AIMEDALLIANCE

# STATE REPORT 2025

## Step Therapy, Oversight, & Artificial Intelligence

*Trends and Best Practices*

JUNE 2025

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# INTRODUCTION

Individuals with chronic conditions depend on health insurance to access the medications and treatments necessary to manage their health and thrive in their daily lives. However, health plans may implement tactics, known as benefit utilization policies, that can restrict, delay, or deny access to necessary care. Recognizing the potential harm of these policies, many state legislators and regulators have taken action to ensure benefit utilization policies are not arbitrary, but instead grounded in peer-reviewed clinical guidelines to ensure consumers can access the treatments that are most appropriate for them.

One common type of benefit utilization policy is step therapy, also known as "fail-first." Step therapy requires patients to try and fail on alternative treatments before their health plan will approve coverage for the medication originally prescribed by their healthcare provider.[1] Without proper guardrails, these policies can be inconsistent with clinical practice guidelines, resulting in delays in accessing appropriate treatments. Consequently, consumers may continue to endure prolonged symptoms without relief and, in some cases, face irreversible disease progression. To address these concerns, more than half of U.S. states have enacted some type of step therapy reform aimed at protecting patients. Despite legislative advancements, many consumers continue to encounter barriers and challenges in accessing timely, effective care due to step therapy requirements.

Given the ongoing impact on patient care, Aimed Alliance identified a need to examine how states regulate the use of step therapy and identify opportunities for additional reform. Aimed Alliance also recognized the importance of understanding how states monitor compliance with step therapy laws, including both proactive and reactive measures, as well as how agencies are beginning to monitor the use of artificial intelligence in step therapy and other benefit utilization policies. Because the regulation of health insurance is divided between state and federal authorities,[2] this report focuses on state laws that apply to individual, small group, and fully-insured large group plans, and state Medicaid programs.

**As part of this research, Aimed Alliance sent letters to each state insurance department requesting information about the state's oversight of step therapy, as well as internal and external appeals. We recognize that state insurance departments operate under demanding schedules and that their time is immensely valuable. Aimed Alliance sincerely thanks the 30 following states' insurance departments for taking the time to either meet with us or respond to our inquiry:**

- Arizona
- California
- Colorado
- Connecticut
- Delaware
- Indiana
- Iowa
- Kansas
- Kentucky
- Maryland
- Michigan
- Minnesota
- Missouri
- Nebraska
- New Hampshire
- New York
- Nevada
- North Dakota
- Ohio
- Oklahoma
- Pennsylvania
- Rhode Island
- Tennessee
- Texas
- Utah
- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming

# STATE STEP THERAPY REFORM

**The full list of state statutes is available in Annex A.**

In recent years, many states have enacted legislation establishing clear criteria for when a consumer may qualify for a complete exception from a step therapy policy. Some states have gone further, implementing complete bans on step therapy or more limited bans for certain conditions, such as cancer or serious mental illnesses. However, relatively few states have passed legislation to ensure that when step therapy is used, the policies themselves are reasonable and consistent with clinical practice guidelines. To address this gap, Aimed Alliance analyzed current trends in step therapy reform to help inform advocacy efforts and inform future legislative approaches.

## COMMERCIAL MARKETS
## (Individual, Small Group, and Large Group Fully-Insured Plans)

### Exceptions

As of May 30, 2025, 35 states have enacted some type of step therapy reform. However, only 15 of these states have extended these reforms to their state Medicaid programs.[4] The most common type of reform seeks to ensure that, under specific circumstances, consumers can bypass step therapy requirements entirely.

