As Introduced

136th General Assembly
Regular Session
2025-2026

S. B. No. 164

Senator Cutrona

To amend section 3902.50 and to enact section 3902.80 of the Revised Code to regulate the use of artificial intelligence by health insurers.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That section 3902.50 be amended and section 3902.80 of the Revised Code be enacted to read as follows:

Sec. 3902.50. As used in sections 3902.50 to ~~3902.72~~ 3902.80 of the Revised Code:

(A) "Ambulance" has the same meaning as in section 4765.01 of the Revised Code.

(B) "Clinical laboratory services" has the same meaning as in section 4731.65 of the Revised Code.

(C) "Cost sharing" means the cost to a covered person under a health benefit plan according to any copayment, coinsurance, deductible, or other out-of-pocket expense requirement.

(D) "Covered" or "coverage" means the provision of benefits related to health care services to a covered person in accordance with a health benefit plan.

(E) "Covered person," "health benefit plan," "health care

services," and "health plan issuer" have the same meanings as in section 3922.01 of the Revised Code.

(F) "Drug" has the same meaning as in section 4729.01 of the Revised Code.

(G) "Emergency facility" has the same meaning as in section 3701.74 of the Revised Code.

(H) "Emergency services" means all of the following as described in 42 U.S.C. 1395dd:

(1) Medical screening examinations undertaken to determine whether an emergency medical condition exists;

(2) Treatment necessary to stabilize an emergency medical condition;

(3) Appropriate transfers undertaken prior to an emergency medical condition being stabilized.

(I) "Health care practitioner" has the same meaning as in section 3701.74 of the Revised Code.

(J) "Pharmacy benefit manager" has the same meaning as in section 3959.01 of the Revised Code.

(K) "Prior authorization requirement" means any practice implemented by a health plan issuer in which coverage of a health care service, device, or drug is dependent upon a covered person or a provider obtaining approval from the health plan issuer prior to the service, device, or drug being performed, received, or prescribed, as applicable. "Prior authorization requirement" includes prospective or utilization review procedures conducted prior to providing a health care service, device, or drug.

(L) "Unanticipated out-of-network care" means health care services, including clinical laboratory services, that are covered under a health benefit plan and that are provided by an out-of-network provider when either of the following conditions applies:

(1) The covered person did not have the ability to request such services from an in-network provider.

(2) The services provided were emergency services.

Sec. 3902.80. (A) As used in this section, "provider" has the same meaning as in section 1751.01 of the Revised Code.

(B)(1) Each health plan issuer, annually, on or before the first day of March, shall file a report with the superintendent of insurance covering all of the following information:

(a) Each provider in the health plan issuer's network;

(b) The number of covered persons enrolled in health benefit plans issued by the health plan issuer in this state in the preceding calendar year;

(c) 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:

(i) The algorithm criteria;

(ii) Data sets used to train the algorithm;

(iii) The algorithm itself;

(iv) Outcomes of the software in which the algorithm is used;

(v) Data on the amount of time a human reviewer spends

examining an adverse determination prior to signing off on each such determination.

(2) The health plan issuer shall submit the report in a form prescribed by the superintendent. An officer of the health plan issuer shall verify the contents of the report.

(3) The superintendent shall publish a copy of the report on the web site of the department of insurance. The health plan issuer shall publish a copy of the report on the health plan issuer's publicly accessible web site.

(C)(1) No health plan issuer shall make a decision regarding the care of a covered person, including the decision to deny, delay, or modify health care services based on medical necessity, based solely on results derived from the use or application of artificial intelligence.

(2) A determination of medical necessity under a health benefit plan must meet both of the following requirements:

(a) 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.

(b) The determination takes into consideration the requesting provider's recommendation, the covered person's medical or other clinical history, and individual clinical circumstances.

(3) Any physician who participates in a determination of medical necessity or a utilization review process on behalf of a health plan issuer shall open and document the review of the individual clinical records or data prior to making an individualized documented decision.

(4) 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 shall be accompanied by a plain language explanation of the rationale used in making the decision.

(D) The superintendent may audit a health plan issuer's use of an artificial intelligence-based algorithm at any time and may contract with a third party for the purposes of conducting such an audit.

(E) This section applies to health benefit plans issued, amended, or renewed on or after the effective date of this section.

Section 2. That existing section 3902.50 of the Revised Code is hereby repealed.