2026 Legislative Session Update

Indiana Hospital Association

Indiana General Assembly

- The 2026 legislative session is a short session that began in December to consider redistricting and is expected to end by February 27
  - **Short, non-budget sessions typically run through March 14**
  - **753 bills have been introduced (compared to over 1,200 bills in 2025)**
  - **“Not a health care session”**

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Bills of Note – Medical Debt

- **SB 85 (Health care debt and costs) – Likely not moving forward**
  - **Payment Plan Requirements:** Would create specific payment plan requirements (i.e., for individuals below 400% of the FPL or whose total bill is greater than 10% of their monthly income, the payment plan cannot be less than 24 months, greater than 10% of their monthly income, applicable during a coverage appeal, etc.)
  - **Garnishments and Liens:** Would create specific regulations for garnishments and liens (i.e., no garnishments for individuals below 200% of the FPL, and garnishments for individuals above 200% of the FPL could not be more than 10% of their weekly wages)

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Bills of Note – Medical Debt

- **HB 1271 (Payment of Health Claims) – Moving forward**
  - **Payment Plan Transparency:** Requires hospitals to provide information related to charity care, financial assistance, and any other payment plans available to patients at either intake, discharge, or with the first billing statement; the information must include a description of the programs, eligibility criteria, application instructions, and contact information for assistance to complete the application if needed
  - **Downcoding:** Prohibits AI alone to be used to downcode a claim; if a claim is downcoded, the insurer shall use the CARC / RARC code(s) to clearly indicate the claim has been downcoded, the specific reasons for the downcoding (including the clinical criteria used to justify the downcoding), and a notice of the right to appeal
  - **Recoupments:** Decreases the recoupment timeframe from two years to one year (except for instances of fraud); the same timeframe will be applicable to providers to request a correction in a payment error

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Bills of Note – Medical Debt

- **SB 225 (Health Matters) – Moving forward**
  - **Medical Debt Collection:** Provides that a hospital may not pursue collection of medical debt if the hospital is out of compliance with certain statutes (Hospital Fiscal Report statute, Annual Community Benefit Report statute, Schedule H statute, and Notice of Closure statute – see below)
    - "Medical debt" is defined to mean amounts at least 120 days past due
    - IDOH will determine compliance semiannually; the AG can only enforce the statute once IDOH has made a final determination and any administrative appeals are complete
  - **Notice of Closure or Elimination of Service Lines:** Hospitals must provide IDOH 60 days' notice prior to closing a hospital or completely eliminating a service line, which IDOH will then post on its website
    - A hospital may seek a waiver of the 60-day timeline if the closure or elimination is due to a natural disaster, catastrophic facility failure, or other emergency event beyond the hospital's control, or IDOH determines the waiver is necessary to protect the public's health and safety, including the loss of practitioners necessary to provide the service line

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Bills of Note – Community Benefit

- **SB 173 (Health Care Matters) – Likely not moving forward**
  - Would limit what constitutes community benefit for purposes of state law (i.e., would have removed "education") and would add additional reporting requirements to the Annual Community Benefit Report (i.e., the estimated impact of each activity conducted to address the CHNA, the estimated value of a nonprofit hospital's state tax exemptions, the net revenue derived from the 340B program, etc.)

- **HB 1335 (Nonprofit Hospitals) – Likely not moving forward**
  - Would require nonprofit hospitals to have preceptors in 60% of their clinical departments as a part of their community benefit
  - Would require a nonprofit hospital's community benefit to exceed their state tax exemptions on an annual basis, or otherwise be subject to a corrective action plan and potential financial penalties