- 33 states require an exception to be granted when a patient has previously tried and failed on the required drug.[5]
- 32 states require an exception to be granted when a required drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient.[6]
- 31 states require an exception to be granted when a required drug is expected to be ineffective.[7]
- 24 states require an exception to be granted when it is not in the best interest of the patient because it could cause a barrier to treatment compliance, impact a comorbid condition, result in a clinically predictable negative reaction, or decrease the patient's ability to achieve or maintain a reasonable functional ability to perform daily activities.[8]
- 22 states require an exception to be granted when the patient is stable on their current treatment.
- 2 states require an exception to be granted when the required drug has not been approved by the FDA for the medical condition being treated.[9]
- 1 state requires an exception to be granted when the patient's condition is classified as life-threatening.[10]
- 1 state permits step therapy exception requests but only requires the plan to consider potential negative consequences, clinical effectiveness of prerequisite drugs, past patient experience, and previous trial and failure of the required drug.[11]

## Timeframes

While the exceptions, processes, and circumstances are critical to ensuring consumers can bypass a step therapy process when appropriate, they are only effective if the plan responds to exception requests. As such, several states have enacted legislation requiring health plans to respond within specific statutory timeframes.

**16 states require health plans to respond to an exception request within:**

- 72 hours in a non-emergency
- 24 hours in an emergency.[12]

**4 states require health plans to respond to an exception request within:**

- 48 hours for a non-emergency
- 24 hours for an emergency.[13]

**1 state requires health plans to respond to an exception request within:**

- 3 business days in a non-emergency
- 24 hours in an emergency.[14]

**3 states require health plans to respond to an exception request within:**

- 5 business days in a non-emergency
- 72 hours in an emergency.[15]

**1 state requires health plans to respond to an exception request within:**

- 10 business days in a non-emergency
- 48 hours in an emergency.[16]

These timeframes are critical to making the exceptions process accessible and ensuring patients have a reasonable pathway to bypass step therapy requirements and access to the most appropriate treatments. However, in some cases, health care providers reported submitting exception requests without receiving a response from the health plan within the statutory timeframe. As a result, health care providers are forced to either abandon their request or file a complaint with the state insurance commissioner, a process that can be both time-consuming and burdensome. To address this issue, 6 states (Delaware, Georgia, Louisiana, Ohio, Oklahoma, and New York) have enacted laws stating that if a plan fails to respond within a statutory period, the exception is automatically deemed approved. This safeguard helps ensure that health care providers and patients are not penalized when a plan fails to comply with the law and protects them from retroactive denials when proceeding with the recommended treatment.

## Prohibitions on Step Therapy

When patients are required to complete a step therapy protocol before accessing their originally prescribed medication, they may be required to try and fail on several medications. Each trial requires sufficient time to determine effectiveness, ranging from as little as 30 days to as long as six months.[18] During this period, patients may continue to experience symptoms and disease progression. For some conditions, disease progression can be degenerative, irreversible, or even fatal. Acknowledging these risks, legislatures have increasingly recognized that step therapy is inappropriate for certain serious or progressive diseases. Except for Illinois,[19] most prohibitions on step therapy have focused on cancer and serious mental illness.

- 7 states prohibit step therapy for the **treatment of metastatic cancer, or stage 3 or 4 cancers**.[20]

