SENATE BILL No. 180

AM018006 has been incorporated into introduced printing.

Synopsis: Various health care 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. 180

A BILL FOR AN ACT to amend the Indiana Code concerning health.

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

SECTION 1. IC 12-8-1.6-2, AS ADDED BY P.L.174-2025, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 2. (a) As used in this chapter, "home and community based services waiver" refers to a federal Medicaid waiver granted to the state under 42 U.S.C. 1396n(c) to provide home and community based long term care services and supports to individuals with disabilities **and the elderly.**

(b) The term does not include home and community services offered as part of the approved Medicaid state plan.

SECTION 2. IC 12-8-1.6-4, AS ADDED BY P.L.174-2025, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 4. (a) The office of the secretary has all powers necessary and convenient to administer a home and community based services waiver.

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

(1) Administer money appropriated or allocated to the office of the secretary by the state, including money appropriated or allocated for a home and community based services waiver.

(2) Take any action necessary to implement a home and community based services waiver, including applying to the United States Department of Health and Human Services for approval to amend or renew the waiver, implement a new Medicaid waiver, or amend the Medicaid state plan.

(3) Ensure that a home and community based services waiver is subject to funding available to the office of the secretary.

(4) Ensure, in coordination with the budget agency, that the cost of a home and community based services waiver does not exceed the total amount of funding available by the budget agency, including state and federal funds, for the Medicaid programs established to provide services under a home and community based services waiver.

(5) Establish and administer a program for a home and community based services waiver, **including the assisted living waiver described in IC 12-15-1.3-26,** to provide an eligible individual with care that does not cost more than services provided to a similarly situated individual residing in an institution.

(6) Within the limits of available resources, provide service coordination services to individuals receiving services under a home and community based services waiver, including the development of an individual service plan that:

(A) addresses an individual's needs;

(B) identifies and considers family and community resources that are potentially available to meet the individual's needs; and

(C) is consistent with the person centered care approach for receiving services under a waiver.

(7) Monitor services provided by a provider that:

(A) provides services to an individual using funds provided by the office of the secretary or under the authority of the office of the secretary; or

(B) entered into one (1) or more provider agreements to provide services under a home and community based services waiver.

(8) Establish and administer a confidential complaint process for:

(A) an individual receiving; or

(B) a provider described in subdivision (7) providing;

services under a home and community based services waiver.

(c) The office of the secretary may do the following:

(1) At the office's discretion, delegate any of its authority under this chapter to any division or office within the office of the secretary.

(2) Issue administrative orders under IC 4-21.5-3-6 regarding the provision of a home and community based services waiver.

SECTION 3. IC 12-8-1.6-9, AS ADDED BY P.L.174-2025, SECTION 14, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 9. A home and community based services waiver, including the delivery and receipt of services provided under the home and community based services waiver, must meet the following requirements:

(1) Be provided under public supervision.

(2) Be individualized and designed to meet the needs of individuals eligible to receive services under the home and community based services waiver.

(3) Meet applicable state and federal standards.

(4) Be provided by qualified personnel.

(5) Be provided, to the extent appropriate, with services provided under the home and community based services waiver that are provided in a home and community based setting where nonwaiver individuals receive services.

(6) Be provided in accordance with an individual's:

(A) service plan; **and**

(B) choice of provider of waiver services.

SECTION 4. IC 12-8-1.6-10, AS AMENDED BY THE TECHNICAL CORRECTIONS BILL OF THE 2026 GENERAL ASSEMBLY, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 10. (a) This section applies to **the following:**

(1) A home and community based services waiver that included assisted living services as an available service before July 1, 2025.

(2) An assisted living waiver described in IC 12-15-1.3-26.

(b) As used in this section, "office" includes the following:

(1) The office of the secretary of family and social services.

(2) A managed care organization that has contracted with the office of Medicaid policy and planning under IC 12-15.

(3) A person that has contracted with a managed care

organization described in subdivision (2).

(c) Under a home and community based services waiver that provides services to an individual who is aged or disabled, the office shall reimburse for the following services provided to the individual by a provider of assisted living services, if included in the individual's home and community based ~~service~~ **services** plan:

(1) Assisted living services.

(2) Integrated health care coordination.

(3) Transportation.

(d) If the office approves an increase in the level of services for a recipient of assisted living services, the office shall reimburse the provider of assisted living services for the level of services for the increase as of the date that the provider has documentation of providing the increase in the level of services.

(e) The office may reimburse for any home and community based services provided to a Medicaid recipient beginning on the date of the individual's Medicaid application.

(f) The office may not do any of the following concerning assisted living services provided in a home and community based services program:

(1) Require the installation of a sink in the kitchenette within any living unit of an entity that participated in the Medicaid home and community based services program before July 1, 2018.

(2) Require all living units within a setting that provides assisted living services to comply with physical plant requirements that are applicable to individual units occupied by a Medicaid recipient.

(3) Require a provider to offer only private rooms.

(4) Require a housing with services establishment provider to provide housing when:

(A) the provider is unable to meet the health needs of a resident without:

(i) undue financial or administrative burden; or

(ii) fundamentally altering the nature of the provider's operations; and

(B) the resident is unable to arrange for services to meet the resident's health needs.

(5) Require a housing with services establishment provider to separate an agreement for housing from an agreement for services.

(6) Prohibit a housing with services establishment provider from

offering studio apartments with only a single sink in the unit.

(7) Preclude the use of a shared bathroom between adjoining or shared units if the participants consent to the use of a shared bathroom.

(8) Reduce the scope of services that may be provided by a provider of assisted living services under the aged and disabled Medicaid waiver in effect on July 1, 2021.

(g) A Medicaid recipient who has a home and community based services plan that includes:

(1) assisted living services; and

(2) integrated health care coordination;

shall choose whether the provider of assisted living services or the office provides the integrated health care coordination to the recipient.

(h) Integrated health care coordination provided by a provider of assisted living services under this section is not duplicative of any services provided by the office.

~~(g)~~ **(i)** The office of the secretary may adopt rules under IC 4-22-2 that establish the right, and an appeals process, for a resident to appeal a provider's determination that the provider is unable to meet the health needs of the resident as described in subsection (f)(4). The process:

(1) must require an objective third party to review the provider's determination in a timely manner; and

(2) may not be required if the provider is licensed by the Indiana department of health and the licensure requirements include an appellate procedure for such a determination.

