HOUSE BILL 795

J5 6lr2074

By: **Delegates Wu, Schindler, and Terrasa**
Introduced and read first time: February 4, 2026
Assigned to: Health

A BILL ENTITLED

AN ACT concerning

Health Insurance – Artificial Intelligence – Grievance Process and Reporting (AI Health Insurance Accountability Act of 2026)

FOR the purpose of requiring that a carrier's internal grievance process provide for human review of grievances resulting from adverse decisions made using artificial intelligence, algorithm, or other software tools; requiring carriers to report certain information on grievances resulting from adverse decisions made using artificial intelligence, algorithm, or other software tools; requiring carriers to provide for a model review process of certain artificial intelligence, algorithm, or other software tools under certain circumstances; and generally relating to health insurance and the use of artificial intelligence.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–10A–02(b)(2) and 15–10A–06
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–10B–05.1
Annotated Code of Maryland
(2017 Replacement Volume and 2025 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

15–10A–02.

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

(b) (2) In addition to the requirements of Subtitle 10B of this title, an internal grievance process established by a carrier under this section shall:

(i) include an expedited procedure for use in an emergency case for purposes of rendering a grievance decision within 24 hours of the date a grievance is filed with the carrier;

(ii) provide that a carrier render a final decision in writing on a grievance within 30 working days after the date on which the grievance is filed unless:

1. the grievance involves an emergency case under item (i) of this paragraph;

2. the member, the member's representative, or a health care provider filing a grievance on behalf of a member agrees in writing to an extension for a period of no longer than 30 working days; or

3. the grievance involves a retrospective denial under item (iv) of this paragraph;

(iii) allow a grievance to be filed on behalf of a member by a health care provider or the member's representative;

(iv) provide that a carrier render a final decision in writing on a grievance within 45 working days after the date on which the grievance is filed when the grievance involves a retrospective denial; **[**and**]**

(v) for a retrospective denial, allow a member, the member's representative, or a health care provider on behalf of a member to file a grievance for at least 180 days after the member receives an adverse decision**; AND**

(VI) FOR A GRIEVANCE RESULTING FROM AN ADVERSE DECISION MADE USING ARTIFICIAL INTELLIGENCE, ALGORITHM, OR OTHER SOFTWARE TOOLS, PROVIDE FOR THE HUMAN REVIEW OF THE ADVERSE DECISION, INCLUDING FOR COMPLIANCE WITH § 15–10B–05.1 OF THIS TITLE.

15–10A–06.

(a) (1) On a quarterly basis, each carrier shall submit to the Commissioner, on the form the Commissioner requires, a report that describes the following information aggregated by zip code as required by the Commissioner:

(i) the number of members entitled to health care benefits under a policy, plan, or certificate issued or delivered in the State by the carrier;

(ii) the number of clean claims for reimbursement processed by the carrier;

(iii) the activities of the carrier under this subtitle, including:

1. the outcome of each grievance filed with the carrier;

2. the number and outcomes of cases that were considered emergency cases under § 15–10A–02(b)(2)(i) of this subtitle;

3. the time within which the carrier made a grievance decision on each emergency case;

4. the time within which the carrier made a grievance decision on all other cases that were not considered emergency cases;

5. the number of grievances filed with the carrier that resulted from an adverse decision involving length of stay for inpatient hospitalization as related to the medical procedure involved;

6. the number of adverse decisions issued by the carrier under § 15–10A–02(f) of this subtitle, whether the adverse decision involved a prior authorization or step therapy protocol, the type of service at issue in the adverse decisions, and whether an artificial intelligence, algorithm, or other software tool was used in making the adverse decision;

7. the number of adverse decisions overturned after a reconsideration request under § 15–10B–06 of this title; **[**and**]**

8. the number of requests made and granted under § 15–831(c)(1) and (2) of this title; and

9. THE TOTAL NUMBER OF GRIEVANCES REVIEWED UNDER § 15–10A–02(B)(2)(VI) OF THIS SUBTITLE AND AGGREGATED BY:

A. TYPE OF CLAIM;

B. RACE, GENDER, AND PROFESSION OF MEMBER; AND

C. TYPE OF POLICY, INCLUDING INDIVIDUAL, SMALL GROUP, OR LARGE GROUP AND WHETHER THE POLICY WAS PURCHASED ON THE HEALTH BENEFIT EXCHANGE; AND

(iv) the number and outcome of all other cases that are not subject to activities of the carrier under this subtitle that resulted from an adverse decision involving the length of stay for inpatient hospitalization as related to the medical procedure involved.

