January 16, 2026

SENATE BILL No. 173

DIGEST OF SB 173 (Updated January 14, 2026 2:55 pm - DI 104)

Citations Affected: IC 5-10; IC 6-1.1; IC 12-15; IC 16-18; IC 16-21; IC 16-42; IC 16-46; IC 27-1; IC 27-8; IC 27-13; IC 34-30.

Synopsis: Health care matters. Prohibits: (1) the state employee health plan; (2) the Medicaid program; (3) an accident and sickness insurance policy; and (4) a health maintenance organization individual or group contract; from imposing a time limit on the amount of anesthesia time for a medical procedure or otherwise restricting or excluding coverage or payment of anesthesia time. 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. Allows for certain practitioners to provide neuroplastogen treatment concerning qualified patients with life threatening conditions if certain requirements are met.
(Continued next page)

Effective: July 1, 2026.

Johnson T, Charbonneau, Brown L

January 5, 2026, read first time and referred to Committee on Health and Provider Services.
January 15, 2026, amended, reported favorably — Do Pass; reassigned to Committee on Appropriations.

Digest Continued

Allows for research to be conducted on neuroplastogen access. Requires reporting of adverse events and annual reporting of patient statistical information concerning the neuroplastogen treatment. Provides for immunity when treating using neuroplastogens. Requires a clinical peer to disclose certain information for a peer to peer review of an adverse determination. Prohibits a utilization review entity from using artificial intelligence as the primary means for making adverse determinations. Prohibits a health insurer from engaging in certain downcoding practices and sets forth conditions for downcoding a claim. Authorizes the department of insurance to enforce the downcoding requirements and impose certain penalties for a violation. Prohibits an insurer, pharmacy benefit manager, or other administrator of pharmacy benefits from designating a prescription drug as a specialty drug unless certain conditions are met.

January 16, 2026

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.

SENATE BILL No. 173

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

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

SECTION 1. IC 5-10-8-14.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 14.5. (a) As used in this section, "anesthesia time" means the period beginning when an anesthesia practitioner begins to prepare a patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient. The term includes blocks of time around an interruption in anesthesia time provided that the anesthesia practitioner is furnishing continuous anesthesia care within the time periods surrounding the interruption.**

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

(c) 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 that is entered into or renewed under section 7(c) of this chapter;

that is issued, amended, or renewed after June 30, 2026, to provide individual or group health coverage that includes coverage for anesthesia services.

(d) The state employee health plan may not impose any of the following concerning the provision of anesthesia services to a covered individual during a medical procedure:

(1) A time limit on the amount of covered anesthesia time for any medical procedure.

(2) Restrictions or exclusions of coverage or payment of anesthesia time.

SECTION 2. IC 6-1.1-10-16, AS AMENDED BY P.L.230-2025, SECTION 26, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 16. (a) All or part of a building is exempt from property taxation if it is owned, occupied, and used by a person for educational, literary, scientific, religious, or charitable purposes.

(b) A building is exempt from property taxation if it is owned, occupied, and used by a town, city, township, or county for educational, literary, scientific, fraternal, or charitable purposes.

(c) A tract of land, including the campus and athletic grounds of an educational institution, is exempt from property taxation if:

(1) a building that is exempt under subsection (a) or (b) is situated on it;

(2) a parking lot or structure that serves a building referred to in subdivision (1) is situated on it; or

(3) the tract:

(A) is owned by a nonprofit entity established for the purpose of retaining and preserving land and water for their natural characteristics;

(B) does not exceed five hundred (500) acres; and

(C) is not used by the nonprofit entity to make a profit.

(d) A tract of land is exempt from property taxation if:

(1) it is purchased for the purpose of erecting a building that is to be owned, occupied, and used in such a manner that the building will be exempt under subsection (a) or (b); and

(2) not more than four (4) years after the property is purchased, and for each year after the four (4) year period, the owner demonstrates substantial progress and active pursuit towards the

erection of the intended building and use of the tract for the exempt purpose. To establish substantial progress and active pursuit under this subdivision, the owner must prove the existence of factors such as the following:

(A) Organization of and activity by a building committee or other oversight group.

(B) Completion and filing of building plans with the appropriate local government authority.

(C) Cash reserves dedicated to the project of a sufficient amount to lead a reasonable individual to believe the actual construction can and will begin within four (4) years.

(D) The breaking of ground and the beginning of actual construction.

(E) Any other factor that would lead a reasonable individual to believe that construction of the building is an active plan and that the building is capable of being completed within eight (8) years considering the circumstances of the owner.

If the owner of the property sells, leases, or otherwise transfers a tract of land that is exempt under this subsection, the owner is liable for the property taxes that were not imposed upon the tract of land during the period beginning January 1 of the fourth year following the purchase of the property and ending on December 31 of the year of the sale, lease, or transfer. The county auditor of the county in which the tract of land is located may establish an installment plan for the repayment of taxes due under this subsection. The plan established by the county auditor may allow the repayment of the taxes over a period of years equal to the number of years for which property taxes must be repaid under this subsection.

(e) Personal property is exempt from property taxation if it is owned and used in such a manner that it would be exempt under subsection (a) or (b) if it were a building.