SECTION 5. IC 12-15-1.3-26 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 26. (a) Not later than September 1, 2026, the office of the secretary shall apply to the United States Department of Health and Human Services for a Medicaid waiver to provide assisted living services effective July 1, 2026, in a waiver separate from the Medicaid home and community based services waiver that included assisted living services as an available service before July 1, 2026.**

(b) The office of the secretary shall establish a work group of interested stakeholders to assist in the development and implementation of the waiver described in subsection (a). The governor shall appoint the members of the work group and include providers of assisted living services as members of the work group.

SECTION 6. IC 12-15-13-1.8, AS AMENDED BY P.L.213-2025, SECTION 112, IS AMENDED TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2026]: Sec. 1.8. (a) As used in this section, "covered population" means all Medicaid recipients who meet the criteria set forth in subsection (b).

(b) **Except as provided in subsection (e),** an individual is a member of the covered population if the individual:

(1) is eligible to participate in the federal Medicare program (42 U.S.C. 1395 et seq.) and receives nursing facility services; or

(2) is:

(A) at least sixty (60) years of age;

(B) blind, aged, or disabled; and

(C) receiving services through one (1) of the following:

(i) The aged and disabled Medicaid waiver.

(ii) A risk based managed care program for aged, blind, or disabled individuals who are not eligible to participate in the federal Medicare program.

(iii) The state Medicaid plan.

(c) The office of the secretary may implement a risk based managed care program for the covered population.

(d) Any managed care organization that participates in the risk based managed care program under subsection (c) that fails to pay a claim submitted by a nursing facility provider for payment under the program later than:

(1) twenty-one (21) days, if the claim was electronically filed; or

(2) thirty (30) days, if the claim was filed on paper;

from receipt by the managed care organization shall pay a penalty of five hundred dollars ($500) per calendar day per claim.

(e) Upon an individual receiving nursing facility services for a consecutive period of one hundred (100) days, the individual is no longer a member of the covered population. An individual who was part of the covered population is no longer part of the covered population on the one hundredth day and shall receive Medicaid services under a fee for service program.

SECTION 7. IC 16-18-2-146.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 146.5. "Generative artificial intelligence", for purposes of IC 16-51-3, has the meaning set forth in IC 16-51-3-2.**

SECTION 8. IC 16-18-2-163, AS AMENDED BY P.L.179-2022(ss), SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 163. (a) Except as provided in subsection (c), "health care provider", for purposes of

IC 16-21 and IC 16-41, means any of the following:

(1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or legally authorized by this state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), a dentist, a registered or licensed practical nurse, a midwife, an optometrist, a pharmacist, a podiatrist, a chiropractor, a physical therapist, a respiratory care practitioner, an occupational therapist, a psychologist, a paramedic, an emergency medical technician, an advanced emergency medical technician, an athletic trainer, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.

(2) A college, university, or junior college that provides health care to a student, a faculty member, or an employee, and the governing board or a person who is an officer, employee, or agent of the college, university, or junior college acting in the course and scope of the person's employment.

(3) A blood bank, community mental health center, community intellectual disability center, community health center, or migrant health center.

(4) A home health agency (as defined in IC 16-27-1-2).

(5) A health maintenance organization (as defined in IC 27-13-1-19).

(6) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).

(7) A corporation, partnership, or professional corporation not otherwise qualified under this subsection that:

(A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;

(B) is organized or registered under state law; and

(C) is determined to be eligible for coverage as a health care provider under IC 34-18 for the corporation's, partnership's, or professional corporation's health care function.

Coverage for a health care provider qualified under this subdivision is limited to the health care provider's health care functions and does not extend to other causes of action.

(b) "Health care provider", for purposes of IC 16-35, has the meaning set forth in subsection (a). However, for purposes of IC 16-35,

the term also includes a health facility (as defined in section 167 of this chapter).

(c) "Health care provider", for purposes of IC 16-32-5, IC 16-36-5, IC 16-36-6, and IC 16-41-10 means an individual licensed or authorized by this state to provide health care or professional services as:

(1) a licensed physician;
(2) a registered nurse;
(3) a licensed practical nurse;
(4) an advanced practice registered nurse;
(5) a certified nurse midwife;
(6) a paramedic;
(7) an emergency medical technician;
(8) an advanced emergency medical technician;
(9) an emergency medical responder, as defined by section 109.8 of this chapter;
(10) a licensed dentist;
(11) a home health aide, as defined by section 174 of this chapter; or
(12) a licensed physician assistant.

The term includes an individual who is an employee or agent of a health care provider acting in the course and scope of the individual's employment.

(d) "Health care provider", for purposes of IC 16-36-7, has the meaning set forth in IC 16-36-7-12.

(e) "Health care provider", for purposes of IC 16-40-4, means any of the following:

(1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or authorized by the state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), an ambulatory outpatient surgical center, a dentist, an optometrist, a pharmacist, a podiatrist, a chiropractor, a psychologist, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.
(2) A blood bank, laboratory, community mental health center, community intellectual disability center, community health center, or migrant health center.

(3) A home health agency (as defined in IC 16-27-1-2).

(4) A health maintenance organization (as defined in IC 27-13-1-19).

(5) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).

(6) A corporation, partnership, or professional corporation not otherwise specified in this subsection that:

(A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;

(B) is organized or registered under state law; and

(C) is determined to be eligible for coverage as a health care provider under IC 34-18 for the corporation's, partnership's, or professional corporation's health care function.

(7) A person that is designated to maintain the records of a person described in subdivisions (1) through (6).

(f) "Health care provider", for purposes of IC 16-45-4, has the meaning set forth in 47 CFR 54.601(a).

(g) "Health care provider", for purposes of IC 16-51-3, has the meaning set forth in IC 16-51-3-3.

SECTION 9. IC 16-18-2-167.9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 167.9. "Health plan", for purposes of IC 16-51-3, has the meaning set forth in IC 16-51-3-4.**

SECTION 10. IC 16-18-2-187.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 187.4. "Indiana user", for purposes of IC 16-51-3, has the meaning set forth in IC 16-51-3-5.**

SECTION 11. IC 16-18-2-188.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 188.4. "Individually identifiable health information", for purposes of IC 16-51-3, has the meaning set forth in IC 16-51-3-6.**

SECTION 12. IC 16-18-2-225.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 225.5. "Mental health chat bot", for purposes of IC 16-51-3, has the meaning set forth in IC 16-51-3-7.**

SECTION 13. IC 16-18-2-264 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 264. **(a)** "Operator", for purposes of IC 16-41-31, has the meaning set forth in IC 16-41-31-4.

