HOUSE BILL No. 1201

DIGEST OF INTRODUCED BILL

Citations Affected: IC 25-1-23.5; IC 27-1; IC 27-8; IC 27-13.

Synopsis: Various mental health and insurance matters. 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.

Effective: July 1, 2026.

Rowray

January 5, 2026, read first time and referred to Committee on Insurance.

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.

HOUSE BILL No. 1201

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

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

SECTION 1. 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, "board" means any of the following:

(1) The behavioral health and human services licensing board.

(2) The state psychology board.

Sec. 3. 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. 4. As used in this chapter, "licensed mental health professional" means an individual who holds an unlimited license to practice as any of the following in Indiana:

(1) Any behavioral health and human services professional licensed under IC 25-23.6.

(2) A psychologist licensed under IC 25-33.

Sec. 5. A person or entity may not use an artificial intelligence system to:

(1) impersonate; or

(2) act as a substitute for;

a licensed mental health professional during any interaction that is required to be performed by the licensed mental health professional.

Sec. 6. A licensed mental health professional who violates this chapter is subject to disciplinary action under IC 25-1-9.

Sec. 7. If a board finds that a person or an entity violates section 5 of this chapter, the board may impose a civil penalty of not more than five thousand dollars ($5,000) per violation. Penalties collected under this section must be deposited in the state general fund.

SECTION 2. 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) Contract with an objective third party to verify that health carriers are in compliance with the network adequacy standards.

SECTION 3. 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 4. 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:**

(1) makes a material change; or

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

SECTION 5. 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 6. 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 7. 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 section 10 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 8. 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 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 9. 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 10. 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 provides coverage for mental and behavioral care services;

(2) network access to the mental and behavioral care services does not meet reasonable appointment wait time standards; and

(3) 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 mental and behavioral 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 11. 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 12. 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 provides coverage for mental and behavioral care services;

(2) network access to the mental and behavioral care services does not meet reasonable appointment wait time standards; and

(3) 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 mental and behavioral 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 13. 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 section 8 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 14. 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 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 15. 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.