(2) If the number of adverse decisions issued by a carrier for a type of service has grown by 10% or more in the immediately preceding calendar year or 25% or more in the immediately preceding 3 calendar years, the carrier shall submit in the report required under paragraph (1) of this subsection:

(i) a description of any changes in medical management contributing to the rise in adverse decisions for the type of service;

(ii) any other known reasons for the increase; and

(iii) a description of the carrier's efforts and actions taken to determine the reason for the increase.

(3) IF, WITHIN A 6–MONTH PERIOD, MORE THAN A SPECIFIED PERCENTAGE, AS DETERMINED BY THE COMMISSIONER, OF A CARRIER'S ADVERSE DECISIONS MADE USING THE SAME ARTIFICIAL INTELLIGENCE, ALGORITHM, OR SOFTWARE TOOL RESULT IN A GRIEVANCE, THE CARRIER SHALL PROVIDE FOR A MODEL REVIEW PROCESS OF THE ARTIFICIAL INTELLIGENCE, ALGORITHM, OR SOFTWARE TOOL AND SUBMIT THE FINDINGS IN THE REPORT REQUIRED UNDER PARAGRAPH (1) OF THIS SUBSECTION.

(b) The Commissioner shall:

(1) compile an annual summary report based on the information provided:

(i) under subsection (a) of this section; and

(ii) by the Secretary under § 19–705.2(e) of the Health – General Article;

(2) report any violations or actions taken under § 15–10B–11 of this title; and

(3) provide copies of the summary report to the Governor and, subject to § 2–1257 of the State Government Article, to the General Assembly.

(c) The Commissioner may use information provided under subsection (a) of this section as the basis for an examination under Title 2, Subtitle 2 of this article.

15–10B–05.1.

(a) (1) In this section the following words have the meanings indicated.

(2) "Artificial intelligence" means an engineered or machine–based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer

from the input it receives how to generate outputs that can influence physical or virtual environments.

(3) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) any other person that provides health benefit plans subject to regulation by the State.

(b) This section applies to:

(1) a carrier that:

(i) uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review; or

(ii) contracts with or otherwise works through an entity that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review; and

(2) a pharmacy benefits manager or private review agent that:

(i) contracts with a carrier to provide utilization review on behalf of the carrier; and

(ii) uses an artificial intelligence, algorithm, or other software tool for the purpose of conducting utilization review on behalf of the carrier.

(c) Subject to subsection (d) of this section, an entity subject to this section shall ensure that:

(1) an artificial intelligence, algorithm, or other software tool bases its determinations on:

(i) an enrollee's medical or other clinical history;

(ii) individual clinical circumstances as presented by a requesting provider; or

(iii) other relevant clinical information contained in the enrollee's medical or other clinical record;

(2) an artificial intelligence, algorithm, or other software tool does not base its determinations solely on a group dataset;

(3) the criteria and guidelines for using an artificial intelligence, algorithm, or other software tool for making determinations comply with the requirements of this title;

(4) an artificial intelligence, algorithm, or other software tool does not replace the role of a health care provider in the determination process under § 15–10B–07 of this subtitle;

(5) the use of an artificial intelligence, algorithm, or other software tool does not result in unfair discrimination;

(6) an artificial intelligence, algorithm, or other software tool is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the federal Department of Health and Human Services;

(7) an artificial intelligence, algorithm, or other software tool is open to inspection for audit or compliance reviews by the Commissioner;

(8) written policies and procedures are included in the utilization plan submitted under § 15–10B–05 of this subtitle, including how an artificial intelligence, algorithm, or other software tool will be used and what oversight will be provided;

(9) the performance, use, and outcomes of an artificial intelligence, algorithm, or other software tool are reviewed and revised, if necessary and at least on a quarterly basis, to maximize accuracy and reliability;

(10) patient data is not used beyond its intended and stated purpose, consistent with the federal Health Insurance Portability and Accountability Act of 1996, as applicable; and

(11) an artificial intelligence, algorithm, or other software tool does not directly or indirectly cause harm to an enrollee.

(d) An artificial intelligence, algorithm, or other software tool may not deny, delay, or modify health care services.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2026.