(b) "Operator", for purposes of IC 16-51-3, has the meaning

set forth in IC 16-51-3-8.

SECTION 14. IC 16-18-2-362.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 362.2. "User input", for purposes of IC 16-51-3, has the meaning set forth in IC 16-51-3-9.**

SECTION 15. IC 16-27.5-5-5, AS ADDED BY P.L.143-2025, SECTION 24, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE SEPTEMBER 1, 2025 (RETROACTIVE)]: Sec. 5. ~~(a)~~ A home health aide competency evaluation program must:

(1) operate in accordance with 42 CFR 484.80; and

(2) address each topic described in section 4(a) of this chapter.

~~(b) A home health aide competency evaluation program must include at least seventy-five (75) hours of training. At least sixteen (16) hours of classroom training must occur before supervised practical training.~~

SECTION 16. IC 16-41-14-17 IS REPEALED [EFFECTIVE JULY 1, 2026]. ~~Sec. 17. (a) This section does not apply to a person who transfers for research purposes semen that contains antibodies for the human immunodeficiency virus (HIV).~~

~~(b) A person who, for the purpose of artificial insemination, recklessly, knowingly, or intentionally donates, sells, or transfers semen that contains antibodies for the human immunodeficiency virus (HIV) commits transferring contaminated semen, a Level 5 felony. The offense is a Level 4 felony if the offense results in the transmission of the virus to another person.~~

SECTION 17. IC 16-51-3 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]:

Chapter 3. Mental Health Chat Bots

Sec. 1. As used in this chapter, "artificial intelligence" has the meaning set forth in IC 4-13.1-5-1.

Sec. 2. As used in this chapter, "generative artificial intelligence" means an artificial intelligence technology system that:

(1) is trained on data;

(2) is designed to simulate human conversation with a consumer through:

(A) text;

(B) audio;

(C) visual communication; or

(D) any combination of communication described in clauses (A) through (C); and

(3) generates, with limited or no human oversight, nonscripted output that is similar to output created by a human.

Sec. 3. As used in this chapter, "health care provider" has the meaning set forth in 45 CFR 160.103.

Sec. 4. As used in this chapter, "health plan" has the meaning set forth in 45 CFR 160.103.

Sec. 5. As used in this chapter, "Indiana user" means an individual located in Indiana at the time the individual accesses or uses a mental health chat bot.

Sec. 6. As used in this chapter, "individually identifiable health information" refers to information relating to the physical or mental health of an individual.

Sec. 7. (a) As used in this chapter, "mental health chat bot" means an artificial intelligence application that:

(1) uses generative artificial intelligence to engage in interactive conversations with a user of the application in a manner that is similar to the confidential communication that an individual would have with a mental health professional; and

(2) an operator represents or a reasonable person would believe is capable of:

(A) providing mental health services to a user; or

(B) helping a user manage or treat a mental health condition.

(b) The term does not include artificial intelligence technology that only:

(1) provides scripted output, such as a guided meditation or a mindfulness exercise; or

(2) analyzes a user's input to connect the user with a mental health professional.

Sec. 8. As used in this chapter, "operator" refers to a person who operates a mental health chat bot.

Sec. 9. As used in this chapter, "user input" means content provided to a mental health chat bot by an Indiana user.

Sec. 10. (a) This section does not apply to individually identifiable health information that is:

(1) requested by a health care provider with the consent of an Indiana user; or

(2) upon request by an Indiana user, provided to a health plan of the Indiana user.

(b) Except as provided in section 11 of this chapter, an

operator may not share with or sell to a third party the following:

(1) Individually identifiable health information of an Indiana user.

(2) User input.

Sec. 11. (a) If necessary to ensure the effective functionality of the mental health chat bot, an operator may share individually identifiable health information of an Indiana user with a person with whom the operator has contracted concerning the functioning of the mental health chat bot.

(b) In sharing the information described in subsection (a), an operator shall comply with 45 CFR Part 160 and 45 CFR Part 164, Subparts A and E applicable to a:

(1) covered entity; and

(2) business associate;

as defined in 45 CFR 160.103.

Sec. 12. (a) An operator may not use a mental health chat bot to advertise a product or service to an Indiana user unless the operator clearly and conspicuously:

(1) identifies the product or service as an advertisement; and

(2) discloses to the Indiana user any:

(A) sponsorship by;

(B) business affiliation with; or

(C) agreement with;

a third party to promote, advertise, or recommend the product or service.

(b) An operator may not utilize user input to determine:

(1) whether to display an advertisement for a product or service other than the mental health chat bot to the Indiana user;

(2) a product, service, or category of product or service to advertise to the Indiana user; or

(3) customizations to how an advertisement is displayed to an Indiana user.

(c) This section does not prohibit a mental health chat bot from providing a recommendation for counseling, mental health services, or other assistance from a licensed professional to the Indiana user.

Sec. 13. (a) An operator shall clearly and conspicuously disclose in the mental health chat bot that the mental health chat bot is:

(1) artificial intelligence technology; and

(2) not a human.

(b) The disclosure described in subsection (a) must be provided:

(1) before an Indiana user accesses the mental health chat bot;

(2) if an Indiana user has not accessed the mental health chat bot in the preceding seven (7) days, at the beginning of any interaction between the mental health chat bot and the Indiana user; and

(3) when an Indiana user asks or otherwise prompts the mental health chat bot about whether artificial intelligence is being used.

Sec. 14. If an operator violates this chapter, the attorney general may bring an action to obtain any of the following against the operator:

(1) Injunctive relief.

(2) A civil penalty of not more than two thousand five hundred dollars ($2,500).

(3) The attorney general's reasonable costs of:

(A) the investigation of the violation; and

(B) maintaining the action.

(4) Other appropriate relief.

Sec. 15. If the attorney general has reasonable cause to believe that any person has violated this chapter, the attorney general may issue a civil investigative demand under IC 4-6-3-3.

SECTION 18. IC 25-1-23.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]:

Chapter 23.5. Use of Artificial Intelligence Systems

Sec. 1. As used in this chapter, "artificial intelligence system" means a machine based system that, for explicit or implicit objectives, infers from the input it receives how to generate outputs, including:

(1) predictions;

(2) content;

(3) recommendations; or

(4) decisions;

that can influence physical or virtual environments. The term includes generative artificial intelligence.

