HOUSE BILL No. 1373

DIGEST OF INTRODUCED BILL

Citations Affected: IC 5-10-8; IC 27-1-37.5; IC 27-8-5; IC 27-13-7.

Synopsis: Breast reconstruction coverage. Repeals provisions requiring a state employee health plan, policy of accident and sickness insurance, and health maintenance organization contract to provide certain post-mastectomy coverage. Requires a state employee health plan, policy of accident and sickness insurance, and health maintenance organization contract to: (1) provide coverage for breast reconstruction surgery and all modalities, types, and techniques of a health care service provided for the breast reconstruction surgery; and (2) provide access to an adequate breast reconstruction surgeon network. Prohibits a utilization review entity from denying a claim for breast reconstruction surgery for which prior authorization was granted unless the utilization review entity provides a formal declaration of compelling evidence of health care provider fraud in the prior authorization or claim submission process.

Effective: January 1, 2027.

King, Barrett

January 8, 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. 1373

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 IC 5-10-8-16.5 IS REPEALED [EFFECTIVE JANUARY 1, 2027]. ~~Sec. 16.5. (a) As used in this section, "covered individual" means an individual who is entitled to coverage under a state employee health plan.~~

~~(b) As used in this section, "mastectomy" means the removal of all or part of a breast for reasons that are determined by a licensed physician to be medically necessary.~~

~~(c) A state employee health plan that provides coverage for a mastectomy must provide coverage as required under 29 U.S.C. 1185b, including coverage for:~~

~~(1) prosthetic devices; and~~

~~(2) reconstructive surgery incident to a mastectomy including:~~

~~(A) all stages of reconstruction of the breast on which the mastectomy has been performed;~~

~~(B) surgery and reconstruction of the other breast to produce symmetry; and~~

~~(C) chest wall reconstruction and aesthetic flat closure (as~~

~~defined by the National Cancer Institute);~~

~~in the manner determined by the attending physician and the covered individual to be appropriate.~~

~~(d) In addition to the coverage required by 29 U.S.C. 1185b, a state employee health plan that provides coverage for a mastectomy must provide coverage for:~~

~~(1) custom fabricated breast prostheses; and~~

~~(2) one (1) additional breast prosthesis per breast affected by the mastectomy.~~

~~(e) Coverage required under this section is subject to:~~

~~(1) the deductible and coinsurance provisions applicable to a mastectomy; and~~

~~(2) all other terms and conditions applicable to other benefits.~~

~~(f) A state employee health plan must provide to a covered individual, when the individual's coverage under the state employee health plan begins and annually thereafter, written notice of the coverage required under this section. Notice that is sent by the state employee health plan that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance with this subsection.~~

~~(g) The coverage required under this section applies to a state employee health plan that provides coverage for a mastectomy, regardless of whether an individual who:~~

~~(1) underwent a mastectomy; and~~

~~(2) is covered under the state employee health plan;~~

~~was covered under the state employee health plan at the time of the mastectomy.~~

~~(h) Except as provided in subsection (c)(2)(C) and subsection (d), this section does not require a state employee health plan to provide coverage related to postmastectomy care that exceeds the coverage required for postmastectomy care under federal law.~~

SECTION 2. IC 5-10-8-16.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: **Sec. 16.6. (a) This section applies to a state employee health plan that is established, entered into, amended, or renewed after December 31, 2026.**

(b) As used in this section, "breast reconstruction surgery" means all stages of surgery and revisions to repair physical defects and restore losses of function caused by the extirpation or medical treatment of breast tissue following trauma, the loss of breast tissue due to congenital or noncongenital diseases, a breast-conserving disease treatment surgery including, lumpectomy, wide local incision, segmental mastectomy, and

quadrantectomy, a mastectomy, or surgical prophylaxis against a future disease of the breast. The term includes the following:

(1) Augmentation or reduction.

(2) All states of primary and revision surgery to reconstruct a breast mound or to create a new breast mound.

(3) All procedures for a non-diseased contralateral breast necessary for symmetry between two (2) breasts.

(4) All breast reconstruction modalities, including:

(A) implant-based breast reconstruction;

(B) tissue-based breast reconstruction; and

(C) any breast reconstruction modalities developed after January 1, 2027, that are:

(i) recognized within Level I of the Healthcare Common Procedure Coding System codes; and

(ii) determined by the commissioner to qualify for coverage under this section.

(5) All types of breast reconstruction contained within the modalities under subdivision (4), including:

(A) immediate implant-based breast reconstruction;

(B) delayed implant-based breast reconstruction;

(C) myocutaneous flap tissue-based breast reconstruction;

(D) microvascular free flap tissue-based breast reconstruction;

(E) structural fat grafting tissue-based breast reconstruction;

(F) combined implant-based and tissue-based breast reconstruction; and

(G) any type of breast reconstruction developed after January 1, 2027, that is:

(i) recognized within Level I of the Healthcare Common Procedure Coding System codes; and

(ii) determined by the commissioner to qualify for coverage under this section.