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Bills of Note

- **SB 1 (Human Services Matters)**
  - Codifies the Rural Health Transformation Fund to hold the federal funds received; requires State Budget Committee review for expenditures and specifies that any funds do not revert to the general fund
  - Aligns community engagement requirements with the OBBBA
  - Requires FSSA to conduct semiannual Medicaid redeterminations for nonelderly adults and annual Medicaid determinations for all other Medicaid recipients
  - Requires FSSA to conduct monthly transmissions to HHS to prevent Medicaid enrollment in more than one state
  - Requires FSSA to count any income of a household member who is ineligible due to the household member's immigration status when calculating an individual's financial eligibility for Medicaid
  - Requires FSSA to verify citizenship or satisfactory immigration status for each applicant, recipient, or identified household member of an applicant or recipient, and upon verification that an applicant, recipient, or household member is not a United States citizen or lacks satisfactory immigration status, FSSA is to refer the individual to DHS
  - Increases HIP co-pays from $8 to no more than $35 for individuals over 100% of the FPL
  - Requires a hospital, clinic, or other qualified entity conducting a presumptive eligibility determination to collect and transmit the required information concerning the applicant's immigration status as part of the individual's presumptive eligibility application

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Bills of Note

- **SB 4 (Various Fiscal Matters)**
  - Provides that a county may meet its CMHC funding requirements with any funding source in lieu of or in combination with property taxes, but excluding federal funds
  - Provides that CMHC services must be provided only in a CMHC's designated county or counties, except for DMHA-approved school-based services

- **SB 76 (Immigration Matters)**
  - Starting January 1, 2027, requires the Patient Services Reports to include information on the type of identification provided if Medicaid is the patient's payor (i.e., whether the patient used an Indiana driver's license or identification card, a temporary Indiana driver's license or identification card, a driver's license or identification card issued by another state, a form of identification issued by a foreign government, or no identification)

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Bills of Note

- **SB 189 (Nonparticipating Providers)**
  - Prohibits a health carrier from assessing a health care provider or facility an administrative fee or penalty related to the provision of care to an individual that involves an out of network provider

- **SB 219 (Uniform Antitrust Pre-Merger Notification Act)**
  - Provides that no later than one day after filing a pre-merger notification under the federal Hart-Scott-Rodino Act, a person shall file a complete electronic copy of the form required under that Act with Indiana's Attorney General

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Bills of Note

- **SB 275 (FSSA Fiscal Matters)**
  - Lowers the FPL for Medicaid/Medicare dual eligibles to the federal baseline amounts – Medicare will still cover the individual, but will this impact any dual eligible calculations?

- **HB 1358 (Indiana Department of Health)**
  - Provides that Hospital Fiscal Reports and Patient Services Reports are due by October 1 of the year following the end of the hospital's fiscal year (rather than 120 days following the end of the hospital's fiscal year)

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Bills that Did Not Advance

- **HB 1328 (Charges for Hospital Administered Drugs)**
  - Would have capped hospital administered drugs at 120% of Medicare

- **HB 1384 (Nonprofit Hospital Property Taxes)**
  - Would have provided that real property owned by a nonprofit hospital purchased after June 30, 2026, is not exempt from property taxation if the property is not being used for the performance of revenue producing health care services by the nonprofit hospital that owns the property

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Presumptive Eligibility Update

- As a reminder, Senate Enrolled Act 2 (2025) required FSSA to implement the following presumptive eligibility performance standards:
  - 95% of individuals determined presumptively eligible by the qualified provider must submit a full Indiana Application for Health Coverage;
  - 95% of the full Indiana Application for Health Coverage completed by presumptively eligible individuals must be completed with sufficient information to determine eligibility; and
  - 95% of those who submit the full application must be determined eligible for an IHCP program.

- Q1 of 2026 is the first quarter that the presumptive eligibility performance standards are applicable; the first warning letters for violations of a performance standard in Q1will go out in July 2026

- Please note, duplicate denied and member noncompliance applications will not be included in the warning letters

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DTE Audits & 340B Reports

- As a reminder, House Enrolled Act 1004 (2025) requires the majority of acute care hospitals to offer a direct to employer arrangement at or below 260% of full Medicare and submit to an annual audit with IDOH to demonstrate compliance
  - This may be accomplished through a hospital's own DTE arrangement or by participating in a narrow network to offer a DTE arrangement
- The RedCap survey to demonstrate compliance was distributed last week and must be completed by September 30, 2026, and by September 30 each year thereafter
  - Both the plan upload and plan narrative must be completed
- Expecting to receive a RedCap survey to comply with the 340B transparency report required under Senate Enrolled Act 118 at any time

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Thank you for your engagement

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