



# 2026 Indiana Legislative Session Healthcare Summary

June 2026

## Overview

Following a significant year of healthcare reform in 2025, legislative leaders signaled a more measured approach to additional reforms heading into the 2026 session. During interim discussions, House Speaker Todd Huston suggested that the upcoming session would likely be quieter on healthcare than in recent years, indicating that time was needed to see the effects of previous legislation and gather more data. Senate President Pro Tempore Rodric Bray echoed that sentiment and cautioned against introducing too many new ideas in a complex policy area like healthcare, noting that legislation takes time to produce results: "This is a large ship, and it takes a while to turn."

The 2026 session was not just quieter on healthcare — it was also shorter than normal, even for a "short session." Lawmakers began the 2026 session in December 2025, convening for two weeks to consider mid-decade redistricting and begin limited committee work in order to avoid the additional cost of a special session. However, that decision shortened the 10-week session to eight weeks, even as lawmakers filed roughly the same number of bills as in a typical 10-week session. The compressed timeline accelerated committee activity and significantly narrowed the path forward for many bills.

Of the 742 bills introduced (452 in the House and 290 in the Senate), 163 passed into law (83 House bills and 80 Senate bills), or roughly 22% of all introduced bills.



*This report was prepared by Hallowell Consulting, the lobbying and government affairs firm for the Employers' Forum of Indiana.*



## Contents

<b>Priority Legislation</b> .....	3
HB 1328: Charges for Hospital Administered Drugs .....	3
<b>Other Healthcare Legislation</b> .....	3
HEA 1271: Payment of Health Claims .....	3
SEA 189: Nonparticipating Providers .....	5
SEA 225: Health Matters .....	6
<b>Other Healthcare Provisions</b> .....	7
HEA 1260: Various Insurance Matters .....	7
HEA 1406: Tax and Fiscal Matters.....	7
<b>Appendix A. Other Tracked Healthcare Bills Signed Into Law</b> .....	8
<b>Appendix B. Notable Tracked Healthcare Bills That Were Not Signed Into Law</b> .....	10



## Priority Legislation

### [HB 1328: Charges for Hospital Administered Drugs](#)

Authored by: Rep. Julie McGuire (R-Indianapolis) | Co-authored by: Rep. Brad Barrett (R-Richmond), Rep. Lori Goss-Reaves (R-Marion)

Note: The bill did not receive a hearing and did not become law

#### Summary

1. Prohibits a hospital from billing for an administered drug an amount that exceeds the lesser of the following:
  - a. 120% of the Medicare reimbursement rate for the administered drug.
  - b. The amount the hospital bills for the administered drug on June 30, 2026.
2. Allows a hospital to increase the amount it bills for an administered drug in proportion to the percentage increase in the Medicare reimbursement rate for the administered drug.
3. Requires a hospital to update the Medicare reimbursement rate for an administered drug on January 1 and July 1 of each year.

## Other Healthcare Legislation

### [HEA 1271: Payment of Health Claims](#)

Authored by: Rep. Julie McGuire (R-Indianapolis) | Co-authored by: Rep. Lori Goss-Reaves (R-Marion), Rep. Martin Carbaugh (R-Fort Wayne), Rep. Victoria Garcia Wilburn (D-Fishers) | Sponsored by: Sen. Liz Brown (R-Fort Wayne), Sen. Michael Crider (R-Greenfield), Sen. Tyler Johnson (R-Leo), Sen. Lonnie Randolph (D-East Chicago)

Final votes: House: 87-0 | Senate: 46-1

Effective dates: July 1, 2026, for all provisions

#### Summary: Notice of Payment Assistance Programs

1. Requires a hospital to provide patients with written notice of their payment assistance program during registration or intake for inpatient or outpatient services, at discharge, or with the initial billing statement.
2. Requires a hospital to post conspicuous signage notifying patients of the availability of payment assistance programs in registration areas and emergency departments.
3. Requires a hospital to make a reasonable effort to notify a patient of available payment assistance programs and provide them with an application form before beginning a collection action.
4. Requires a nonprofit hospital to report compliance with the payment assistance program requirements as a part of its community benefits plan.



5. Allows the Department of Health to assess a penalty not to exceed \$1,000 per violation for failure to comply with the payment assistance program requirements.