Sec. 2. As used in this chapter, "generative artificial intelligence" means an automated computing system that, when prompted with human prompts, descriptions, or queries, can produce outputs that simulate human product content, including:

(1) textual outputs, such as short answers, essays, poetry, or longer compositions or answers;

(2) image outputs, such as fine art, photographs, conceptual art, diagrams, and other images;

(3) multimedia outputs, such as audio or video in the form of compositions, songs, or short-form or long-form audio or video; and

(4) other content that would otherwise be produced by human means.

Sec. 3. (a) As used in this chapter, except as provided in subsection (b), "licensed practitioner" means an individual who holds a license issued by a board described in IC 25-0.5-11.

(b) The term does not include a veterinarian licensed under IC 25-38.1.

Sec. 4. A person or entity may not use an artificial intelligence system to:

(1) impersonate; or

(2) act as a substitute for;

a licensed practitioner during any interaction that is required to be performed by the licensed practitioner.

Sec. 5. A licensed practitioner who violates this chapter is subject to disciplinary action under IC 25-1-9.

SECTION 19. IC 25-13-1-4, AS AMENDED BY P.L.103-2011, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 4. (a) Any person desiring to practice dental hygiene in Indiana must procure from the board a license to practice dental hygiene. To procure a license, the applicant must submit to the board proof of graduation from an institution ~~for educating dental hygienists that is approved by the board~~ **described in section 6(2) of this chapter** and other credentials required by this chapter, together with an application on forms prescribed and furnished by the board. Each applicant must pay to the board an application fee set by the board under section 5 of this chapter at the time the application is made and must pass an examination administered by an entity approved by the board. The board may establish under section 5 of this chapter additional requirements as a prerequisite to taking an examination for any applicant who has failed the examination two (2) or more times. Application fees are not refundable.

(b) An applicant described under subsection (a) shall, at the request of the board, make an appearance before the board.

SECTION 20. IC 25-13-1-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 5. (a) The board shall

enforce this chapter.

(b) The board may adopt rules consistent with this chapter and with IC 25-14-1 necessary for the proper enforcement of this chapter, the examination of dental hygienists, **the educational requirements described in section 6(2) of this chapter,** and ~~for~~ the conduct of the practice of dental hygiene.

(c) The board may utilize a dental hygienist education program's accreditation by the Commission on Dental Accreditation of the American Dental Association as evidence that the program has met all or part of the standards for dental hygienist education programs established by the board.

SECTION 21. IC 25-13-1-6, AS AMENDED BY P.L.264-2013, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 6. An applicant:

(1) must not have been convicted of a crime that has a direct bearing on the applicant's ability to practice competently;

(2) must be a graduate of a:

(A) school for dental hygienists that:

~~(A)~~ **(i)** is accredited by the Commission on Dental Accreditation of the American Dental Association;

~~(B)~~ **(ii)** is recognized by the board; and

~~(C)~~ **(iii)** requires a formal course of training of not less than two (2) years of eight (8) months each; **or**

(B) dental college in a foreign country with a degree that is substantially similar to a doctorate of:

(i) dental surgery; or

(ii) dental medicine;

determined and approved by the board;

(3) must pass an examination administered by an entity approved by the board; ~~and~~

(4) may not take the examination described in subdivision (3) more than three (3) times; **and**

(5) if the applicant is a graduate of a dental college described in subdivision (2), must submit the applicant's academic transcripts for review by the board.

SECTION 22. IC 25-13-1-10.7, AS ADDED BY P.L.35-2020, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 10.7. (a) A dental hygienist or dental assistant (as defined in IC 25-14-1-1.5(4)) may administer nitrous oxide under the direct supervision of a licensed dentist if the dental hygienist or dental assistant has:

(1) **either:**

(A) been employed in a dental practice for at least one (1) year; or

(B) ~~has~~ graduated from a program:

(i) accredited by the Commission on Dental Accreditation of the American Dental Association; **or**

(ii) approved by the board;

(2) satisfactorily completed a three (3) hour didactic nitrous oxide administration course **that:**

(A) ~~containing~~ **contains** curriculum on pharmacology, biochemistry, anatomy of nitrous oxide administration, emergency procedures, and the mechanics of operating a nitrous unit; **and**

(B) is accredited by the Commission on Dental Accreditation of the American Dental Association **or approved by the board;** and

(3) demonstrated clinical competency on at least five (5) patients under the direct supervision of a licensed Indiana dentist whose license is in good standing.

(b) The licensed Indiana dentist supervising the clinical competency under subsection (a)(3) shall provide to the dental hygienist or dental assistant a signed affidavit certifying the competency.

(c) Upon receipt of the affidavit provided to a dental hygienist or dental assistant under subsection (b), the provider of an educational program or curriculum described in subsection (a)(2) shall issue a certificate of completion to the dental hygienist or dental assistant. The certificate of completion must be publicly displayed in the dental office of the dental hygienist or dental assistant.

(d) Before permitting a dental hygienist or dental assistant to administer nitrous oxide, the supervising dentist shall:

(1) verify that the dental hygienist or dental assistant has completed the requirements of subsection (a);

(2) determine the maximum percent-dosage of nitrous oxide to be administered to the patient; and

(3) ensure that any administration or monitoring of nitrous oxide by dental hygienists or dental assistants is done in accordance with relevant guidelines and standards developed by the American Dental Association or the American Academy of Pediatric Dentistry.

SECTION 23. IC 25-14-1-3, AS AMENDED BY P.L.264-2013,

SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 3. (a) A person desiring to begin the practice of dentistry in Indiana shall procure from the board a license to practice dentistry in Indiana. Except as provided in section 4.5 of this chapter, to procure the license, the applicant must submit to the board proof of graduation from a dental college recognized by the board. The board may recognize dental schools accredited by the Commission on Dental Accreditation of the American Dental Association, if the board is satisfied that the recognition is consistent with the board's requirements. Every applicant must pass an examination administered by an entity approved by the board and, **except as provided in subsection (b),** may not take the examination more than three (3) times.

(b) The board may establish additional requirements for an applicant who has failed the examination at least three (3) times. The applicant must complete the additional requirements before the applicant may take the examination again.

~~(b)~~ **(c)** A fee paid under this article may not be refunded.

SECTION 24. IC 27-1-37-11, AS ADDED BY P.L.215-2025, SECTION 52, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 11. The department shall do the following:

(1) Require health carriers to meet network adequacy standards that are no less stringent than the network adequacy standards established by the Centers for Medicare and Medicaid Services.