(f) A hospital's property that is exempt from property taxation under subsection (a), (b), or (e) shall remain exempt from property taxation even if the property is used in part to furnish goods or services to another hospital whose property qualifies for exemption under this section.

(g) Property owned by a shared hospital services organization that is exempt from federal income taxation under Section 501(c)(3) or 501(e) of the Internal Revenue Code is exempt from property taxation if it is owned, occupied, and used exclusively to furnish goods or services to a hospital whose property is exempt from property taxation under subsection (a), (b), or (e).

(h) This section does not exempt from property tax an office or a practice of a physician or group of physicians that is owned by a hospital licensed under IC 16-21-2 or other property that is not substantially related to or supportive of the inpatient facility of the hospital unless the office, practice, or other property:

(1) provides or supports the provision of charity care (as defined in ~~IC 16-18-2-52.5),~~ **IC 16-18-2-52.5(b)),** including providing funds or other financial support for health care services for individuals who are indigent (as defined in ~~IC 16-18-2-52.5(b)~~ **IC 16-18-2-52.5(c)** and ~~IC 16-18-2-52.5(c)).~~ **IC 16-18-2-52.5(d));** or

(2) provides or supports the provision of community benefits (as defined in IC 16-21-9-1), including research, education, or government sponsored indigent health care (as defined in IC 16-21-9-2).

However, participation in the Medicaid or Medicare program alone does not entitle an office, practice, or other property described in this subsection to an exemption under this section.

(i) A tract of land or a tract of land plus all or part of a structure on the land is exempt from property taxation if:

(1) the tract is acquired for the purpose of erecting, renovating, or improving a single family residential structure that is to be given away or sold:

(A) in a charitable manner;

(B) by a nonprofit organization; and

(C) to low income individuals who will:

(i) use the land as a family residence; and

(ii) not have an exemption for the land under this section;

(2) the tract does not exceed three (3) acres; and

(3) the tract of land or the tract of land plus all or part of a structure on the land is not used for profit while exempt under this section.

(j) An exemption under subsection (i) terminates when the property is conveyed by the nonprofit organization to another owner.

(k) When property that is exempt in any year under subsection (i) is conveyed to another owner, the nonprofit organization receiving the exemption must file a certified statement with the auditor of the county, notifying the auditor of the change not later than sixty (60) days after the date of the conveyance. The county auditor shall immediately forward a copy of the certified statement to the county assessor. A nonprofit organization that fails to file the statement required by this subsection is liable for the amount of property taxes due on the

property conveyed if it were not for the exemption allowed under this chapter.

(l) If property is granted an exemption in any year under subsection (i) and the owner:

(1) fails to transfer the tangible property within eight (8) years after the assessment date for which the exemption is initially granted; or

(2) transfers the tangible property to a person who:

(A) is not a low income individual; or

(B) does not use the transferred property as a residence for at least one (1) year after the property is transferred;

the person receiving the exemption shall notify the county recorder and the county auditor of the county in which the property is located not later than sixty (60) days after the event described in subdivision (1) or (2) occurs. The county auditor shall immediately inform the county assessor of a notification received under this subsection.

(m) If subsection (l)(1) or (l)(2) applies, the owner shall pay, not later than the date that the next installment of property taxes is due, an amount equal to the sum of the following:

(1) The total property taxes that, if it were not for the exemption under subsection (i), would have been levied on the property in each year in which an exemption was allowed.

(2) Interest on the property taxes at the rate of ten percent (10%) per year.

(n) The liability imposed by subsection (m) is a lien upon the property receiving the exemption under subsection (i). An amount collected under subsection (m) shall be collected as an excess levy. If the amount is not paid, it shall be collected in the same manner that delinquent taxes on real property are collected.

(o) Property referred to in this section shall be assessed to the extent required under IC 6-1.1-11-9.

(p) This subsection applies to assessment dates occurring before January 1, 2026. A for-profit provider of early childhood education services to children who are at least four (4) but less than six (6) years of age on the annual assessment date may receive the exemption provided by this section for property used for educational purposes only if all the requirements of section 46 of this chapter are satisfied. A for-profit provider of early childhood education services that provides the services only to children younger than four (4) years of age may not receive the exemption provided by this section for property used for educational purposes.

(q) This subsection applies to assessment dates occurring after

December 31, 2025. Property used by a for-profit provider of early childhood education services to children who are less than six (6) years of age on the annual assessment date may receive the exemption provided by this section for property used for educational purposes only if all the requirements of section 46 of this chapter are satisfied.

(r) This subsection applies only to property taxes that are first due and payable in calendar years 2025 and 2026. All or part of a building is deemed to serve a charitable purpose and is exempt from property taxation if it is owned by a nonprofit entity that is:

(1) registered as a continuing care retirement community under IC 23-2-4 and charges an entry fee of not more than five hundred thousand dollars ($500,000) per unit;

(2) defined as a small house health facility under IC 16-18-2-331.9;

(3) licensed as a health care or residential care facility under IC 16-28; or

(4) licensed under IC 31-27 and designated as a qualified residential treatment provider that provides services under a contract with the department of child services.

This subsection expires January 1, 2027.