(6) All procedural variations, iterations, or approaches associated with the breast reconstruction types under subdivision (5), as noted within the short descriptor or the description for the Level I Healthcare Common Procedure Coding System code covering the modalities and types of breast reconstruction.

(7) Chest wall reconstruction, including an aesthetic flat closure.

(8) Custom fabricated breast prostheses, including

replacement of the breast prostheses.

(9) Hybrid procedures that involve both an autologous breast reconstruction procedure and biologic or synthetic products and devices.

(10) Mechanical, medical, and surgical prophylaxis to prevent physical complications of a mastectomy, breast conserving surgery, chest wall reconstruction, radiation, or lymph node surgery.

(11) Mechanical, medical, and surgical treatment of physical complications of a mastectomy, breast conserving surgery, chest wall reconstruction, radiation, or lymph node surgery.

(c) As used in this section, "commissioner" means the insurance commissioner appointed under IC 27-1-1-2.

(d) As used in this section, "covered individual" means an individual entitled to coverage under a state employee health plan.

(e) As used in this section, "health care professional" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of the person's profession.

(f) As used in this section, "health care professional reimbursement rate" means the amount paid to a health care professional by a state employee health plan for health care services.

(g) As used in this section, "health care service" means an item or service provided to an individual for the purposes of alleviating, curing, healing, or preventing human illness, injury, or physical disability.

(h) As used in this section, "mastectomy" means the removal of all or part of the breast for reasons that are determined by a licensed physician to be medically necessary.

(i) As used in this section, "out of network provider" means a health care professional who:

(1) provides health care services to a covered individual; and

(2) is not a participating provider.

(j) As used in this section, "participating provider" means a health care professional who has a health care contract with a contracting entity to provide health care services to a covered individual with the expectation of receiving payment either directly from the contracting entity or from a state employee health plan affiliated with the contracting entity.

(k) As used in this section, "state employee health plan" means a:

(1) self-insurance program established under section 7(b) of this chapter; or

(2) contract with a prepaid health care delivery plan entered into under section 7(c) of this chapter;

to provide group health coverage for state employees.

(l) A state employee health plan shall do the following:

(1) Provide coverage for:

(A) any breast reconstruction surgery that is determined as the best course of treatment by a health care professional, consistent with prevailing medical standards, and in consultation with the covered individual; and

(B) all modalities, types, and techniques of a health care service provided for the breast reconstruction surgery.

(2) Provide access to an adequate breast reconstruction surgeon network.

(m) An adequate breast reconstruction surgeon network must include, for each modality, type, and technique of breast reconstruction surgery, a provider network consisting of:

(1) for a state employee health plan with less than twenty thousand (20,000) female covered individuals, at least one (1) physician; or

(2) for a state employee health plan with twenty thousand (20,000) female covered individuals or more, at least one (1) physician for every twenty thousand (20,000) female covered individuals;

who is a participating provider that actively submits claims that include a Healthcare Common Procedure Coding System Level I code covering the breast reconstruction modality, type, and technique. The commissioner shall develop exceptions to these requirements for counties that do not have any physicians with the Medicare provider taxonomy codes 2086S0122X and 208200000X.

(n) The coverage for breast reconstruction surgery under this section:

(1) is subject to policy deductibles, copayment requirements, or coinsurance requirements of a state employee health plan at a cost that is not more than the costs associated with the state employee health plan's in network rate for the health care service;

(2) may not diminish or limit benefits otherwise allowable under a state employee health plan; and

(3) may not affect a covered individual's eligibility or continued eligibility to enroll or renew coverage under the

terms of the state employee health plan solely for the purpose of avoiding the requirements of this section.

(o) If a covered individual is forced to use an out of network provider due to a state employee health plan's network inadequacy, the covered individual's financial responsibility must remain at an in network rate.

(p) If a state employee health plan does not have a participating provider who provides breast reconstruction surgery, the state employee health plan shall:

(1) automatically approve a single case agreement for an out of network provider to provide breast reconstruction surgery that is determined as the best course of treatment by a health care professional, consistent with prevailing medical standards, and in consultation with the covered individual;

(2) reimburse the out of network provider who performs breast reconstruction surgery at an amount that is the lesser of:

(A) the health care professional's billed charges for the health care services; or

(B) the eightieth percentile of all charges for the particular health care service:

(i) performed by a health care professional in the same or similar specialty; and

(ii) provided in the same or similar geographical area as reported in a benchmarking data base maintained by a nonprofit organization that is not affiliated with, financially supported by, or otherwise supported by the state employee health plan.