#### Summary: Downcoding by Insurers

1. Defines "downcoding" as "the unilateral alteration by an insurer of the payment for an evaluation and management service code or other service code; or level of evaluation and management service code or other service code submitted on a claim that results in a lower payment."
2. Defines "health plan" as a fully insured plan, an individual or group contract with a health maintenance organization (HMO), or a preferred provider plan under which dental services are provided.
3. Defines "insurer" as an insurer that issues fully insured products, an HMO that provides coverage for basic health care services under an individual or group contract, and an insurer that enters into a preferred provider plan under which dental services are provided.
4. Prohibits an insurer from downcoding that prevents a provider from submitting a claim for actual health care services performed and collecting reimbursement from the insurer for those services.
5. Prohibits an insurer from using an automated process, including AI, as the sole basis to downcode a claim based on medical necessity without a review of the patient's medical record by an employer or contractor of the insurer.
6. Prohibits a provider from using an automated process, including AI, to submit a claim without a review of a provider or other person involved in the development of the claim for submission.
7. Requires an insurer to disclose when AI is used to make an adverse determination on a prior authorization request or downcode a claim.
8. Prohibits an insurer from downcoding a claim based solely on the reported diagnosis code.
9. Requires an insurer to notify a provider using the appropriate CARC and RARC to indicate that the claim has been downcoded and provide certain information, including a clear and accessible process for appealing the downcoded claim. The timeline for submission of an appeal cannot be less than 180 days.
10. Requires an insurer to permit a provider to appeal in batches claims involving substantially similar downcoding issues without restriction.
11. Prohibits an insurer from downcoding in a targeted or discriminatory manner against providers that routinely treat patients with complex or chronic conditions.
12. Excludes the state's Medicaid program from the downcoding provisions.

#### Summary: Recoupment and Auditing

1. Prohibits an insurer and an HMO from retroactively reducing the reimbursement rate for any CPT code.
2. Requires an insurer and an HMO to provide at least 60 days' written notice by mail or email to a provider and post on the insurer's website before prospectively implementing a rate reduction for a CPT code.
3. Reduces the timeframe an insurer and an HMO may request a provider repay an overpayment or adjust subsequent claims from two years to 180 days.
4. Prohibits an insurer and an HMO from recouping or refunding a paid claim more than 180 days after the date on which a claim was initially paid.



5. Prohibits an insurer and an HMO from retroactively auditing a paid claim more than three years after the date on which a claim was initially paid.
6. Reduces the timeframe for an insurer and an HMO to correct a payment error to a provider from two years to 180 days.
7. Allows an insurer and a hospital to enter into a written agreement that provides for different timeframes for repayment, recoupment, refunding, or correcting a payment error.
8. Provides exceptions to certain timeframe adjustments if a court has made a final determination of fraud.
9. Provides that if an insurer or an HMO recoups payment from a provider due to an error in coordination of benefits, the provider may submit a claim for the same services to the appropriate insurer or HMO not later than 90 days after the recoupment is made, unless given more time.

### [SEA 189: Nonparticipating Providers](#)

Authored by: Sen. Scott Baldwin (R-Noblesville), Sen. Chris Garten (R-Charlestown), Sen. Tyler Johnson (R-Leo) | Co-authored by: Sen. Lonnie Randolph (D-East Chicago), Sen. Eric Koch (R-Bedford), Sen. Liz Brown (R-Fort Wayne) | Sponsored by: Rep. Brad Barrett (R-Richmond), Rep. Martin Carbaugh (R-Fort Wayne), Rep. Craig Snow (R-Warsaw), Rep. Chris Campbell (D-West Lafayette)

Final votes: House: 96-0 | Senate: 49-0

Effective date: Upon passage

#### Summary

1. Requires an initiating party that files a federal IDR request to notify the facility within three business days and provide a copy of the IDR submission.
2. Subjects an initiating party that fails to provide timely notice to enforcement by the appropriate licensing board or the Department of Insurance, including potential civil penalties.
3. Permits a health carrier to trigger a formal notice process if 25 or more qualified IDR disputes are filed within a 90-day period.
4. Requires the health carrier, out-of-network provider, and facility to engage in good faith negotiations to address the conduct described in the health carrier's notice within 30 days after such notice is issued.
5. Mandates at least one conference between authorized representatives and a reasonable exchange of payment and claim information.
6. Prohibits the conference from adjudicating individual claims or altering any rights or obligations under federal or state law.
7. Limits the conference process to no more than once per calendar quarter and makes the outcome informational only.
8. Requires the parties to prepare and file a written memorandum with the Department of Insurance summarizing the disputes reviewed, including the initial payment, negotiation offers, requested amount, and qualifying payment amount (QPA).
9. Protects claim-specific payment information in the memorandum from public disclosure.