SECTION 3. IC 6-1.1-10-18.5, AS AMENDED BY P.L.230-2025, SECTION 27, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 18.5. (a) This section does not exempt from property tax an office or a practice of a physician or group of physicians that is owned by a hospital licensed under IC 16-21-2 or other property that is not substantially related to or supportive of the inpatient facility of the hospital unless the office, practice, or other property:

(1) provides or supports the provision of charity care (as defined in ~~IC 16-18-2-52.5),~~ **IC 16-18-2-52.5(b)),** including funds or other financial support for health care services for individuals who are indigent (as defined in ~~IC 16-18-2-52.5(b)~~ **IC 16-18-2-52.5(c)** and ~~IC 16-18-2-52.5(c));~~ **IC 16-18-2-52.5(d));** or

(2) provides or supports the provision of community benefits (as defined in IC 16-21-9-1), including research, education, or government sponsored indigent health care (as defined in IC 16-21-9-2).

However, participation in the Medicaid or Medicare program, alone, does not entitle an office, a practice, or other property described in this subsection to an exemption under this section.

(b) Tangible property is exempt from property taxation if it is:

(1) owned by an Indiana nonprofit corporation; and

(2) used by an Indiana nonprofit corporation in the operation of a hospital licensed under IC 16-21, a health facility licensed under IC 16-28, a residential care facility for the aged and licensed under IC 16-28, or a Christian Science home or sanatorium.

(c) This subsection applies only to property taxes first due and payable in calendar years 2025 and 2026. Tangible property that is not otherwise exempt from property taxation under subsection (b) is exempt from property taxation if it is:

(1) owned by an Indiana nonprofit corporation; and

(2) used by an Indiana nonprofit corporation in the operation of a continuing care retirement community under IC 23-2-4 that charges an entry fee of not more than five hundred thousand dollars ($500,000) per unit as described in section 16(r)(1) of this chapter, a small house health facility under IC 16-18-2-331.9, or a qualified residential treatment provider listed in section 16(r)(4) of this chapter.

This subsection expires January 1, 2027.

(d) Property referred to in this section shall be assessed to the extent required under IC 6-1.1-11-9.

SECTION 4. IC 12-15-5-22 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 22. (a) As used in this section, "anesthesia time" means the period beginning when an anesthesia practitioner begins to prepare a patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient. The term includes blocks of time around an interruption in anesthesia time provided that the anesthesia practitioner is furnishing continuous anesthesia care within the time periods surrounding the interruption.**

(b) Unless otherwise prohibited by federal law, the state Medicaid plan may not impose any of the following concerning the provision of anesthesia services during a medical procedure:

(1) A time limit on the amount of covered anesthesia time for any medical procedure.

(2) Restrictions or exclusions of coverage or payment of anesthesia time.

SECTION 5. IC 16-18-2-52.5, AS AMENDED BY P.L.188-2025, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 52.5. **(a) "Charity care", for purposes of IC 16-21-6 and IC 16-21-9, means medically necessary health care**

services provided free of charge or at a discounted rate under the hospital's written financial assistance policy to patients who meet income and asset criteria.

~~(a)~~ **(b)** "Charity care", for purposes of ~~IC 16-21-6, IC 16-21-9, and~~ IC 16-40-6, means the unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services:

(1) to a person classified by the hospital as financially indigent or medically indigent on an inpatient or outpatient basis; and

(2) to financially indigent patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

~~(b)~~ **(c)** As used in ~~this section,~~ **subsection (b),** "financially indigent" means an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's financial criteria and procedure used to determine if a patient is eligible for charity care. The criteria and procedure must include income levels and means testing indexed to the federal poverty guidelines. A hospital may determine that a person is financially or medically indigent under the hospital's eligibility system after health care services are provided.

~~(c)~~ **(d)** As used in ~~this section,~~ **subsection (b),** "medically indigent" means a person whose medical or hospital bills after payment by third party payors exceed a specified percentage of the patient's annual gross income as determined in accordance with the hospital's eligibility system, and who is financially unable to pay the remaining bill.

SECTION 6. IC 16-18-2-65.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 65.2. "Community health needs assessment", for purposes of IC 16-21-9, has the meaning set forth in IC 16-21-9-1.5.**

SECTION 7. IC 16-18-2-247.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 247.5. "Neuroplastogen", for purposes of IC 16-42-26.7, has the meaning set forth in IC 16-42-26.7-1.**

SECTION 8. IC 16-18-2-288, AS AMENDED BY P.L.96-2014, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 288. (a) "Practitioner", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-5.

(b) "Practitioner", for purposes of IC 16-41-14, has the meaning set forth in IC 16-41-14-4.

(c) "Practitioner", for purposes of IC 16-42-21, has the meaning set forth in IC 16-42-21-3.

(d) "Practitioner", for purposes of IC 16-42-22 and IC 16-42-25, has the meaning set forth in IC 16-42-22-4.5.

(e) "Practitioner", for purposes of IC 16-42-26.7, has the meaning set forth in IC 16-42-26.7-2.

SECTION 9. IC 16-18-2-317.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 317.4. "Research institution", for purposes of IC 16-42-26.7, has the meaning set forth in IC 16-42-26.7-3.**

SECTION 10. IC 16-21-9-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 1. **(a)** As used in this chapter, "community benefits" means the unreimbursed cost to a hospital of providing **the following:**

(1) Charity care.