(q) The following apply if a state employee health plan does not reimburse an out of network provider as required under this section:

(1) The state employee health plan, in addition to making the required payment for the health care services, shall pay the out of network provider an amount that is three (3) times the difference between:

(A) the initial payment, or in the case of a notice of denial of payment, zero dollars ($0); and

(B) the out of network reimbursement rate required under this section, less any cost sharing required to be paid by the covered individual.

(2) The payment that is required under subdivision (1) is subject to interest in a manner specified by the commissioner.

(r) A state employee health plan may not, by contract or any other means, implement or enforce any system of referral that materially impedes a covered individual's access to breast reconstruction surgery, including:

(1) causing an undue delay in service by requiring a waiting period for the covered individual to receive breast reconstruction surgery that exceeds the clinically appropriate time frame, as determined by the referring health care professional in accordance with established medical standards; and

(2) requiring the covered individual to travel an unreasonable distance for the breast reconstruction surgery, accounting for the covered individual's medical condition and available transportation resources.

(s) A state employee health plan shall provide to a covered individual, at the time the policy is issued and annually thereafter, written notice of the coverage required under this section. Notice sent by a state employee health plan that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance with this subsection.

(t) The provisions of this section may not be waived by contract. A contractual arrangement or action taken in conflict with this section or that purports to waive any requirement of this section is void.

(u) This section may not be used by a state employee health plan to lower reimbursement rates for other health care services involving breast reconstruction provided by a participating provider.

(v) The commissioner shall adopt rules under IC 4-22-2 to implement and administer this section.

SECTION 3. IC 27-1-37.5-12, AS AMENDED BY P.L.144-2025, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: Sec. 12. (a) **Except as provided in subsection (b),** this section applies to a claim for a health care service rendered by a health care provider:

(1) for which:

(A) prior authorization is requested after June 30, 2025; and

(B) a utilization review entity gives prior authorization; and

(2) that is rendered in accordance with the authorization.

(b) This section does not apply to a claim for breast reconstruction surgery that is subject to section 12.5 of this chapter.

~~(b)~~ **(c)** The utilization review entity shall not deny the claim described in subsection (a) unless:

(1) the health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from the utilization review entity;

(2) the health care service was no longer a covered benefit on the date the health care service was provided;

(3) the health care provider was no longer contracted with the patient's health plan on the date the health care service was provided;

(4) the health care provider failed to meet the utilization review entity's timely filing requirements;

(5) the utilization review entity does not have liability for the claim; or

(6) the patient was not covered under the health plan on the date on which the health care service was rendered.

~~(c)~~ **(d)** If:

(1) the claim described in subsection (a) contains an unintentional and inaccurate inconsistency with the request for prior authorization; and

(2) the inconsistency results in denial of the claim;

the health care provider may resubmit the claim with accurate, corrected information.

SECTION 4. IC 27-1-37.5-12.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: **Sec. 12.5. (a) This section applies to a claim for breast reconstruction surgery rendered by a health care provider:**

(1) for which:

(A) prior authorization is requested after December 31, 2026; and

(B) a utilization review entity gives prior authorization; and

(2) that is rendered in accordance with the authorization.

(b) As used in this section, "breast reconstruction surgery" has the meaning set forth in IC 27-8-5-26.1.

(c) A utilization review entity may not deny a claim described in subsection (a) unless the utilization review entity provides a formal declaration of compelling evidence of health care provider fraud in the prior authorization or claim submission process.

SECTION 5. IC 27-8-5-0.1, AS ADDED BY P.L.220-2011,

SECTION 435, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The amendments made to section 1 of this chapter by P.L.257-1985 apply to insurance policies issued after December 31, 1985.

(2) The amendments made to section 21 of this chapter by P.L.98-1990 apply to a policy issued for delivery in Indiana after June 30, 1990.

(3) The addition of section 23 of this chapter by P.L.152-1990 applies to a statute or rule mandating the offering of health care coverage enacted or adopted after December 31, 1990.

(4) The amendments made to section 23 of this chapter by P.L.119-1991 apply to an insurance policy that is issued or renewed after June 30, 1991.

(5) The addition of section 2.5 of this chapter by P.L.93-1995 applies to all individual accident and sickness policies issued or renewed after December 31, 1997.

(6) The addition of section 2.6 of this chapter (before its repeal) by P.L.93-1995 applies to all individual accident and sickness policies issued or renewed after December 31, 1995.

(7) The amendments made to sections 3 and 19 of this chapter by P.L.91-1998 apply to all accident and sickness policies in force on April 1, 1998.

(8) The amendments made to section 26 of this chapter **(before its repeal)** by P.L.204-2003 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.

(9) The amendments made to section 15.6 of this chapter by P.L.226-2003 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2003.

(10) The amendments made to section 2.5 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.

(11) The amendments made to section 16.5 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.

(12) The amendments made to section 19 of this chapter by P.L.127-2006 apply to a certificate of coverage under a nonemployer based association group policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2006.

(13) The amendments made to section 3 of this chapter by P.L.98-2007 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after December 31, 2007.