(2) When assessing whether a health carrier has met the network adequacy standards, consider the availability and variety of independent specialty providers that provide services within in network provider facilities in the health carrier's network.

(3) Require a health carrier to provide proof that the health carrier meets the network adequacy standards on an annual basis.

(4) Contract with an objective third party to verify that health carriers are in compliance with the network adequacy standards.

SECTION 25. IC 27-1-37.1-5 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 5. A person who enters into a health provider contract with a provider shall provide written notice to the provider of any amendment to the health provider contract not less than ~~forty-five (45)~~ **sixty (60)** days before the proposed effective date of the amendment.

SECTION 26. IC 27-1-37.1-5.5 IS ADDED TO THE INDIANA

CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 5.5. Before an amendment to a health provider contract that makes a material change or reduces the reimbursement rate for any CPT code (as defined in IC 27-8-5.7-2.5) goes into effect, a person shall obtain either:**

(1) the department's approval of the amendment; or

(2) the provider's approval of the amendment and the provider's signature.

SECTION 27. IC 27-1-52.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]:

Chapter 52.1. Downcoding of Health Benefits Claims

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

Sec. 2. As used in this chapter, "downcoding" means the adjustment of a health benefits claim by an insurer to a less complex or lower cost service to reimburse a provider in an amount less than the required amount under the provider contract. The term includes the use of remark codes.

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

Sec. 4. As used in this chapter, "health plan" means the following:

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

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

Sec. 5. As used in this chapter, "insurer" means the following:

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

(2) A health maintenance organization (as defined in IC 27-13-1-19) that provides coverage for basic health care services (as defined in IC 27-13-1-4) under an individual contract (as defined in IC 27-13-1-21) or a group contract (as defined in IC 27-13-1-16).

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

Sec. 7. Notwithstanding any other law or regulation to the contrary, an insurer may not use downcoding in a manner that prevents a provider from:

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

(2) collecting reimbursement from the insurer for the actual service performed.

Sec. 8. The department shall adopt rules under IC 4-22-2 to carry out this chapter.

SECTION 28. IC 27-8-5-15.8, AS ADDED BY P.L.103-2020, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 15.8. (a) As used in this section, "treatment of a mental illness or substance abuse" means:

(1) treatment for a mental illness, as defined in IC 12-7-2-130(1); and

(2) treatment for drug abuse or alcohol abuse.

(b) As used in this section, "act" refers to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 and any amendments thereto, plus any federal guidance or regulations relevant to that act, including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).

(c) As used in this section, "nonquantitative treatment limitations" refers to those limitations described in 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR 146.136.

(d) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for treatment of a mental illness or substance abuse shall submit a report to the department not later than December 31 of each year that contains the following information:

(1) A description of the processes:

(A) used to develop or select the medical necessity criteria for coverage of services for treatment of a mental illness or substance abuse; and

(B) used to develop or select the medical necessity criteria for coverage of services for treatment of other medical or surgical conditions.

(2) Identification of all nonquantitative treatment limitations that are applied to:

(A) coverage of services for treatment of a mental illness or

substance abuse; and

(B) coverage of services for treatment of other medical or surgical conditions;

within each classification of benefits.

(3) The reimbursement rates for providers of mental illness or substance abuse services relative to Medicare rates and the reimbursement rates for providers of medical or surgical services relative to Medicare rates in the respective classification of benefits.

(e) There may be no separate nonquantitative treatment limitations that apply to coverage of services for treatment of a mental illness or substance abuse that do not apply to coverage of services for treatment of other medical or surgical conditions within any classification of benefits.

(f) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for treatment of a mental illness or substance abuse shall also submit an analysis showing the insurer's compliance with this section and the act to the department not later than December 31 of each year. The analysis must do the following:

(1) Identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected.

(2) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation.

(3) Provide the comparative analyses, including the results of the analyses, performed to determine the following:

(A) That the processes and strategies used to design each nonquantitative treatment limitation for coverage of services for treatment of a mental illness or substance abuse are comparable to, and applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation for coverage of services for treatment of other medical or surgical conditions.

(B) That the processes and strategies used to apply each nonquantitative treatment limitation for treatment of a mental illness or substance abuse are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative limitation for treatment of other medical or surgical conditions.

(g) This subsection applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2026. An insurer that issues a policy of accident and sickness insurance that provides coverage of services for treatment of a mental illness or substance abuse shall reimburse providers of mental illness or substance abuse services at rates that are at least as favorable relative to Medicare rates as reimbursement rates are for providers of medical or surgical services relative to Medicare rates in the respective classification of benefits.

~~(g)~~ **(h)** The department shall adopt rules to ensure compliance with this section and the applicable provisions of the act.

SECTION 29. IC 27-8-5.7-0.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 0.5. Section 6.7 of this chapter, as added in the 2026 session of the general assembly, and sections 10 and 11 of this chapter, as amended in the 2026 session of the general assembly, apply to an accident and sickness insurance policy that is issued, delivered, amended, or renewed after June 30, 2026.**

SECTION 30. IC 27-8-5.7-6.7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 6.7. (a) An insurer may not retroactively reduce the reimbursement rate for any CPT code.**

(b) An insurer:

(1) shall provide at least sixty (60) days notice to a provider; and

(2) must obtain the:

(A) approval of the department; or

(B) approval and signature of a provider;

in accordance with IC 27-1-37.1-5.5;

before implementing a rate reduction for any CPT code.

SECTION 31. IC 27-8-5.7-10, AS ADDED BY P.L.55-2006, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 10. ~~(a) An insurer may not, more than two (2) years after the date on which an overpayment on a provider claim was made to the provider by the insurer:~~

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

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

(a) An insurer may not retroactively audit a paid claim or seek recoupment or a refund of a paid claim more than:

(1) one hundred eighty (180) days after the date on which the claim was initially paid; or

(2) the same number of days that a provider is required to submit a claim to the insurer;

whichever occurs first.

(b) An insurer may not be required to correct a payment error to a provider ~~more than two (2) years~~ after the ~~date on which a payment on a provider claim was made to the provider by the insurer.~~ **period described in subsection (a).**

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

SECTION 32. IC 27-8-5.7-11, AS ADDED BY P.L.55-2006, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 11. **(a) An insurer may adjust a subsequent claim for recoupment of an overpayment only if:**

(1) the insurer finds that fraud was committed by the provider on a previous provider claim; and

(2) the adjustment is made to recoup the overpayment on the previous provider claim.