10. Requires the Department of Insurance to publish the aggregate number of memorandums filed with the department.
11. Prohibits insurers from charging hospitals administrative fees or penalties for care involving an out-of-network provider.
12. Declares such as an unfair and deceptive act or practice in the business of insurance, subjecting the carrier to certain penalties and procedures.

### [SEA 225: Health Matters](#)

Authored by: Sen. Justin Busch (R-Fort Wayne), Sen. Ed Charbonneau (R-Valparaiso), Sen. Fady Qaddoura (D-Indianapolis) | Co-authored by: Sen. Shelli Yoder (D-Bloomington) | Sponsored by: Rep. Brad Barrett (R-Richmond), Rep. Martin Carbaugh (R-Fort Wayne), Rep. Julie McGuire (R-Indianapolis), Rep. Joanna King (R-Middlebury)

Final votes: House: 94-1 | Senate: 49-0

Effective dates: July 1, 2026, for all provisions

#### Summary: Statutory Compliance and Medical Debt Collection

1. Prohibits a hospital, debt collector, or other third party on behalf of a hospital from pursuing collection of medical debt unless a hospital is in compliance with the Hospital Financial Disclosure Statute, Community Benefits Statute, Schedule H Statute, and the Notice of Closure or Elimination Statute.
2. Requires the Department of Health to determine on a semiannual basis whether a hospital is in compliance with these statutes and notify a hospital of its determination.
3. Permits the attorney general to suspend a noncompliant hospital's authority to pursue medical debt collection.
4. Requires the Department of Health to post and update a list of noncompliant hospitals on its website.

#### Summary: Hospital Closure and Service Line Elimination Notification

1. Requires a hospital to provide a written notice to the Department of Health at least 60 days before the hospital permanently terminates all operations or completely eliminates a service line for longer than 90 days.
2. Requires the notice to include the proposed date of closure or elimination, a description of the affected services and capacity, and the hospital's plan for continuity of care.
3. Requires the Department of Health to post a summary of the closure or elimination of a service line on its website not later than 10 days after receiving the notice, and to notify the Secretary of Family and Social Services and other state agencies.
4. Allows the Department of Health to waive the notice requirements under certain circumstances or if the department determines it is necessary to protect the public's health and safety, including the loss of practitioners necessary to provide the service line.



5. Grants the Department of Health a reasonable time to post any waiver granted and the justification for the waiver on its website.

#### Miscellaneous Provisions

1. Removes the hospital privileges requirement for ambulatory outpatient surgical centers.

## Other Healthcare Provisions

### [HEA 1260: Various Insurance Matters](#)

Authored by: Rep. Matt Lehman (R-Berne) | Co-authored by: Rep. Martin Carbaugh (R-Fort Wayne) | Sponsored by: Sen. Scott Baldwin (R-Noblesville), Sen. Lonnie Randolph (D-East Chicago)

Final votes: House: 78-12 | Senate: 48-0

Effective dates: July 1, 2026, for selected provisions

#### Selected Provisions

1. Requires insurers and HMOs to give insurance producers access to a complete list of providers in their networks and to make that information available through producer communication portals.
2. Sets forth a fee schedule for providing unrestricted data to certain entities from the all-payer claims database.
3. Permits the commissioner of the Department of Insurance to implement, establish, create, administer, or otherwise implement a health benefit exchange.