(14) The amendments made to section 2 of this chapter by P.L.218-2007 apply to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.

(15) The addition of section 28 of this chapter by P.L.218-2007 applies to a policy of accident and sickness insurance that is issued, delivered, amended, or renewed after June 30, 2007.

SECTION 6. IC 27-8-5-16.5, AS AMENDED BY P.L.11-2011, SECTION 30, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: Sec. 16.5. (a) As used in this section, "delivery state" means any state other than Indiana in which a policy is delivered or issued for delivery.

(b) Except as provided in subsection (c), (d), or (e), a certificate may not be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana.

(c) A certificate may be issued to a resident of Indiana pursuant to a group policy not described in subsection (d) that is delivered or issued for delivery in a state other than Indiana if:

(1) the delivery state has a law substantially similar to section 16 of this chapter;

(2) the delivery state has approved the group policy; and

(3) the policy or the certificate contains provisions that are:

(A) substantially similar to the provisions required by:

(i) section 19 of this chapter;

(ii) section 21 of this chapter; and

(iii) IC 27-8-5.6; and

(B) consistent with the requirements set forth in:

(i) section 24 of this chapter;

(ii) IC 27-8-6;

(iii) IC 27-8-14;

(iv) IC 27-8-23;

(v) 760 IAC 1-38.1; and

(vi) 760 IAC 1-39.

(d) A certificate may be issued to a resident of Indiana under an association group policy, a discretionary group policy, or a trust group policy that is delivered or issued for delivery in a state other than Indiana if:

(1) the delivery state has a law substantially similar to section 16 of this chapter;

(2) the delivery state has approved the group policy; and

(3) the policy or the certificate contains provisions that are:

(A) substantially similar to the provisions required by:

(i) section 19 of this chapter or, if the policy or certificate is described in section 2.5(b)(2) of this chapter, section 2.5 of this chapter;

(ii) section 19.3 of this chapter if the policy or certificate contains a waiver of coverage;

(iii) section 21 of this chapter; and

(iv) IC 27-8-5.6; and

(B) consistent with the requirements set forth in:

(i) section 15.6 of this chapter;

(ii) section 24 of this chapter;

(iii) section ~~26~~ **26.1** of this chapter;

(iv) IC 27-8-6;

(v) IC 27-8-14;

(vi) IC 27-8-14.1;

(vii) IC 27-8-14.5;

(viii) IC 27-8-14.7;

(ix) IC 27-8-14.8;

(x) IC 27-8-20;

(xi) IC 27-8-23;

(xii) IC 27-8-24.3;

(xiii) IC 27-8-26;

(xiv) IC 27-8-28;

(xv) IC 27-8-29;

(xvi) 760 IAC 1-38.1; and

(xvii) 760 IAC 1-39.

(e) A certificate may be issued to a resident of Indiana pursuant to a group policy that is delivered or issued for delivery in a state other than Indiana if the commissioner determines that the policy pursuant to which the certificate is issued meets the requirements set forth in section 17(a) of this chapter.

(f) This section does not affect any other provision of Indiana law governing the terms or benefits of coverage provided to a resident of Indiana under any certificate or policy of insurance.

SECTION 7. IC 27-8-5-26 IS REPEALED [EFFECTIVE JANUARY 1, 2027]. ~~Sec. 26. (a) As used in this section, "mastectomy" means the removal of all or part of the breast for reasons that are determined by a licensed physician to be medically necessary.~~

~~(b) A policy of accident and sickness insurance that provides coverage for a mastectomy may not be issued, amended, delivered, or renewed in Indiana unless the policy provides coverage as required under 29 U.S.C. 1185b, including coverage for:~~

~~(1) prosthetic devices; and~~

~~(2) reconstructive surgery incident to a mastectomy including:~~

~~(A) all stages of reconstruction of the breast on which the mastectomy has been performed;~~

~~(B) surgery and reconstruction of the other breast to produce symmetry; and~~

~~(C) chest wall reconstruction, including aesthetic flat closure (as defined by the National Cancer Institute);~~

~~in the manner determined by the attending physician and the patient to be appropriate.~~

~~(c) In addition to the coverage required by 29 U.S.C. 1185b, a policy of accident and sickness insurance that provides coverage for a mastectomy must provide coverage for:~~

~~(1) custom fabricated breast prostheses; and~~

~~(2) one (1) additional breast prosthesis per breast affected by the mastectomy.~~

~~(d) Coverage required under this section is subject to:~~

~~(1) the deductible and coinsurance provisions applicable to a mastectomy; and~~

~~(2) all other terms and conditions applicable to other benefits.~~

~~(e) An insurer that issues a policy of accident and sickness insurance shall provide to an insured, at the time the policy is issued and annually thereafter, written notice of the coverage required under this section. Notice that is sent by the insurer that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance with this subsection.~~