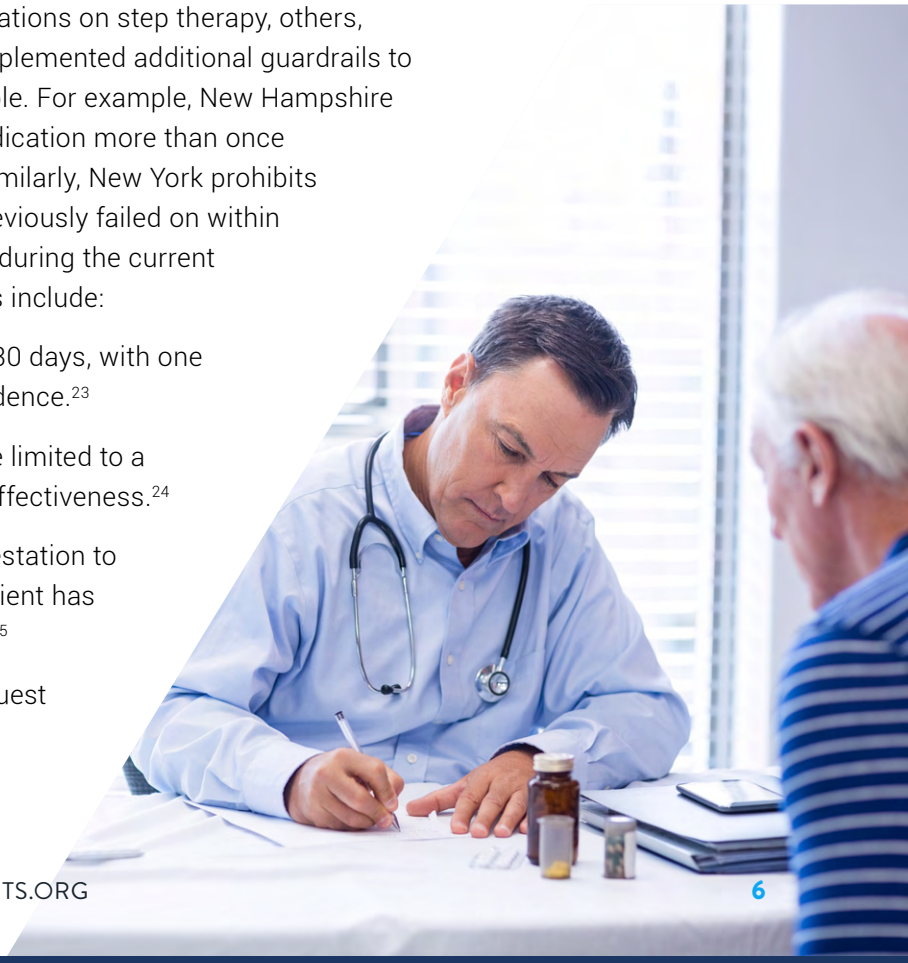
- 4 states prohibit step therapy for the **treatment of psychosis or a serious mental illness**.[21]
- 1 state limits step therapy to **no more than 1 step** for the treatment of serious mental illness.[22]

Louisiana also prohibits the use of step therapy for the treatment of perimenopause, menopause, and postpartum depression, and for ventilators. Similarly, Maine prohibits step therapy for all HIV prevention treatments.

## Guardrails

While only a few states impose categorical limitations on step therapy, others, such as New Hampshire and New York, have implemented additional guardrails to ensure that step therapy protocols are reasonable. For example, New Hampshire prohibits requiring a patient to try and fail a medication more than once while continuously enrolled in the same plan. Similarly, New York prohibits imposing step therapy if the medication was previously failed on within the past 365 days, or was approved by the plan during the current or previous plan year. Additional state guardrails include:

- 3 states limit step therapy to no more than 30 days, with one 7-day extension, if supported by clinical evidence.[23]
- 1 state requires step therapy protocols to be limited to a duration sufficient to demonstrate clinical effectiveness.[24]
- 1 state requires a health care provider's attestation to be considered sufficient evidence that a patient has previously tried and failed on a medication.[25]
- 2 states require a step therapy exception request to be upheld for at least 180 days, or the duration of treatment if less than 180 days.[26]



# MEDICAID PLANS

While many states have acknowledged the importance of step therapy exceptions in commercial coverage, comparable protections have not been as widely adopted within Medicaid programs. For example:

- 12 states require an exception to be granted when the patient has previously tried and failed on the drug.[27]
- 11 states require an exception to be granted when a required drug is contraindicated or will likely cause an adverse reaction or physical or mental harm.[28]
- 11 states require an exception to be granted when a required drug is expected to be ineffective.[29]
- 6 states require an exception to be granted when a patient is stable on their current medication.[30]
- 3 states require an exception to be granted when it is not in the best interest of the patient.[31]
- 2 states require an exception to be granted when a drug is likely to prevent the recipient from performing the responsibilities of their occupation or engaging in activities of daily life.[32]
- 1 state requires an exception to be granted when there is no preferred drug available to treat the disease or condition.[33]

## Prohibitions on Step Therapy

Similar to the commercial market, several states have implemented targeted bans restricting the use of step therapy for serious mental illnesses and certain cancers.

