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H.B. 579
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Bill Analysis

Version: As Introduced

Primary Sponsor: Rep. Schmidt

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SUMMARY

- Prohibits a health plan issuer from making a decision regarding the care of a covered person based solely on results derived from the use or application of artificial intelligence.
- Requires any decision to deny, delay, or modify health care services under a health benefit plan in which an artificial intelligence-based algorithm is used to be accompanied by a plain text explanation of the rationale used to make the decision.
- Authorizes the Superintendent of Insurance to audit a health plan issuer's use of an artificial intelligence-based algorithm at any time, and contract with a third party to conduct such an audit.
- Specifies certain requirements for a determination of medical necessity under a health benefit plan, and requires any physician who participates in such a determination on behalf of a health plan issuer to open and document review of the individual clinical records.
- Requires each health plan issuer to file an annual report with the Superintendent of Insurance containing certain information, including information about artificial intelligence-based algorithm usage.
- Applies the bill's requirements only to health benefit plans issued, amended, or renewed after the bill's effective date.

DETAILED ANALYSIS

Artificial intelligence health care decisions

The bill prohibits a health plan issuer from making a decision regarding the care of a covered person *based solely* on results derived from the use or application of artificial intelligence, including the decision to deny, delay, or modify health care services based on medical necessity. Any decision to deny, delay, or modify health care services covered under a

health benefit plan in which an artificial intelligence-based algorithm is used must be accompanied by a plain language explanation of the rationale used in making the decision.

The Superintendent of Insurance is authorized by the bill to audit a health plan issuer's use of an artificial intelligence-based algorithm at any time and may contract with the third party for purposes of conducting such an audit.

Continuing law defines the following terms:

- "Covered person" means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan, and includes a person's authorized representative regarding an internal appeal or external review.
- "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.
- "Health plan issuer" means an entity subject to Ohio's insurance laws or the Superintendent of Insurance's jurisdiction that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan.
- "Health benefit plan" means, with certain exceptions, a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including benefit plans marketed in the individual or group market by all associations, whether bona fide or nonbona fide.[1]

Medical necessity determination

Under the bill, a determination of medical necessity under a health benefit plan must meet both of the following requirements:

- The determination is made by a licensed physician or a provider that is qualified to evaluate the specific clinical issues involved in the requested health care services.
- The determination takes into consideration the requesting provider's recommendation, the covered person's medical or other clinical history, and individual clinical circumstances.

Further, any physician who participates in a determination of medical necessity or a utilization review process on behalf of a health plan issuer must open and document the review of the individual clinical records or data prior to making an individualized documented decision.[2]

Under continuing law, a "provider" generally means any natural person or partnership of natural persons who are licensed, certified, accredited, or otherwise authorized in this state to furnish health care services, or any professional association organized under Ohio law.[3]

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[1] R.C. 3902.50 and 3902.80(C)(1) and (4) and (D); R.C. 3922.01(E), (L), (O), and (P), not in the bill.

[2] R.C. 3902.80(C)(2) and (3).

[3] R.C. 3902.80(A); R.C. 1751.01(Y), not in the bill.

Annual report

Each health plan issuer is required by the bill to file an annual report with the Superintendent of Insurance, on or before March 1, in a form prescribed by the Superintendent. An officer of the health plan issuer must verify the contents of the report. The report must cover all of the following information:

- Each provider in the health plan issuer's network;
- The number of covered persons enrolled in health benefit plans issued by the health plan issuer in this state in the preceding calendar year;
- Whether the health plan issuer used, is using, or will use artificial intelligence-based algorithms in utilization review processes for those health benefit plans and, if so, all of the following information:
  - The algorithm criteria;
  - Data sets used to train the algorithm;
  - The algorithm itself;
  - Outcomes of the software in which the algorithm is used;
  - Data on the amount of time a human reviewer spends examining an adverse determination prior to signing off on each such determination.

Copies of the report must be published: (1) by the Superintendent on the Department of Insurance's website, and (2) by the health plan issuer on the issuer's publicly accessible website.[4]

Affected plans

The bill's requirements apply only to health benefit plans issued, amended, or renewed after the bill's effective date.[5]

HISTORY

Action	Date
Introduced	11-05-25

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[4] R.C. 3902.80(B).

[5] R.C. 3902.80(E).