(b) Every subsequent claim that is adjusted by an insurer for reimbursement on an overpayment of a previous provider claim made to the provider must be accompanied by an explanation of the reason for the adjustment, including:

(1) an identification of:

(A) the claim on which the overpayment was made; and

(B) if ascertainable, the party financially responsible for the overpaid amount; and

(2) the amount of the overpayment that is being reimbursed to the insurer through the adjusted subsequent claim.

SECTION 33. IC 27-8-11-15 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 15. (a) This section applies if:**

(1) an insurer's network access to the health care services does not meet reasonable appointment wait time standards; and

(2) the insured receives care from an out of network provider.

(b) The insured's treating provider may collect from the insured only the deductible or copayment, if any, that the insured would be responsible to pay if the health care services had been provided by a provider with which the insurer has entered into an

agreement under section 3 of this chapter.

(c) The insured may not be billed by the insurer or by the out of network provider for any difference between the out of network provider's charge and the amount paid by the insurer to the out of network provider.

SECTION 34. IC 27-13-7-14.2, AS ADDED BY P.L.103-2020, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 14.2. (a) As used in this section, "treatment of a mental illness or substance abuse" means:

(1) treatment for a mental illness, as defined in IC 12-7-2-130(1); and

(2) treatment for drug abuse or alcohol abuse.

(b) As used in this section, "act" refers to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 and any amendments thereto, plus any federal guidance or regulations relevant to that act, including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).

(c) As used in this section, "nonquantitative treatment limitations" refers to those limitations described in 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR 146.136.

(d) An individual contract or a group contract that provides coverage of services for treatment of a mental illness or substance abuse shall submit a report to the department not later than December 31 of each year that contains the following information:

(1) A description of the processes:

(A) used to develop or select the medical necessity criteria for coverage of services for treatment of a mental illness or substance abuse; and

(B) used to develop or select the medical necessity criteria for coverage of services for treatment of other medical or surgical conditions.

(2) Identification of all nonquantitative treatment limitations that are applied to:

(A) coverage of services for treatment of a mental illness or substance abuse; and

(B) coverage of services for treatment of other medical or surgical conditions;

within each classification of benefits.

(3) The reimbursement rates for providers of mental illness or substance abuse services relative to Medicare rates and the reimbursement rates for providers of medical or surgical services relative to Medicare rates in the respective

classification of benefits.

(e) There may be no separate nonquantitative treatment limitations that apply to coverage of services for treatment of a mental illness or substance abuse that do not apply to coverage of services for treatment of other medical or surgical conditions within any classification of benefits.

(f) An individual contract or a group contract that provides coverage of services for treatment of a mental illness or substance abuse shall also submit an analysis showing the insurer's compliance with this section and the act to the department not later than December 31 of each year. The analysis must do the following:

(1) Identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected.

(2) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation.

(3) Provide the comparative analyses, including the results of the analyses, performed to determine the following:

(A) That the processes and strategies used to design each nonquantitative treatment limitation for coverage of services for treatment of a mental illness or substance abuse are comparable to, and applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation for coverage of services for treatment of other medical or surgical conditions.

(B) That the processes and strategies used to apply each nonquantitative treatment limitation for treatment of a mental illness or substance abuse are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative limitation for treatment of other medical or surgical conditions.

(g) This subsection applies to an individual contract or a group contract that is entered into, delivered, amended, or renewed after June 30, 2026. An individual contract or a group contract that provides coverage of services for treatment of a mental illness or substance abuse shall reimburse providers of mental illness or substance abuse services at rates that are at least as favorable relative to Medicare rates as reimbursement rates are for providers of medical or surgical services relative to Medicare rates in the respective classification of benefits.

~~(g)~~ **(h)** The department shall adopt rules to ensure compliance with

this section and the applicable provisions of the act.

SECTION 35. IC 27-13-36-5.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 5.5. (a) This section applies if:**

(1) a health maintenance organization's network access to health care services does not meet reasonable appointment wait time standards; and

(2) the enrollee receives care from an out of network provider.

(b) The enrollee's treating provider may collect from the enrollee only the deductible or copayment, if any, that the enrollee would be responsible to pay if the health care services had been provided by a participating provider.

(c) The enrollee may not be billed by the health maintenance organization or by the out of network provider for any difference between the out of network provider's charge and the amount paid by the health maintenance organization to the out of network provider.

SECTION 36. IC 27-13-36.2-0.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 0.5. Section 4.7 of this chapter, as added in the 2026 session of the general assembly, and sections 8 and 9 of this chapter, as amended in the 2026 session of the general assembly, apply to an individual contract and a group contract that is entered into, delivered, amended, or renewed after June 30, 2026.**

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

(b) A health maintenance organization:

(1) shall provide at least sixty (60) days notice to a provider; and

(2) must obtain the:

(A) approval of the department; or

(B) approval and signature of a provider;

in accordance with IC 27-1-37.1-5.5;

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

SECTION 38. IC 27-13-36.2-8, AS ADDED BY P.L.55-2006, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2026]: Sec. 8. ~~(a) A health maintenance organization may not, more than two (2) years after the date on which an overpayment on a provider claim was made to the provider by the health maintenance organization:~~

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

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

(a) A health maintenance organization may not retroactively audit a paid claim or seek recoupment or a refund of a paid claim more than:

(1) one hundred eighty (180) days after the date on which the claim was initially paid; or

(2) the same number of days that a provider is required to submit a claim to the health maintenance organization;

whichever occurs first.

(b) A health maintenance organization may not be required to correct a payment error to a provider ~~more than two (2) years~~ after the ~~date on which a payment on a provider claim was made to the provider by the health maintenance organization.~~ **period described in subsection (a).**

(c) This section does not apply in cases of fraud by the provider, the enrollee, or the health maintenance organization with respect to the claim on which the overpayment or underpayment was made.

SECTION 39. IC 27-13-36.2-9, AS ADDED BY P.L.55-2006, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 9. **(a) A health maintenance organization may adjust a subsequent claim for recoupment of an overpayment only if:**

(1) the health maintenance organization finds that fraud was committed by the provider on a previous provider claim; and

(2) the adjustment is made to recoup the overpayment on the previous provider claim.

(b) Every subsequent claim that is adjusted by a health maintenance organization for ~~reimbursement on~~ **recoupment of** an overpayment of a previous provider claim made to the provider must be accompanied by an explanation of the reason for the adjustment, including:

(1) an identification of:

(A) the claim on which the overpayment was made; and

(B) if ascertainable, the party financially responsible for the amount overpaid; and

(2) the amount of the overpayment that is being reimbursed to the health maintenance organization through the adjusted subsequent claim.