(2) Government sponsored indigent health care. ~~donations, education, government sponsored program services, research, and subsidized health services.~~

(3) Subsidized clinical services provided despite a net financial loss if not providing the services would result in the community loss of access to the services.

(4) Services and activities that address needs identified in the nonprofit hospital's community health needs assessment.

(b) The term does not include **any of the following:**

(1) The cost to the hospital of paying any taxes or other governmental assessments.

(2) Bad debt.

(3) Contractual allowances and discounts negotiated with third party payors.

(4) Payment disruptions unrelated to hospital policy.

(5) Staff education required for licensure or certification.

(6) Activities with a primary purpose of marketing, lobbying, fundraising, or routine operations.

SECTION 11. IC 16-21-9-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 1.5. As used in this chapter, "community health needs assessment" refers to a nonprofit hospital's most recent assessment that meets the requirements set forth in 26 U.S.C. 501(r)(3).**

SECTION 12. IC 16-21-9-7, AS AMENDED BY P.L.6-2012, SECTION 115, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 7. (a) Each nonprofit hospital shall prepare an annual report of the community benefits plan. The report

must include, in addition to the community benefits plan itself, the following ~~background~~ information:

(1) The hospital's mission statement.

(2) A disclosure of the health care needs of the community that were considered in developing the hospital's community benefits plan.

(3) A disclosure of the amount and types of community benefits actually provided, including charity care. Charity care must be reported as a separate item from other community benefits.

(4) The following information concerning the hospital's charity care program:

(A) The eligibility criteria.

(B) The number of program applications received by the hospital in the previous calendar year.

(C) The number of approvals and denials of the applications received, as described in clause (B).

(5) Each government sponsored indigent health care program that the hospital participated in during the previous calendar year and the net cost of the program to the hospital. Net costs must account for any supplemental payments made to the hospital under the program, including those provided under IC 12-15-16.

(6) A list of each clinical service provided at a subsidized cost by the hospital and the net cost to the hospital for the subsidized clinical service.

(7) A list of each service provided, and any activity invested in, to address any need identified in the community health needs assessment, and the following information for each service or activity listed:

(A) The net cost of each item.

(B) The need in the community health needs assessment that each item addresses.

(C) The estimated impact of the item on addressing the identified need.

(8) An estimate of the value of the:

(A) sales tax exemption under IC 6-2.5-5; and

(B) property tax exemption under IC 6-1.1-10;

for the hospital.

(9) Any net revenue derived from the hospital's participation in the federal 340B Drug Pricing Program under 42 U.S.C. 256b(a)(4).

(b) **Not later than one hundred twenty (120) days after the close**

of a nonprofit hospital's fiscal year, each nonprofit hospital shall annually file ~~a~~ **the** report ~~of the community benefits plan~~ **described in subsection (a)** with the state department. ~~For a hospital's fiscal year that ends before July 1, 2011, the report must be filed not later than one hundred twenty (120) days after the close of the hospital's fiscal year. For a hospital's fiscal year that ends after June 30, 2011, the report must be filed at the same time the nonprofit hospital files its annual return described under Section 6033 of the Internal Revenue Code that is timely filed under Section 6072(e) of the Internal Revenue Code, including any applicable extension authorized under Section 6081 of the Internal Revenue Code.~~ **The nonprofit hospital shall post the report on the nonprofit hospital's website.**

(c) Each nonprofit hospital shall prepare a statement that notifies the public that the annual report of the community benefits plan is:

(1) public information;

(2) filed with the state department; and

(3) available to the public on **the nonprofit hospital's website and by** request from the state department.

This statement shall be posted in prominent places throughout the hospital, including the emergency room waiting area and the admissions office waiting area. The statement shall also be printed in the hospital patient guide or other material that provides the patient with information about the admissions criteria of the hospital.

(d) Each nonprofit hospital shall develop a written notice about any charity care program operated by the hospital and how to apply for charity care. The notice must be in appropriate languages if possible. The notice must also be conspicuously posted in the following areas:

(1) The general waiting area.

(2) The waiting area for emergency services.

(3) The business office.

(4) Any other area that the hospital considers an appropriate area in which to provide notice of a charity care program.

(e) The state department shall post a report submitted under this section on the state department's website.

SECTION 13. IC 16-21-9-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 8. **(a)** The state department may assess a civil penalty against a nonprofit hospital that fails to make a report of the community benefits plan as required under this chapter. The penalty may not exceed ~~one~~ **ten** thousand dollars ~~($1,000)~~ **($10,000)** for each day a report is delinquent after the date on which the report is due. ~~No penalty may be assessed against a hospital under this section until thirty (30) business days have elapsed after~~

~~written notification to the hospital of its failure to file a report.~~

(b) The penalty collected under this section shall be deposited in the local public health fund established by IC 16-46-10-1.

SECTION 14. IC 16-42-26.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]:

Chapter 26.7. Right to Try Investigational Neuroplastogens

Sec. 1. As used in this chapter, "neuroplastogen" means a drug or compound that:

(1) demonstrates rapid onset neuroplastic effects in humans; and

(2) has successfully completed Phase I of a federal Food and Drug Administration approved clinical trial.

The term includes psilocybin (as defined in IC 12-21-9-2).

Sec. 2. As used in this chapter, "practitioner" means a health professional who:

(1) is licensed and in good standing under IC 25;

(2) has prescriptive authority; and

(3) is acting within the health professional's scope of practice.