### [HEA 1406: Tax and Fiscal Matters](#)

Authored by: Rep. Jeffrey Thompson (R-Lizton) | Sponsored by: Sen. Travis Holdman (R-Markle), Sen. Scott Baldwin (R-Noblesville)

Final vote: House: 65-31 | Senate: 46-1

Effective date: January 1, 2027, for selected provision

#### Summary: Property Tax Exemptions for Big Five Nonprofit Hospital Systems

1. Provides a property tax exemption for land acquired by a Big Five nonprofit hospital system for the purpose of constructing a building that would qualify for the charitable property tax exemption (among others).
2. Requires the hospital system to prove it has been issued a certificate of occupancy or has submitted a certificate of completion and compliance within four years after purchasing the land.



3. Requires, if the land is sold, leased, or otherwise transferred, the hospital system to repay property taxes that would have been imposed beginning in the fourth year after the land is purchased through the year of the transfer.
4. Allows the county auditor to establish an installment repayment plan for those taxes.

## Appendix A. Other Tracked Healthcare Bills Signed Into Law

### **HEA 1029: Alzheimer's Disease and Dementia Education**

Digest: Requires the Indiana Department of Health (state department) to: (1) collaborate with a national Alzheimer's disease and dementia organization in educating the public about Alzheimer's disease and dementia; and (2) identify and collaborate with additional partners in the education. Requires the state department to partner for outreach in the education and publish certain educational materials on the state department's website. Allows the state department to accept grants, services, and property from public and private entities for the education.

### **HEA 1114: Coverage for Certain Cancer Prescriptions**

Digest: Prohibits a state employee health plan, a policy of accident and sickness insurance, and a health maintenance organization that provides coverage for advanced, metastatic cancer and associated conditions from requiring that, before providing coverage for a prescription drug, the insured fail to successfully respond to a different prescription drug or prove a history of failure of a different prescription drug.

### **HEA 1358: Indiana Department of Health**

Digest: Changes the statewide standing order for the dispensing of a smoking cessation product to a tobacco, vaping, or nicotine cessation product. Amends the date by which a hospital must submit the hospital's fiscal report and patient information report to the Indiana Department of Health (state department). Removes a requirement that a home health aide competency evaluation program include at least 75 hours of training and 16 hours of classroom training before supervised practical training. Adds Parkinson's disease to the definition of "chronic disease" for provisions concerning the chronic disease registry. Requires: (1) the state department to maintain a trauma registry; and (2) certain health care facilities to submit data to the registry. Establishes requirements for the handling and transporting of infectious waste. Sets forth factors the state department must consider in determining the nature of and civil penalty for a violation of infectious waste requirements. Expands provisions concerning epinephrine, including provisions allowing a pharmacist to dispense and an entity to prescribe epinephrine rather than auto-injectable epinephrine. Removes the expiration of provisions concerning lead screening for children. Requires a registered manufacturer, processor, repackager, or wholesale distributor of food, drugs, or cosmetics to comply with federal regulations concerning good manufacturing practices. Allows the state health commissioner to enter and inspect the premises of the manufacturer, processor, repackager, or wholesale distributor. Permits a local



health department to conduct inspections of certain manufacturers, processors, repackagers, or wholesale distributors. Amends the information a local child fatality review team and the statewide child fatality review committee may review in conducting a child fatality review. Allows a suicide and overdose fatality review team and a fetal-infant mortality review team to provide records to the state department. Requires the state department to maintain the confidentiality of these records. Requires a medical school to: (1) include nutrition education in the school's curriculum; and (2) require students to complete a rural health rotation. Voids administrative rules concerning infectious waste and the state trauma registry.

### **SEA 90: Consent for Pelvic, Prostate, and Rectal Exams**

Digest: Prohibits health practitioners and other specified individuals from performing pelvic, prostate, or rectal examinations on an anesthetized or unconscious patient except in specified circumstances. Specifies the requirements of a notice of informed consent.

### **SEA 91: Syringe Exchange Program**

Digest: Prohibits a qualified entity that operates a syringe exchange program (program) from establishing or operating a fixed site for the distribution or exchange of a syringe or needle within 1,000 feet of specified facilities. Creates an exception. Allows the Indiana Department of Health to deny, suspend, or revoke a qualified entity's annual registration for a violation. Amends the duties of a qualified entity that operates a program. Establishes requirements for program participation. Prohibits a qualified entity that operates a program from providing chemical reagents or precursors. Requires the state health commissioner to investigate any complaint regarding a qualified entity's noncompliance with the qualified entity's duties concerning the operation of a program. Permits the state health commissioner to suspend or terminate the approval of a qualified entity for noncompliance. Extends the expiration of the program to July 1, 2031.