SECTION 40. IC 35-52-16-58 IS REPEALED [EFFECTIVE JULY 1, 2026]. ~~Sec. 58. IC 16-41-14-17 defines a crime concerning communicable diseases.~~

SECTION 41. IC 36-8-4-5, AS AMENDED BY P.L.66-2020, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 5. **(a) The following definitions apply throughout this section:**

(1) "Firefighter" means a current or former firefighter.

(2) "Police officer" means a current or former police officer.

~~(a)~~ **(b)** A city shall pay for the care of a police officer or firefighter who suffers an injury while performing the person's duty or while the person is on duty or who contracts illness caused by the performance of the person's duty, including an injury or illness that results in a disability or death presumed incurred in the line of duty under IC 5-10-13. This care includes:

(1) medical and surgical care;

(2) medicines and laboratory, curative, and palliative agents and means;

(3) X-ray, diagnostic, and therapeutic service, including during the recovery period; and

(4) hospital and special nursing care if the physician or surgeon in charge considers it necessary for proper recovery.

~~(b)~~ **(c)** Expenditures required by subsection ~~(a)~~ **(b)** shall be paid from the general fund of the city.

~~(c)~~ **(d)** A city that has paid for the care of a police officer or firefighter under subsection ~~(a)~~ **(b)** has a cause of action for reimbursement of the amount paid under subsection ~~(a)~~ **(b)** against any third party against whom the police officer or firefighter has a cause of action for an injury sustained because of or an illness caused by the third party. The city's cause of action under this subsection is in addition to, and not in lieu of, the cause of action of the police officer or firefighter against the third party.

(e) The medical benefits under this section are independent and distinct from any medical benefits that are available under IC 22-3. A police officer or firefighter may recover medical benefits under this section without first pursuing a claim for medical benefits under IC 22-3. If a police officer or firefighter pursues a claim for medical benefits under IC 22-3 and the claim

is withdrawn or denied, the police officer or firefighter is not precluded from recovering medical benefits under this section.

SECTION 42. IC 36-8-4.3-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 2. **(a) The following definitions apply throughout this section:**

(1) "Firefighter" means a current or former full-time, paid firefighter.

(2) "Police officer" means a current or former full-time, paid police officer.

~~(a)~~ **(b)** A special service district shall pay for the care of:

(1) a ~~full-time, paid~~ police officer who:

(A) suffers an injury; or

(B) contracts an illness;

during the performance of the **police** officer's duty; or

(2) a ~~full-time, paid~~ firefighter who:

(A) suffers an injury; or

(B) contracts an illness;

during the performance of the firefighter's duty.

~~(b)~~ **(c)** The special service district shall pay for the following expenses incurred by a police officer or firefighter described in subsection ~~(a).~~ **(b):**

(1) Medical and surgical care.

(2) Medicines and laboratory, curative, and palliative agents and means.

(3) X-ray, diagnostic, and therapeutic service, including during the recovery period.

(4) Hospital and special nursing care if the physician or surgeon in charge considers it necessary for proper recovery.

~~(c)~~ **(d)** Expenditures required by subsection ~~(a)~~ **(b) or (c)** shall be paid from the general fund of the special service district.

~~(d)~~ **(e)** A special service district that has paid for the care of a police officer or firefighter under subsection ~~(a)~~ **(b) or (c)** has a cause of action for reimbursement of the amount paid under subsection ~~(a)~~ **(b) or (c)** against any third party against whom the police officer or firefighter has a cause of action for an injury sustained because of, or an illness caused by, the third party. The special service district's cause of action under this subsection is in addition to, and not in lieu of, the cause of action of the police officer or firefighter against the third party.

(f) The medical benefits under this section are independent and distinct from any medical benefits that are available under IC 22-3.

A police officer or firefighter may recover medical benefits under this section without first pursuing a claim for medical benefits under IC 22-3. If the police officer or firefighter pursues a claim for medical benefits under IC 22-3 and the claim is withdrawn or denied, the police officer or firefighter is not precluded from recovering medical benefits under this section.

SECTION 43. IC 36-8-4.5-10 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 10. (a) A town shall pay for the care of a current or retired full-time paid member of a town fire department who suffers an injury while performing the person's duty or while the person is on duty or who contracts illness caused by the performance of the person's duty, including an injury or illness that results in a disability or death presumed incurred in the line of duty under IC 5-10-13. This care includes:**

(1) medical and surgical care;

(2) medicines and laboratory, curative, and palliative agents and means;

(3) X-ray, diagnostic, and therapeutic service, including during the recovery period; and

(4) hospital and special nursing care if the physician or surgeon in charge considers it necessary for proper recovery.

(b) Expenditures required by subsection (a) shall be paid from the general fund of the town.

(c) A town that has paid for the care of a member of a town fire department under subsection (a) has a cause of action for reimbursement of the amount paid under subsection (a) against any third party against whom the member of the town fire department has a cause of action for an injury sustained because of or an illness caused by the third party. The town's cause of action under this subsection is in addition to, and not in lieu of, the cause of action of the member of the town fire department against the third party.

(d) The medical benefits under this section are independent and distinct from any medical benefits that are available under IC 22-3. A current or retired full-time paid member of a town fire department may recover benefits under this section without first pursuing a claim for medical benefits under IC 22-3. If a current or retired full-time paid member of a town fire department pursues a claim for medical benefits under IC 22-3 and the claim is withdrawn or denied, the current or retired full-time paid member of the town fire department is not precluded from

recovering medical benefits under this section.

SECTION 44. IC 36-8-9-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 8. **(a) As used in this section, "police officer" means a current or former full-time, paid police officer.**

~~(a)~~ **(b)** A town shall pay for the care of a ~~full-time, paid~~ police officer who:

(1) suffers an injury; or

(2) contracts an illness;

during the performance of the **police** officer's duty.

~~(b)~~ **(c)** The town shall pay for the following expenses incurred by a police officer described in subsection ~~(a).~~ **(b):**

(1) Medical and surgical care.

(2) Medicines and laboratory, curative, and palliative agents and means.

(3) X-ray, diagnostic, and therapeutic service, including during the recovery period.

(4) Hospital and special nursing care if the physician or surgeon in charge considers it necessary for proper recovery.