Sec. 3. As used in this chapter, "research institution" means an organization that meets all of the following:

(1) Has an academic institution that operates an institutional review board (IRB) that oversees research.

(2) Publishes the results of previous clinical trials in peer reviewed publications.

(3) Has access to a clinical research center and the center's resources, including research dedicated medical staff.

Sec. 4. An individual must meet the following requirements in order to qualify as an eligible patient under this chapter:

(1) Has been diagnosed with a life threatening condition as defined in 21 CFR 312.81 and meets the criteria set forth in 21 U.S.C. 360bbb-0a.

(2) Provides written informed consent to the practitioner for the treatment.

Sec. 5. (a) Notwithstanding IC 35-48, a practitioner may administer or supervise the psychotherapy supported administration of a neuroplastogen to a patient if the following conditions are met:

(1) The practitioner has evaluated the patient, reviewed the patient's medical history, and documented in the patient's medical charts the clinical rationale for the practitioner determining that the patient is qualified and could benefit

from the treatment.

(2) The practitioner has obtained and documented the patient's written informed consent as set forth in subsection (b) for the treatment.

(3) The patient meets the requirements set forth in section 4 of this chapter.

(4) The practitioner takes reasonable steps to ensure patient safety, including structured psychological monitoring and integration services, during the patient's neuroplastogen treatment and recovery.

(5) The neuroplastogen is obtained from a manufacturer or distributor that is registered with the federal Drug Enforcement Agency.

(6) The practitioner notifies the state department in the manner prescribed by the state department not later than thirty (30) days from the initial administration of the neuroplastogen to a patient.

(7) The practitioner submits the report required by section 7 of this chapter.

(b) Written informed consent under subsection (a)(2) must include the following:

(1) An explanation of the currently approved products and treatments for the individual's condition.

(2) An attestation by the individual of the individual's life threatening condition and that the individual concurs with the individual's physician that all currently approved treatments are unlikely to prolong the individual's life or improve the individual's life threatening condition.

(3) A clear identification of the investigational neuroplastogen treatment proposed to be used to treat the individual.

(4) A description of the best and worst outcomes, including the most likely outcome, resulting from use of the investigational treatment of the individual's life threatening condition. The description of outcomes must be based on the treating physician's knowledge of both the investigational neuroplastogen treatment and the individual's life threatening condition.

(5) A statement acknowledging that new, unanticipated, different, or worse symptoms or death may result from the proposed treatment.

(6) A statement that the individual's health insurance may not be obligated to pay for any care or treatment and that the

patient may be liable for all expenses of the treatment unless specifically required to do so by contract or law.

(7) A statement that eligibility for hospice care may be withdrawn if the individual begins investigational neuroplastogen treatment and does not meet hospice care eligibility requirements.

(8) A statement that the individual or the individual's legal guardian consents to the investigational neuroplastogen treatment for the life threatening condition.

(c) The state department shall establish a notification procedure described in subsection (a)(6) to be used under this chapter.

Sec. 6. (a) A practitioner, research institution, or clinic may conduct neuroplastogen outcomes access research if the following conditions are met:

(1) Any data collected and maintained in a patient registry that complies with the federal Health Insurance Portability and Accountability Act (HIPAA) and only includes de-identified patient data.

(2) The practitioner or clinic follows any best practice guidelines and protocols that have been issued by the United States Department of Health and Human Services, including:

(A) safety monitoring;

(B) psychotherapy support; and

(C) outcome measures.

(b) The state department may do the following:

(1) Implement Institutional Review Board (IRB) oversight protocols, including protocols for streamlined reporting of data under this chapter.

(2) Collaborate with research institutions in the development of standards and protocols to be used for research conducted under this chapter.

(3) Establish a registry to maintain data collected under this chapter.

(4) Adopt rules under IC 4-22-2 to implement this chapter, including rules concerning the following:

(A) Safety standards.

(B) Standardized informed consent forms.

(C) Data elements for inclusion in a registry.

(D) Adverse event reporting.

(E) Staff qualifications for psychotherapy support.

(F) Standardized notification forms for section 4 of this chapter.

(G) Report formatting.

Sec. 7. (a) Before February 1 of each year, a practitioner who performs neuroplastogen treatment under this chapter shall report the following information concerning the previous calendar year to the state department:

(1) The number of patients for whom the practitioner has conducted neuroplastogen treatment.

(2) Each neuroplastogen used and the typical dosage range.

(3) Any adverse event (as defined in 21 CFR 312.32(a)).

The report may not include patient identifying information.

(b) Before May 1 of each year, the state department shall aggregate and publish on the state department's website de-identified statistics from the reports submitted under subsection (a).

Sec. 8. Nothing in this chapter may be construed to do any of the following:

(1) Allow nonmedical use of neuroplastogens.

(2) Supersede federal law or regulation.

(3) Reschedule a controlled substance.

(4) Create a fiscal burden on the state.

(5) Require a practitioner, clinic, research institution, or other person to participate in providing treatment under this chapter.

(6) Mandate insurance coverage for treatment under this chapter.

Sec. 9. A practitioner, eligible facility (as defined in IC 16-42-26.5-1), research institution, or other person participating in providing treatment that complies with the requirements of this chapter is immune from criminal or civil liability.

