 4 reimbursement for inpatient and outpatient hospital  
 5 services under IC 16-21-10-8.5 to cover the amount of  
 6 the reduction in fees; and  
 7 (C) office does not use alternative financial support to cover  
 8 the amount of the reduction in fees.  
 9 (3) The Medicaid waiver approving the plan is revoked,  
 10 rescinded, vacated, or otherwise altered in a manner that the  
 11 state cannot comply with the requirements of this chapter.  
 12 (c) If federal financial participation for recipients covered under  
 13 the plan is less than ninety percent (90%), the ~~office~~ **secretary** may  
 14 terminate the plan in accordance with section 6(b) of this chapter.  
 15 (d) If the plan is terminated under subsection (b), the secretary  
 16 may implement a plan for coverage of the affected population in a  
 17 manner consistent with the healthy Indiana plan (IC 12-15-44.2 (before  
 18 its repeal)) in effect on January 1, 2014:  
 19 (1) subject to prior approval of the United States Department of  
 20 Health and Human Services; and  
 21 (2) using funding from the incremental fee set forth in  
 22 IC 16-21-10-13.3.  
 23 (e) The ~~office~~ **secretary** may not operate the plan in a manner that  
 24 would obligate the state to financial participation beyond the level of  
 25 state appropriations or funding otherwise authorized for the plan.  
 26 (f) The office of the secretary shall submit annually to the budget  
 27 committee an actuarial analysis of the plan that reflects a determination  
 28 that sufficient funding is reasonably estimated to be available to  
 29 operate the plan.  
 30 SECTION 20. IC 12-15-44.5-4.2, AS ADDED BY P.L.126-2025,  
 31 SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE  
 32 UPON PASSAGE]: Sec. 4.2. (a) Notwithstanding section 3 of this  
 33 chapter, the ~~office of the~~ secretary shall amend the Medicaid state plan  
 34 to not include individuals described in 42 CFR 435.119. The ~~office of~~  
 35 ~~the~~ secretary shall delay the effective date of the amendment to not  
 36 later than upon the completion of negotiations with the United States  
 37 Department of Health and Human Services for a 3.0 plan waiver and  
 38 an approved implementation of the waiver.  
 39 (b) The ~~office of the~~ secretary shall continue to operate the plan,  
 40 as in effect on January 1, 2025, until the effective date of a 3.0 plan  
 41 waiver authorized by the United States Department of Health and  
 42 Human Services or the expiration, termination, or vacatur of the waiver

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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 21. 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 22. 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:

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- 1 (1) one-twelfth (1/12) of the annual income contribution amount;  
 2 or  
 3 (2) ten dollars (\$10);  
 4 is made to the individual's health care account established under  
 5 section 4.5 of this chapter for the individual's participation in the plan.  
 6 To continue to participate in the plan, an individual must contribute to  
 7 the individual's health care account at least two percent (2%) of the  
 8 individual's annual household income per year or an amount  
 9 determined by the secretary that is based on the individual's annual  
 10 household income per year, but not less than one dollar (\$1) per month.  
 11 The amount determined by the secretary under this subsection must be  
 12 approved by the United States Department of Health and Human  
 13 Services and must be budget neutral to the state as determined by the  
 14 state budget agency.
- 15 (d) If an applicant who is approved to participate in the plan fails  
 16 to make the initial payment into the individual's health care account, at  
 17 least the following must occur:
- 18 (1) If the individual has an annual income that is at or below one  
 19 hundred percent (100%) of the federal poverty income level, the  
 20 individual's benefits are reduced as specified in subsection  
 21 (e)(1).  
 22 (2) If the individual has an annual income of more than one  
 23 hundred percent (100%) of the federal poverty income level, the  
 24 individual is not enrolled in the plan.
- 25 (e) If an enrolled individual's required monthly payment to the  
 26 plan is not made within sixty (60) days after the required payment date,  
 27 the following, at a minimum, occur:
- 28 (1) For an individual who has an annual income that is at or  
 29 below one hundred percent (100%) of the federal income  
 30 poverty level, the individual is:
- 31 (A) transferred to a plan that has a material reduction in  
 32 benefits, including the elimination of benefits for vision and  
 33 dental services; and  
 34 (B) required to make copayments for the provision of  
 35 services that may not be paid from the individual's health  
 36 care account.
- 37 (2) For an individual who has an annual income of more than  
 38 one hundred percent (100%) of the federal poverty income level,  
 39 the individual shall be terminated from the plan and may not  
 40 reenroll in the plan for at least six (6) months.
- 41 (f) The state shall contribute to the individual's health care account  
 42 the difference between the individual's payment required under this

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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 23. 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

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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



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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 24. 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 25. 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 26. 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

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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 27. 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

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1 **secretary** shall, if required, provide notice of termination of the plan  
 2 to the United States Department of Health and Human Services and  
 3 begin the process of phasing out the plan.

4 (c) Before submitting:

5 (1) an extension of; or

6 (2) a material amendment to;

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

10 SECTION 28. IC 12-15-44.5-8, AS AMENDED BY  
 11 P.L.152-2017, SECTION 35, IS AMENDED TO READ AS  
 12 FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. The following  
 13 requirements apply to funds appropriated by the general assembly to  
 14 the plan and the incremental fee used for purposes of IC 16-21-10-13.3:

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

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

18 (A) administrative costs of; and

19 (B) any profit made by;

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

24 SECTION 29. IC 12-15-44.5-9, AS AMENDED BY P.L.93-2024,  
 25 SECTION 113, IS AMENDED TO READ AS FOLLOWS  
 26 [EFFECTIVE UPON PASSAGE]: Sec. 9. The ~~office~~ **secretary** may  
 27 adopt rules under IC 4-22-2 necessary to implement:

28 (1) this chapter; or

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

32 SECTION 30. IC 12-15-44.5-10, AS AMENDED BY  
 33 P.L.126-2025, SECTION 13, IS AMENDED TO READ AS  
 34 FOLLOWS [EFFECTIVE JANUARY 1, 2027]: Sec. 10. (a) The  
 35 secretary has the authority to provide benefits to individuals eligible  
 36 under the adult group described in 42 CFR 435.119 only in accordance  
 37 with this chapter.

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

41 (c) The secretary may negotiate and make changes to the plan,  
 42 except that the secretary may not negotiate or change the plan in a way

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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.**

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(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 31. P.L.213-2025, SECTION 25, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026 (RETROACTIVE)]: SECTION 25. Except as provided for under IC 4-12-18 **and IC 12-8-15**, the governor of the state of Indiana is solely authorized to accept on behalf of the state any and all federal funds available to the state of Indiana. Federal funds received under this SECTION are appropriated for purposes specified by the federal government, subject to allotment by the budget agency. The provisions of this SECTION and all other SECTIONS concerning the acceptance, disbursement, review, and approval of any grant, loan, or gift made by the federal government or any other source to the state or its agencies and political subdivisions shall apply, notwithstanding any other law.

SECTION 32. P.L.213-2025, SECTION 26, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2026 (RETROACTIVE)]: SECTION 26. Except as provided for under IC 4-12-18 **and IC 12-8-15**, federal funds received as revenue by a state agency or department are not available to the agency or department for expenditure until allotment has been made by the budget agency under IC 4-12-1-12(d).

SECTION 33. **An emergency is declared for this act.**

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