~~(c)~~ **(d)** Expenditures required by subsection ~~(a)~~ **(b) or (c)** shall be paid from the general fund of the town.

~~(d)~~ **(e)** A town that has paid for the care of a police officer under subsection ~~(a)~~ **(b) or (c)** has a cause of action for reimbursement of the amount paid under subsection ~~(a)~~ **(b) or (c)** against any third party against whom the police officer has a cause of action for an injury sustained because of, or an illness caused by, the third party. The town's cause of action under this subsection is in addition to, and not in lieu of, the cause of action of the police officer against the third party.

(f) The medical benefits under this section are independent and distinct from any medical benefits that are available under IC 22-3. A police officer may recover medical benefits under this section without first pursuing a claim for medical benefits under IC 22-3. If the police officer pursues a claim for medical benefits under IC 22-3 and the claim is withdrawn or denied, the police officer is not precluded from recovering medical benefits under this section.

SECTION 45. IC 36-8-11-27 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 27. **(a) As used in this section, "firefighter" means a current or former full-time, paid firefighter.**

~~(a)~~ **(b)** A fire protection district shall pay for the care of a

~~full-time, paid~~ firefighter who: ~~suffers:~~

(1) **suffers** an injury; or

(2) contracts an illness;

during the performance of the firefighter's duties.

~~(b)~~ **(c)** The fire protection district shall pay for the following expenses incurred by a firefighter described in subsection ~~(a):~~ **(b):**

(1) Medical and surgical care.

(2) Medicines and laboratory, curative, and palliative agents and means.

(3) X-ray, diagnostic, and therapeutic service, including service provided during the recovery period.

(4) Hospital and special nursing care if the physician or surgeon in charge considers it necessary for proper recovery.

~~(c)~~ **(d)** Expenditures required by subsection ~~(a)~~ **(b) or (c)** shall be paid from the fund used by the fire protection district for payment of the costs attributable to providing fire protection services in the fire protection district.

~~(d)~~ **(e)** A fire protection district that has paid for the care of a firefighter under subsection ~~(a)~~ **(b) or (c)** has a cause of action for reimbursement of the amount paid under subsection ~~(a)~~ **(b) or (c)** against any third party against whom the firefighter has a cause of action for:

(1) an injury sustained because of; or

(2) an illness caused by;

the third party. The fire protection district's cause of action under this subsection is in addition to, and not instead of, the cause of action of the firefighter against the third party.

(f) The medical benefits under this section are independent and distinct from any medical benefits that are available under IC 22-3. A firefighter may recover medical benefits under this section without first pursuing a claim for medical benefits under IC 22-3. If the firefighter pursues a claim for medical benefits under IC 22-3 and the claim is withdrawn or denied, the firefighter is not precluded from recovering medical benefits under this section.

SECTION 46. IC 36-8-13-9, AS AMENDED BY P.L.236-2023, SECTION 207, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 9. **(a) As used in this section, "firefighter" means a current or former full-time, paid firefighter.**

~~(a)~~ **(b)** A township shall pay for the care of a ~~full-time, paid~~ firefighter who: ~~suffers:~~

(1) **suffers** an injury; or

(2) contracts an illness;

during the performance of the firefighter's duty.

~~(b)~~ **(c)** The township shall pay for the following expenses incurred by a firefighter described in subsection ~~(a).~~ **(b):**

(1) Medical and surgical care.

(2) Medicines and laboratory, curative, and palliative agents and means.

(3) X-ray, diagnostic, and therapeutic service, including during the recovery period.

(4) Hospital and special nursing care if the physician or surgeon in charge considers it necessary for proper recovery.

~~(c)~~ **(d)** Expenditures required by subsection ~~(a)~~ **(b) or (c)** shall be paid from the township firefighting and emergency services fund established by section 4(a)(1) of this chapter or the township firefighting fund established ~~in~~ **by** section 4(a)(2)(A) of this chapter, as applicable.

~~(d)~~ **(e)** A township that has paid for the care of a firefighter under subsection ~~(a)~~ **(b) or (c)** has a cause of action for reimbursement of the amount paid under subsection ~~(a)~~ **(b) or (c)** against any third party against whom the firefighter has a cause of action for an injury sustained because of, or an illness caused by, the third party. The township's cause of action under this subsection is in addition to, and not in lieu of, the cause of action of the firefighter against the third party.

(f) The medical benefits under this section are independent and distinct from any medical benefits that are available under IC 22-3. A firefighter may recover medical benefits under this section without first pursuing a claim for medical benefits under IC 22-3. If the firefighter pursues a claim for medical benefits under IC 22-3 and the claim is withdrawn or denied, the firefighter is not precluded from recovering medical benefits under this section.

SECTION 47. IC 36-8-19-14 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 14. **(a) As used in this section, "firefighter" means a current or former full-time, paid firefighter.**

~~(a)~~ **(b)** A provider unit shall pay for the care of a ~~full-time, paid~~ firefighter who:

(1) suffers an injury; or

(2) contracts an illness;

during the performance of the firefighter's duty.

~~(b)~~ **(c)** The provider unit shall pay for the following expenses

incurred by a firefighter described in subsection ~~(a):~~ **(b):**

(1) Medical and surgical care.

(2) Medicines and laboratory, curative, and palliative agents and means.

(3) X-ray, diagnostic, and therapeutic service, including during the recovery period.

(4) Hospital and special nursing care if the physician or surgeon in charge considers it necessary for proper recovery.

~~(c)~~ **(d)** Expenditures required by subsection ~~(a)~~ **(b) or (c)** shall be paid from the fund used by the provider unit for payment of the costs attributable to providing fire protection services in the provider unit.

~~(d)~~ **(e)** A provider unit that has paid for the care of a firefighter under subsection ~~(a)~~ **(b) or (c)** has a cause of action for reimbursement of the amount paid under subsection ~~(a)~~ **(b) or (c)** against any third party against whom the firefighter has a cause of action for an injury sustained because of, or an illness caused by, the third party. The provider unit's cause of action under this subsection is in addition to, and not in lieu of, the cause of action of the firefighter against the third party.

(f) The medical benefits under this section are independent and distinct from any medical benefits that are available under IC 22-3. A firefighter may recover medical benefits under this section without first pursuing a claim for medical benefits under IC 22-3. If the firefighter pursues a claim for medical benefits under IC 22-3 and the claim is withdrawn or denied, the firefighter is not precluded from recovering medical benefits under this section.

SECTION 48. **An emergency is declared for this act.**