SECTION 15. IC 16-46-10-1, AS AMENDED BY P.L.164-2023, SECTION 39, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 1. (a) The local public health fund is established for the purpose of providing local boards of health with funds as provided in sections 2.1 through 2.3 of this chapter to provide public health services. The fund shall be administered by the state department and consists of:

(1) appropriations by the general assembly;

(2) penalties paid and deposited in the fund under IC 6-8-11-17 **and IC 16-21-9-8;** and

(3) amounts, if any, that another statute requires to be distributed to the fund from the Indiana tobacco master settlement agreement fund.

(b) The expenses of administering the fund shall be paid from money in the fund.

(c) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. Interest that accrues from these investments shall be deposited in the fund.

SECTION 16. IC 27-1-24.2-16, AS ADDED BY P.L.189-2025, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 16. (a) Except as provided in section 15 of this chapter, with respect to the provision of pharmacy or pharmacist services under a health plan, an insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits may not:

(1) prohibit a pharmacy or pharmacist from, or impose a penalty on a pharmacy or pharmacist for:

(A) selling a lower cost alternative to an insured, if a lower cost alternative is available; or

(B) providing information to an insured under subsection (c);

(2) discriminate against any pharmacy or pharmacist that is:

(A) located within the geographic coverage area of the health plan; and

(B) willing to agree to, or accept, terms and conditions established for participation in the insurer's, pharmacy benefit manager's, other administrator's, or health plan's network;

(3) impose limits, including quantity limits or refill frequency limits, on an insured's access to medication from a pharmacy that are more restrictive than those existing for a pharmacy affiliate;

(4) except as provided in subsection (b), require an insured to receive pharmacy or pharmacist services from a pharmacy affiliate, including:

(A) requiring an insured to obtain a specialty drug from a pharmacy affiliate; and

(B) charging less cost sharing to insureds that use pharmacy affiliates than what is charged to insureds that use nonaffiliated pharmacies;

(5) require a pharmacy or pharmacist to enter into an additional contract with an affiliate of the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits as a condition of entering into a contract with this insurer, pharmacy benefit manager, or administrator; ~~or~~

(6) require a pharmacy or pharmacist to, as a condition of a contract, agree to payment rates for any affiliate of the insurer, pharmacy benefit manager, or other administrator of pharmacy

benefits that is not a party to the contract; **or**

(7) designate a prescription drug as a specialty drug unless the drug is a limited distribution that:

(A) requires special handling; and

(B) is not commonly carried at retail pharmacies or oncology clinics or practices.

(b) Subsection (a)(4):

(1) does not apply to a mail order pharmacy; and

(2) may not be construed to prohibit:

(A) communications to insureds regarding networks and prices if the communication is accurate and includes information about all eligible nonaffiliated pharmacies; or

(B) an insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits from providing financial incentives for utilizing the network, if the insurer, pharmacy benefit manager, or other administrator complies with this section and section 14 of this chapter.

(c) A pharmacist shall have the right to provide an insured with information regarding lower cost alternatives to assist the insured in making informed decisions.

SECTION 17. IC 27-1-37.5-17, AS AMENDED BY P.L.144-2025, SECTION 27, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 17. (a) As used in this section, "necessary information" includes the results of any face-to-face clinical evaluation, second opinion, or other clinical information that is directly applicable to the requested health care service that may be required.

(b) If a utilization review entity makes an adverse determination on a prior authorization request by a covered individual's health care provider, the utilization review entity must offer the covered individual's health care provider the option to request a peer to peer review by a clinical peer concerning the adverse determination.

(c) A covered individual's health care provider may request a peer to peer review by a clinical peer either in writing or electronically.

(d) If a peer to peer review by a clinical peer is requested under this section:

(1) the utilization review entity's clinical peer and the covered individual's health care provider or the health care provider's designee shall make every effort to provide the peer to peer review not later than forty-eight (48) hours (excluding weekends and state and federal legal holidays) after the utilization review entity receives the request by the covered individual's health care provider for a peer to peer review if the utilization review entity

has received the necessary information for the peer to peer review; ~~and~~

(2) the utilization review entity must have the peer to peer review conducted between the clinical peer and the covered individual's health care provider or the provider's designee; **and**

(3) the clinical peer must disclose the clinical peer's:

(A) full name;

(B) licensure; and

(C) speciality, if applicable;

to the covered individual's health care provider or the provider's designee.

SECTION 18. IC 27-1-37.5-19.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 19.5. (a) A utilization review entity may not use artificial intelligence as the primary means for making adverse determinations.**

(b) A utilization review entity must disclose in an easily accessible and readable manner when artificial intelligence is used during any part of the prior authorization review process.

SECTION 19. IC 27-1-37.5-20, AS ADDED BY P.L.144-2025, SECTION 29, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 20. (a) A utilization review entity must ensure that:

(1) all:

(A) adverse determinations based on medical necessity are made;

(B) adverse determinations made through the use of artificial intelligence are made; and

~~(B)~~ **(C)** appeals are reviewed and decided;

by a clinical peer; and

(2) when making an adverse determination ~~based on medical necessity~~ or reviewing and deciding an appeal **under subdivision (1),** the clinical peer is under the clinical direction of a medical director of the utilization review entity who is:

(A) responsible for the provision of health care services provided to covered individuals; and

(B) a physician licensed in Indiana under IC 25-22.5.