~~(f) The coverage required under this section applies to a policy of accident and sickness insurance that provides coverage for a mastectomy, regardless of whether an individual who:~~

~~(1) underwent a mastectomy; and~~

~~(2) is covered under the policy;~~

~~was covered under the policy at the time of the mastectomy.~~

~~(g) Except as provided in subsection (b)(2)(C) and subsection (c), this section does not require an insurer to provide coverage related to~~

~~post mastectomy care that exceeds the coverage required for post mastectomy care under federal law.~~

SECTION 8. IC 27-8-5-26.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: **Sec. 26.1. (a) This section applies to a policy of accident and sickness insurance that is issued, entered into, amended, or renewed after December 31, 2026.**

(b) As used in this section, "breast reconstruction surgery" means all stages of surgery and revisions to repair physical defects and restore losses of function caused by the extirpation or medical treatment of breast tissue following trauma, the loss of breast tissue due to congenital or noncongenital diseases, a breast-conserving disease treatment surgery including, lumpectomy, wide local incision, segmental mastectomy, and quadrantectomy, a mastectomy, or surgical prophylaxis against a future disease of the breast. The term includes the following:

(1) Augmentation or reduction.

(2) All states of primary and revision surgery to reconstruct a breast mound or to create a new breast mound.

(3) All procedures for a non-diseased contralateral breast necessary for symmetry between two (2) breasts.

(4) All breast reconstruction modalities, including:

(A) implant-based breast reconstruction;

(B) tissue-based breast reconstruction; and

(C) any breast reconstruction modalities developed after January 1, 2027, that are:

(i) recognized within Level I of the Healthcare Common Procedure Coding System codes; and

(ii) determined by the commissioner to qualify for coverage under this section.

(5) All types of breast reconstruction contained within the modalities under subdivision (4), including:

(A) immediate implant-based breast reconstruction;

(B) delayed implant-based breast reconstruction;

(C) myocutaneous flap tissue-based breast reconstruction;

(D) microvascular free flap tissue-based breast reconstruction;

(E) structural fat grafting tissue-based breast reconstruction;

(F) combined implant-based and tissue-based breast reconstruction; and

(G) any type of breast reconstruction developed after

January 1, 2027, that is:

(i) recognized within Level I of the Healthcare Common Procedure Coding System codes; and

(ii) determined by the commissioner to qualify for coverage under this section.

(6) All procedural variations, iterations, or approaches associated with the breast reconstruction types under subdivision (5), as noted within the short descriptor or the description for the Level I Healthcare Common Procedure Coding System code covering the modalities and types of breast reconstruction.

(7) Chest wall reconstruction, including an aesthetic flat closure.

(8) Custom fabricated breast prostheses, including replacement of the breast prostheses.

(9) Hybrid procedures that involve both an autologous breast reconstruction procedure and biologic or synthetic products and devices.

(10) Mechanical, medical, and surgical prophylaxis to prevent physical complications of a mastectomy, breast conserving surgery, chest wall reconstruction, radiation, or lymph node surgery.

(11) Mechanical, medical, and surgical treatment of physical complications of a mastectomy, breast conserving surgery, chest wall reconstruction, radiation, or lymph node surgery.

(c) As used in this section, "commissioner" means the insurance commissioner appointed under IC 27-1-1-2.

(d) As used in this section, "health care professional" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of the person's profession.

(e) As used in this section, "health care professional reimbursement rate" means the amount paid to a health care professional by an insurer for health care services.

(f) As used in this section, "health care service" means an item or service provided to an individual for the purposes of alleviating, curing, healing, or preventing human illness, injury, or physical disability.

(g) As used in this section, "insured" means an individual entitled to coverage under a policy of accident and sickness insurance.

(h) As used in this section, "insurer" means an insurer (as

defined in IC 27-1-2-3(x)) that issues a policy of accident and sickness insurance.

(i) As used in this section, "mastectomy" means the removal of all or part of the breast for reasons that are determined by a licensed physician to be medically necessary.

(j) As used in this section, "out of network provider" means a health care professional who:

(1) provides health care services to an insured; and

(2) is not a participating provider.

(k) As used in this section, "participating provider" means a health care professional who has a health care contract with a contracting entity to provide health care services to an insured with the expectation of receiving payment either directly from the contracting entity or from an insurer affiliated with the contracting entity.

(l) As used in this section, "policy of accident and sickness insurance" does not include a policy, plan, or coverage set forth in IC 27-8-5-2.5(a).

(m) A policy of accident and sickness insurance shall do the following:

(1) Provide coverage for:

(A) any breast reconstruction surgery that is determined as the best course of treatment by a health care professional, consistent with prevailing medical standards, and in consultation with the insured; and

(B) all modalities, types, and techniques of a health care service provided for the breast reconstruction surgery.

(2) Provide access to an adequate breast reconstruction surgeon network.