### **SEA 180: Various Health Care Matters**

Digest: Eliminates a requirement that home health aide competency evaluation program training include at least 75 hours of training and 16 hours of classroom training before supervised practical training. Amends the educational requirements for dental hygienists. Amends the requirements for administration of nitrous oxide by a dental hygienist. Allows the State Board of Dentistry to establish additional requirements for an applicant who has failed the licensure examination at least three times. Amends the licensure and temporary permit requirements for respiratory care practitioners. Provides that a current or former police officer or firefighter (first responder) may recover medical benefits from the first responder's employer for an employment related injury or illness without first proceeding with a worker's compensation claim. Provides that if a first responder pursues a worker's compensation claim for medical benefits and the claim is withdrawn or denied, the first responder is not precluded from recovering medical benefits from the employer. Repeals the penalty in Title 16 concerning the crime of



transferring contaminated semen. (Current statute contains a transferring of contaminated body fluids crime in Title 35 remains in law.)

### **SEA 293: Pharmacist Licensure**

Digest: Removes an examination requirement for certain pharmacists for license reciprocity. Requires an individual to pass the North American Pharmacist Licensure Examination to be eligible for licensure as a pharmacist. Voids or requires the amendment of certain administrative rules. Makes technical changes.

## **Appendix B. Notable Tracked Healthcare Bills That Were Not Signed Into Law**

### **HB 1201: Various Mental Health and Insurance Matters**

Digest: Prohibits the use of an artificial intelligence system to impersonate or act as a substitute for a licensed mental health professional. Requires the Department of Insurance to contract with an objective third party to verify that health carriers are in compliance with network adequacy standards. Sets forth notice requirements for an amendment to a health provider contract. Prohibits the use of downcoding in a specified manner. Requires an insurer and a health maintenance organization to 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. Prohibits an insurer and a health maintenance organization from retroactively auditing a paid claim or seeking recoupment or a refund of a paid claim after a certain time frame. Sets forth a limitation on the amount that an insured or enrollee may be charged for receiving mental and behavioral care services from an out-of-network provider under certain circumstances.

Note: The bill did not receive a hearing in the House Insurance Committee

### **HB 1279: Collection of Cost Sharing**

Digest: Provides that an insurer: (1) must pay a health care provider the full amount due for health care services under the health care provider's agreement with the insurer, including any cost sharing; (2) has the sole responsibility for collecting cost sharing from a covered individual; and (3) upon request of the covered individual, must collect cost sharing throughout the policy year in increments defined by the insurer. Prohibits an insurer from taking certain actions regarding the collection of cost sharing. Requires each insurer to certify to the insurance commissioner, before December 31 of each year, that the insurer has fully and completely complied with the requirements during the previous calendar year.

Note: The bill did not receive a hearing in the House Insurance Committee



### **HB 1335: Nonprofit Hospitals**

Digest: Sets forth additional requirements for a nonprofit hospital's community benefits plan (plan). Requires a nonprofit hospital to spend more under the nonprofit hospital's plan than the nonprofit hospital's estimated tax exemption value. Allows the Department of Health (state department) to enforce compliance with the plan requirements. Sets forth additional reporting requirements for a nonprofit hospital's annual plan report (report). Requires the state department to review the report for compliance and to verify certain reported expenditure data. Allows for the assessment of a penalty for violations.

Note: The bill passed out of the House 92-1, and received a hearing in the Senate Health and Provider Services Committee, but was not voted on

### **HB 1385: Various Hospital Matters**

Digest: Requires (rather than allows) the development of programs designed to increase Medicaid reimbursement. Specifies that the reimbursement rates for a state directed payment program must be at least the Medicare reimbursement rates... Changes the definition of "prices" concerning the hospital statewide average rate study and pricing (study). Amends the requirements to conduct the study and the date by which the study must be completed.