(b) An appeal may not be reviewed or decided by a clinical peer who:

(1) has a financial interest in the outcome of the appeal; or

(2) was involved in making the adverse determination that is the subject of the appeal.

SECTION 20. IC 27-1-52.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]:

Chapter 52.5. Downcoding of Medical Claims

Sec. 1. As used in this chapter, "CARC" refers to the claim adjustment reason codes that provide the reason for a financial adjustment specified to a particular claim or service, as referenced in the transmitted Accredited Standards Committee (ASC) X12 835 standard transaction adopted by the Department of Health and Human Services under 45 CFR 162.1602.

Sec. 2. As used in this chapter, "clinical peer" has the meaning set forth in IC 27-1-37.5-1.7.

Sec. 3. As used in this chapter, "downcoding" means the unilateral alteration by a health insurer of the level of evaluation and management service code or other service code submitted on a claim that results in a lower payment.

Sec. 4. As used in this chapter, "health care provider" has the meaning set forth in IC 27-1-37.5-3.9.

Sec. 5. (a) As used in this chapter, "health insurer" means an entity:

(1) that is subject to this title and the administrative rules adopted under this title; and

(2) that enters into a contract to:

(A) provide health care services;

(B) deliver health care services;

(C) arrange for health care services; or

(D) pay for or reimburse any of the costs of health care services.

(b) The term includes 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(a)).

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

(3) An administrator (as defined in IC 27-1-25-1(a)) that is licensed under IC 27-1-25.

(4) A state employee health plan offered under IC 5-10-8.

(5) A short term insurance plan (as defined in IC 27-8-5.9-3).

(6) Any other entity that provides a plan of health insurance, health benefits, or health care services.

(c) The term does not include:

(1) an insurer that issues a policy of accident and sickness

insurance;

(2) a limited service health maintenance organization (as defined in IC 27-13-34-4); or

(3) an administrator;

that only provides coverage for, or processes claims for, dental or vision care services.

Sec. 6. As used in this chapter, "RARC" refers to remittance advice remark codes that provide:

(1) supplemental information about a financial adjustment indicated by a CARC; or

(2) information about remittance processing.

Sec. 7. (a) A health insurer may not use an automated:

(1) process;

(2) system; or

(3) tool, including artificial intelligence;

to downcode a claim.

(b) A downcoding decision must be made by a clinical peer who:

(1) is licensed in Indiana in the requisite health field concerning the claim;

(2) has the same specialty as the treating health care provider; and

(3) performs a documented review of the clinical information supporting the billed service.

Sec. 8. A health insurer may not downcode a claim based solely on the reported diagnosis code.

Sec. 9. If a claim is downcoded, the health insurer shall:

(1) notify the health care provider using the appropriate CARC and RARC to clearly indicate that the claim has been downcoded; and

(2) provide:

(A) the specific reason for the downcoding, including reference to the clinical criteria used to justify the downcoding;

(B) the original and revised service codes and payment amounts;

(C) the:

(i) national provider identifier;

(ii) credentials;

(iii) board certifications; and

(iv) areas of specialty expertise and training;

of the clinical peer who is responsible for the downcoding decision; and

(D) a notice of the right to appeal as described in section 10 of this chapter.

Sec. 10. (a) A health insurer shall provide health care providers with a clear and accessible process for appealing downcoded claims, including:

(1) a written or electronic notice detailing how to initiate an appeal;

(2) contact information for the individual managing the appeal;

(3) a timeline for submission of an appeal that is not less than one hundred eighty (180) days; and

(4) a timeline for adjudication of an appeal that is not later than forty-eight (48) hours after an appeal is submitted.

(b) A health insurer shall allow a health care provider to appeal in batches of similar claims involving substantially similar downcoding issues without restriction.

Sec. 11. A health insurer may not use downcoding practices in a targeted or discriminatory manner against health care providers who routinely treat patients with complex or chronic conditions.

Sec. 12. (a) The department has the authority to enforce this chapter.

(b) The department may do any of the following:

(1) Impose monetary penalties of not more than fifty thousand dollars ($50,000) per violation of this chapter.

(2) Order a health insurer to reprocess improperly downcoded claims with interest.

(3) If a pattern or practice of discriminatory downcoding is identified by the department, suspend a health insurer's certificate of authority or license.

SECTION 21. IC 27-8-5-27.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 27.5. (a) This section applies to a policy of accident and sickness insurance that provides coverage for anesthesia services and is issued, amended, or renewed after June 30, 2026.**

(b) As used in this section, "anesthesia time" means the period beginning when an anesthesia practitioner begins to prepare a patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient. The term includes blocks of time around an interruption in anesthesia time provided that the anesthesia practitioner is furnishing continuous

anesthesia care within the time periods surrounding the interruption.

(c) A policy of accident and sickness insurance may not impose any of the following concerning the provision of anesthesia services during a medical procedure:

(1) A time limit on the amount of covered anesthesia time for any medical procedure.

(2) Restrictions or exclusions of coverage or payment of anesthesia time.