(n) An adequate breast reconstruction surgeon network must include, for each modality, type, and technique of breast reconstruction surgery, a provider network consisting of:

(1) for a policy of accident and sickness insurance with less than twenty thousand (20,000) female insureds, at least one (1) physician; or

(2) for a policy of accident and sickness insurance with twenty thousand (20,000) female insureds or more, at least one (1) physician for every twenty thousand (20,000) female insureds;

who is a participating provider that actively submits claims that include a Healthcare Common Procedure Coding System Level I code covering the breast reconstruction modality, type, and technique. The commissioner shall develop exceptions to these

requirements for counties that do not have any physicians with the Medicare provider taxonomy codes 2086S0122X and 208200000X.

(o) The coverage for breast reconstruction surgery under this section:

(1) is subject to policy deductibles, copayment requirements, or coinsurance requirements of an insurer at a cost that is not more than the costs associated with the policy of accident and sickness insurance's in network rate for the health care service;

(2) may not diminish or limit benefits otherwise allowable under a policy of accident and sickness insurance; and

(3) may not affect an insured's eligibility or continued eligibility to enroll or renew coverage under the terms of the policy of accident and sickness insurance solely for the purpose of avoiding the requirements of this section.

(p) If an insured is forced to use an out of network provider due to an insurer's network inadequacy, the insured's financial responsibility must remain at an in network rate.

(q) If an insurer does not have a participating provider who provides breast reconstruction surgery, the insurer shall:

(1) automatically approve a single case agreement for an out of network provider to provide breast reconstruction surgery that is determined as the best course of treatment by a health care professional, consistent with prevailing medical standards, and in consultation with the insured;

(2) reimburse the out of network provider who performs breast reconstruction surgery at an amount that is the lesser of:

(A) the health care professional's billed charges for the health care services; or

(B) the eightieth percentile of all charges for the particular health care service:

(i) performed by a health care professional in the same or similar specialty; and

(ii) provided in the same or similar geographical area as reported in a benchmarking data base maintained by a nonprofit organization that is not affiliated with, financially supported by, or otherwise supported by the insurer.

(r) The following apply if an insurer does not reimburse an out of network provider as required under this section:

(1) The insurer, in addition to making the required payment

for the health care services, shall pay the out of network provider an amount that is three (3) times the difference between:

(A) the initial payment, or in the case of a notice of denial of payment, zero dollars ($0); and

(B) the out of network reimbursement rate required under this section, less any cost sharing required to be paid by the insured.

(2) The payment that is required under subdivision (1) is subject to interest in a manner specified by the commissioner.

(s) An insurer may not, by contract or any other means, implement or enforce any system of referral that materially impedes an insured's access to breast reconstruction surgery, including:

(1) causing an undue delay in service by requiring a waiting period for the insured to receive breast reconstruction surgery that exceeds the clinically appropriate time frame, as determined by the referring health care professional in accordance with established medical standards; and

(2) requiring the insured to travel an unreasonable distance for the breast reconstruction surgery, accounting for the insured's medical condition and available transportation resources.

(t) An insurer shall provide to an insured, at the time the policy is issued and annually thereafter, written notice of the coverage required under this section. Notice sent by the insurer that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance with this subsection.

(u) The provisions of this section may not be waived by contract. A contractual arrangement or action taken in conflict with this section or that purports to waive any requirement of this section is void.

(v) This section may not be used by an insurer to lower reimbursement rates for other health care services involving breast reconstruction provided by a participating provider.

(w) The commissioner shall adopt rules under IC 4-22-2 to implement and administer this section.

SECTION 9. IC 27-13-7-0.1, AS ADDED BY P.L.220-2011, SECTION 457, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: Sec. 0.1. The following amendments to this chapter apply as follows:

(1) The addition of sections 15.3 and 16 of this chapter by

P.L.170-1999 applies to health maintenance organization contracts that are issued, delivered, or renewed after June 30, 1999.

(2) The addition of section 18 of this chapter by P.L.166-2003 applies to a health maintenance organization contract that is entered into, delivered, amended, or renewed after December 31, 2003.

(3) The amendments made to section 14 of this chapter **(before its repeal)** by P.L.204-2003 apply to an individual contract or a group contract that is entered into, delivered, amended, or renewed after June 30, 2003.

(4) The amendments made to section 14.8 of this chapter by P.L.226-2003 apply to a group or an individual contract with a health maintenance organization that is entered into, delivered, amended, or renewed after June 30, 2003.

(5) The amendments made to section 14.5 of this chapter by P.L.196-2005 apply to a health maintenance organization contract that is entered into, delivered, amended, or renewed after June 30, 2005.

(6) The amendments made to section 3 of this chapter by P.L.218-2007 apply to a health maintenance organization contract that is entered into, delivered, amended, or renewed after June 30, 2007.