Note: The bill did not receive a hearing in the House Public Health Committee

### **SB 85: Health Care Debt and Costs**

Digest: Authorizes the attorney general to enforce provisions concerning health care debt wage garnishment and principal residence lien restrictions and establish a complaint process. Requires hospitals to do the following: (1) Offer a person who meets certain income guidelines and has received health services the opportunity to pay the charges through a payment plan that satisfies certain requirements. (2) Develop a written notice about a charity care program operated by the hospital, provide the notice to patients, and post the notice. (3) Include certain information concerning financial assistance on a billing statement. (4) Requires a hospital that reports an annual gross patient revenue of at least \$20,000,000 to provide written notice and information to a person who has requested an eligibility determination concerning a payment plan or charity care. Provides that the unpaid earnings of a consumer who meets specified income eligibility requirements may not be attached by garnishment if an individual makes 200% of the federal income poverty level or less, and limits the amount to be garnished over a certain amount of the individual's disposable earnings in satisfaction of: (1) health care debt owed or alleged to be owed by the consumer; or (2) any amount of the judgment that represents health care debt determined to be owed by the consumer. Provides that: (1) health care debt owed or alleged to be owed by a consumer; or (2) in an action against a consumer in which a judgment has been entered, the amount of the judgment that represents health care debt determined to be owed by the consumer; does not constitute a lien against the consumer's principal residence for a consumer. Requires the disclosure of whether a debt is a health care debt in the execution of a judgment. Provides that in any action filed in Indiana for the recovery of health care debt owed or alleged to be owed by a



consumer, the principal residence of the consumer is not liable to judgment or attachment or to be sold on execution against the consumer.

Note: The bill passed out of the Senate 33-15, but did not receive a hearing in the House Public Health Committee

### **SB 157: Disclosures Related to Prescription Drugs**

Digest: Requires certain pharmacists or pharmacies to provide the amount of the national average drug acquisition cost for a generic drug on the written materials provided to an individual at the point of sale of the generic drug.

Note: The bill passed out of the Senate 44-0, but did not receive a hearing in the House Public Health Committee

### **SB 173: Health Care Matters**

Digest: ... Modifies the definitions of "charity care" and "community benefits" for purposes of certain hospital reporting requirements. Requires additional reporting of information by nonprofit hospitals to the Indiana Department of Health (state department). Requires the report to be posted on the nonprofit hospital's website and the state department's website. Increases the penalty for failure to file the report and changes the time frame in which the penalty may be assessed. Specifies that any penalty be deposited in the local public health fund... (Link)

Note: The bill passed 10-0 out of the Senate Health and Provider Services Committee, but did not receive a hearing in the Senate Appropriations Committee

### **SB 183: Income Tax Deduction for Health Insurance Premiums**

Digest: Provides that a taxpayer who is covered by a health insurance plan may deduct from the taxpayer's adjusted gross income an amount equal to the total amount of premiums on the health insurance plan the taxpayer paid for coverage during the taxable year.

Note: The bill received a hearing in the Senate Appropriations Committee but was not voted on

### **SB 220: Health Care Shopping and Decision Support Program**

Digest: Requires, beginning January 1, 2028, a health carrier to: (1) implement a shopping and decision support program; and (2) provide incentives for covered individuals in a health plan who elect to receive a comparable health care service from a network provider that is paid less than the average allowed amount paid by the health carrier to network providers for the comparable health care service. Requires, beginning December 1, 2027, a health carrier to make available an interactive member portal that enables a covered individual to request and obtain certain information. Allows a health carrier to make the information available through a toll free telephone



number. Sets forth reporting requirements for health carriers and the Department of Insurance concerning incentive payments made to covered individuals.

Note: The bill passed 42-2 out of the Senate, but did not receive a hearing in the House Insurance Committee

### **SB 221: Pharmacist Treatment by Standing Order**

Digest: Requires the state health commissioner to issue a standing order, prescription, or protocol to allow a pharmacist to test, treat, or prescribe, if specified requirements are met. Provides a pharmacist with civil immunity in the testing, treating, or prescribing unless the pharmacist's actions constitute gross negligence, willful or wanton misconduct, or intentional wrongdoing. Requires the Indiana Board of Pharmacy to adopt rules concerning a pharmacist testing, treating, or prescribing for individuals.

Note: The bill received a hearing in the Senate Health and Provider Services Committee but was not voted on