SECTION 22. IC 27-13-7-15.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 15.2. (a) This section applies to an individual or group contract that provides coverage for anesthesia services and is issued, amended, or renewed after June 30, 2026.**

(b) As used in this section, "anesthesia time" means the period beginning when an anesthesia practitioner begins to prepare a patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient. The term includes blocks of time around an interruption in anesthesia time provided that the anesthesia practitioner is furnishing continuous anesthesia care within the time periods surrounding the interruption.

(c) An individual or group contract may not impose any of the following concerning the provision of anesthesia services during a medical procedure:

(1) A time limit on the amount of covered anesthesia time for any medical procedure.

(2) Restrictions or exclusions of coverage or payment of anesthesia time.

SECTION 23. IC 34-30-2.1-256.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 256.5. IC 16-42-26.7-9 (Concerning practitioners, eligible facilities, research institutions, and other persons participating in providing neuroplastogen treatment).**

COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 173, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 16, delete lines 7 through 42.

Delete pages 17 through 20.

Page 21, delete lines 1 through 17, begin a new paragraph and insert:

"SECTION 21. IC 27-1-24.2-16, AS ADDED BY P.L.189-2025, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 16. (a) Except as provided in section 15 of this chapter, with respect to the provision of pharmacy or pharmacist services under a health plan, an insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits may not:

(1) prohibit a pharmacy or pharmacist from, or impose a penalty on a pharmacy or pharmacist for:

(A) selling a lower cost alternative to an insured, if a lower cost alternative is available; or

(B) providing information to an insured under subsection (c);

(2) discriminate against any pharmacy or pharmacist that is:

(A) located within the geographic coverage area of the health plan; and

(B) willing to agree to, or accept, terms and conditions established for participation in the insurer's, pharmacy benefit manager's, other administrator's, or health plan's network;

(3) impose limits, including quantity limits or refill frequency limits, on an insured's access to medication from a pharmacy that are more restrictive than those existing for a pharmacy affiliate;

(4) except as provided in subsection (b), require an insured to receive pharmacy or pharmacist services from a pharmacy affiliate, including:

(A) requiring an insured to obtain a specialty drug from a pharmacy affiliate; and

(B) charging less cost sharing to insureds that use pharmacy affiliates than what is charged to insureds that use nonaffiliated pharmacies;

(5) require a pharmacy or pharmacist to enter into an additional contract with an affiliate of the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits as a

condition of entering into a contract with this insurer, pharmacy benefit manager, or administrator; ~~or~~

(6) require a pharmacy or pharmacist to, as a condition of a contract, agree to payment rates for any affiliate of the insurer, pharmacy benefit manager, or other administrator of pharmacy benefits that is not a party to the contract; **or**

(7) designate a prescription drug as a specialty drug unless the drug is a limited distribution that:

(A) requires special handling; and

(B) is not commonly carried at retail pharmacies or oncology clinics or practices.

(b) Subsection (a)(4):

(1) does not apply to a mail order pharmacy; and

(2) may not be construed to prohibit:

(A) communications to insureds regarding networks and prices if the communication is accurate and includes information about all eligible nonaffiliated pharmacies; or

(B) an insurer, a pharmacy benefit manager, or any other administrator of pharmacy benefits from providing financial incentives for utilizing the network, if the insurer, pharmacy benefit manager, or other administrator complies with this section and section 14 of this chapter.

(c) A pharmacist shall have the right to provide an insured with information regarding lower cost alternatives to assist the insured in making informed decisions.".

Page 22, line 25, delete ";" and insert "**are made;**".

Page 23, line 8, after "2." insert "**As used in this chapter, "clinical peer" has the meaning set forth in IC 27-1-37.5-1.7.**

Sec. 3.".

Page 23, line 12, delete "3." and insert "**4. As used in this chapter, "health care provider" has the meaning set forth in IC 27-1-37.5-3.9.**

Sec. 5.".

Page 23, line 42, delete "4." and insert "**6.**".

Page 24, line 5, delete "5." and insert "**7.**".

Page 24, line 10, delete "physician" and insert "**clinical peer**".

Page 24, line 11, delete "under IC 25-22.5;" and insert "**in the requisite health field concerning the claim;**".

Page 24, line 12, delete "physician;" and insert "**health care provider;**".

Page 24, line 15, delete "6." and insert "**8.**".

Page 24, line 17, delete "7." and insert "**9.**".

Page 24, line 18, delete "physician" and insert "**health care provider**".

Page 24, line 32, delete "physician" and insert "**clinical peer**".

Page 24, line 34, delete "8" and insert "**10**".

Page 24, line 36, delete "8." and insert "**10.**".

Page 24, line 36, delete "physicians" and insert "**health care providers**".

Page 25, line 4, delete "physician" and insert "**health care provider**".

Page 25, line 7, delete "9." and insert "**11.**".

Page 25, line 8, delete "physicians" and insert "**health care providers**".

Page 25, line 10, delete "10." and insert "**12.**".

Page 25, delete lines 20 through 42.

Delete pages 26 through 31.

Page 32, delete lines 1 through 28.

Renumber all SECTIONS consecutively.

and when so amended that said bill do pass and be reassigned to the Senate Committee on Appropriations.

(Reference is to SB 173 as introduced.)

CHARBONNEAU, Chairperson

Committee Vote: Yeas 10, Nays 0.