(7) The addition of section 19 of this chapter by P.L.109-2008 applies to an individual contract or a group contract that is entered into, delivered, amended, or renewed after June 30, 2008.

SECTION 10. IC 27-13-7-14 IS REPEALED [EFFECTIVE JANUARY 1, 2027]. ~~Sec. 14. (a) As used in this section, "mastectomy" means the removal of all or part of the breast for reasons that are determined by a licensed physician to be medically necessary.~~

~~(b) A contract with a health maintenance organization that provides coverage for a mastectomy must provide coverage as required under 29 U.S.C. 1185b, including coverage for:~~

~~(1) prosthetic devices; and~~

~~(2) reconstructive surgery incident to a mastectomy including:~~

~~(A) all stages of reconstruction of the breast on which the mastectomy has been performed;~~

~~(B) surgery and reconstruction of the other breast to produce symmetry; and~~

~~(C) chest wall reconstruction, including aesthetic flat closure (as defined by the National Cancer Institute);~~

~~in the manner determined by the attending physician and the~~

~~patient to be appropriate.~~

~~(c) In addition to the coverage required by 29 U.S.C. 1185b, a health maintenance organization contract that provides coverage for a mastectomy must provide coverage for:~~

~~(1) custom fabricated breast prostheses; and~~

~~(2) one (1) additional breast prosthesis per breast affected by the mastectomy.~~

~~(d) Coverage required under this section is subject to:~~

~~(1) the deductible and coinsurance provisions applicable to a mastectomy; and~~

~~(2) all other terms and conditions applicable to other services under the contract.~~

~~(e) A health maintenance organization shall provide to an enrollee, at the time that an individual contract or a group contract is entered into and annually thereafter, written notice of the coverage required under this section. Notice that is sent by the health maintenance organization that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance with this subsection.~~

~~(f) The coverage required under this section applies to a contract with a health maintenance organization that provides coverage for a mastectomy, regardless of whether an individual who:~~

~~(1) underwent a mastectomy; and~~

~~(2) is covered under the contract;~~

~~was covered under the contract at the time of the mastectomy.~~

~~(g) Except as provided in subsection (b)(2)(C) and subsection (c), this section does not require a health maintenance organization to provide coverage related to post mastectomy care that exceeds the coverage required for post mastectomy care under federal law.~~

SECTION 11. IC 27-13-7-14.1 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2027]: **Sec. 14.1. (a) This section applies to an individual contract or a group contract that is entered into, amended, or renewed after December 31, 2026.**

(b) As used in this section, "breast reconstruction surgery" means all stages of surgery and revisions to repair physical defects and restore losses of function caused by the extirpation or medical treatment of breast tissue following trauma, the loss of breast tissue due to congenital or noncongenital diseases, a breast-conserving disease treatment surgery including, lumpectomy, wide local incision, segmental mastectomy, and quadrantectomy, a mastectomy, or surgical prophylaxis against a future disease of the breast. The term includes the following:

(1) Augmentation or reduction.

(2) All states of primary and revision surgery to reconstruct a breast mound or to create a new breast mound.

(3) All procedures for a non-diseased contralateral breast necessary for symmetry between two (2) breasts.

(4) All breast reconstruction modalities, including:

(A) implant-based breast reconstruction;

(B) tissue-based breast reconstruction; and

(C) any breast reconstruction modalities developed after January 1, 2027, that are:

(i) recognized within Level I of the Healthcare Common Procedure Coding System codes; and

(ii) determined by the commissioner to qualify for coverage under this section.

(5) All types of breast reconstruction contained within the modalities under subdivision (4), including:

(A) immediate implant-based breast reconstruction;

(B) delayed implant-based breast reconstruction;

(C) myocutaneous flap tissue-based breast reconstruction;

(D) microvascular free flap tissue-based breast reconstruction;

(E) structural fat grafting tissue-based breast reconstruction;

(F) combined implant-based and tissue-based breast reconstruction; and

(G) any type of breast reconstruction developed after January 1, 2027, that is:

(i) recognized within Level I of the Healthcare Common Procedure Coding System codes; and

(ii) determined by the commissioner to qualify for coverage under this section.

(6) All procedural variations, iterations, or approaches associated with the breast reconstruction types under subdivision (5), as noted within the short descriptor or the description for the Level I Healthcare Common Procedure Coding System code covering the modalities and types of breast reconstruction.

(7) Chest wall reconstruction, including an aesthetic flat closure.

(8) Custom fabricated breast prostheses, including replacement of the breast prostheses.

(9) Hybrid procedures that involve both an autologous breast

reconstruction procedure and biologic or synthetic products and devices.

(10) Mechanical, medical, and surgical prophylaxis to prevent physical complications of a mastectomy, breast conserving surgery, chest wall reconstruction, radiation, or lymph node surgery.

(11) Mechanical, medical, and surgical treatment of physical complications of a mastectomy, breast conserving surgery, chest wall reconstruction, radiation, or lymph node surgery.

(c) As used in this section, "health care professional" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of the person's profession.

(d) As used in this section, "health care professional reimbursement rate" means the amount paid to a health care professional by a health maintenance organization for health care services.

(e) As used in this section, "mastectomy" means the removal of all or part of the breast for reasons that are determined by a licensed physician to be medically necessary.

(f) As used in this section, "out of network provider" means a health care professional who:

(1) provides health care services to an enrollee; and

(2) is not a participating provider.

(g) As used in this section, "participating provider" means a health care professional who has a health care contract with a contracting entity to provide health care services to an enrollee with the expectation of receiving payment either directly from the contracting entity or from a health maintenance organization affiliated with the contracting entity.

(h) An individual contract or a group contract shall do the following:

(1) Provide coverage for:

(A) any breast reconstruction surgery that is determined as the best course of treatment by a health care professional, consistent with prevailing medical standards, and in consultation with the enrollee; and

(B) all modalities, types, and techniques of a health care service provided for the breast reconstruction surgery.

(2) Provide access to an adequate breast reconstruction surgeon network.

(i) An adequate breast reconstruction surgeon network must

include, for each modality, type, and technique of breast reconstruction surgery, a provider network consisting of:

(1) for a contract with less than twenty thousand (20,000) female enrollees, at least one (1) physician; or

(2) for a contract with twenty thousand (20,000) female enrollees or more, at least one (1) physician for every twenty thousand (20,000) female enrollees;

who is a participating provider that actively submits claims that include a Healthcare Common Procedure Coding System Level I code covering the breast reconstruction modality, type, and technique. The commissioner shall develop exceptions to these requirements for counties that do not have any physicians with the Medicare provider taxonomy codes 2086S0122X and 208200000X.

(j) The coverage for breast reconstruction surgery under this section:

(1) is subject to policy deductibles, copayment requirements, or coinsurance requirements of a health maintenance organization at a cost that is not more than the costs associated with the health maintenance organization's in network rate for the health care service;

(2) may not diminish or limit benefits otherwise allowable under an individual contract or a group contract; and

(3) may not affect an enrollee's eligibility or continued eligibility to enroll or renew coverage under the terms of the individual contract or group contract solely for the purpose of avoiding the requirements of this section.

(k) If an enrollee is forced to use an out of network provider due to a health maintenance organization's network inadequacy, the enrollee's financial responsibility must remain at an in network rate.

(l) If a health maintenance organization does not have a participating provider who provides breast reconstruction surgery, the health maintenance organization shall:

(1) automatically approve a single case agreement for an out of network provider to provide breast reconstruction surgery that is determined as the best course of treatment by a health care professional, consistent with prevailing medical standards, and in consultation with the enrollee;

(2) reimburse the out of network provider who performs breast reconstruction surgery at an amount that is the lesser of:

(A) the health care professional's billed charges for the

health care services; or

(B) the eightieth percentile of all charges for the particular health care service:

(i) performed by a health care professional in the same or similar specialty; and

(ii) provided in the same or similar geographical area as reported in a benchmarking data base maintained by a nonprofit organization that is not affiliated with, financially supported by, or otherwise supported by the health maintenance organization.

(m) The following apply if a health maintenance organization does not reimburse an out of network provider as required under this section:

(1) The health maintenance organization, in addition to making the required payment for the health care services, shall pay the out of network provider an amount that is three

(3) times the difference between:

(A) the initial payment, or in the case of a notice of denial of payment, zero dollars ($0); and

(B) the out of network reimbursement rate required under this section, less any cost sharing required to be paid by the enrollee.

(2) The payment that is required under subdivision (1) is subject to interest in a manner specified by the commissioner.

(n) A health maintenance organization may not, by contract or any other means, implement or enforce any system of referral that materially impedes an enrollee's access to breast reconstruction surgery, including:

(1) causing an undue delay in service by requiring a waiting period for the enrollee to receive breast reconstruction surgery that exceeds the clinically appropriate time frame, as determined by the referring health care professional in accordance with established medical standards; and

(2) requiring the enrollee to travel an unreasonable distance for the breast reconstruction surgery, accounting for the enrollee's medical condition and available transportation resources.

(o) A health maintenance organization shall provide to an enrollee, at the time the contract is issued and annually thereafter, written notice of the coverage required under this section. Notice sent by the health maintenance organization that meets the requirements set forth in 29 U.S.C. 1185b constitutes compliance

with this subsection.

(p) The provisions of this section may not be waived by contract. A contractual arrangement or action taken in conflict with this section or that purports to waive any requirement of this section is void.

(q) This section may not be used by a health maintenance organization to lower reimbursement rates for other health care services involving breast reconstruction provided by a participating provider.

(r) The commissioner shall adopt rules under IC 4-22-2 to implement and administer this section.