- 3 states ban the use of step therapy for **serious mental illnesses**.[33]

- Uniquely, Colorado also prohibits the use of step therapy for treatments for **substance use disorders.**

- 2 states ban the use of step therapy for **metastatic cancer or stage 3 or 4 cancers.**[34]

- Louisiana bans its use for the treatment of **perimenopause and menopause.**

## Timeframes

Several states that provide exceptions also mandate that exception requests be approved within a reasonable timeframe.

- **7 states require a plan to respond to an exception request within:**
  - 72 hours in a non-emergency
  - 24 hours in an emergency.[35]
- **1 state requires a plan to respond to all requests within:**
  - 72 hours.[36]
- **1 state requires a plan to respond to an exception request within:**
  - 48 hours.[37]
- **1 state requires a plan to respond to an exception request within:**
  - 10 business days for a non-emergency
  - 48 hours for an emergency.[38]

**While 10 states impose response timeframe requirements, only 2 state Medicaid programs mandate that a plan's failure to respond within the statutory period be automatically considered an approval of the exception request.[39]**

## Guardrails

While many states have not extended their step therapy protections to Medicaid markets, several have implemented other guardrails to enhance transparency and accountability in the use of step therapy. For example, Oregon requires health plans to make the clinical review criteria for each step therapy protocol readily accessible. Similarly, New Jersey requires the publication of step therapy statistics, including the number of exception requests, approvals, and denials, to be published on the plan's website. Other guardrails include:

- 1 state requires a step therapy exception to be upheld for the duration of treatment.[40]
- 1 state limits the use of step therapy to no more than 1 drug for typical or atypical antipsychotics or anticonvulsant medications.[41]
- 1 state limits the use of step therapy to one drug for no more than 30 days.[42]
- 3 states require a step therapy protocol to be based on clinical practice guidelines.[43]

Kentucky also prohibits step therapy trials longer than 30 days, with the exception of a one-time 7-day extension, and requires step therapy protocols to be posted online and made available upon a health care professional's request.

## Looking Forward

In addition to the laws already enacted, several states are currently considering a range of step therapy reforms during their 2025 legislative session, including:

- 18 states are considering bans on step therapy for certain conditions.
- 6 states are considering the adoption of exceptions processes.
- 6 states are considering additional guardrails on step therapy.
- 1 state is considering additional transparency and reporting requirements related to step therapy denials.

### Prohibitions for Certain Conditions

- 8 states are considering legislation that would ban step therapy for advanced metastatic cancer treatments;[46]
- 3 states are considering legislation that would ban step therapy for postpartum depression;[47]
- 9 states are considering legislation that would ban step therapy for mental health, behavioral health, or serious mental illnesses;[48]
- 1 state is considering legislation that would ban step therapy for the treatment of disabling or life threatening chronic diseases or conditions;[49]
- 2 states are considering legislation that would ban step therapy for the treatment of autoimmune disorders, cancer, diabetes, high blood pressure or substance use disorders; and[50]
- 1 state is considering a complete ban on step therapy for managed care organizations.[51]

### Exceptions

- 6 states are considering legislation to establish step therapy exception processes; and[44]
- 2 states are considering legislation that would require step therapy policies to be based on clinical practice guidelines.[45]

### Guardrails

- 2 states are considering legislation that would limit step therapy to a maximum of 20 or 30 days;[52]
- 1 state is considering legislation that would ban step therapy for serious mental illnesses ("SMI") in Medicaid;[53]
- 1 state is considering legislation that would require a health maintenance organization to approve a step therapy override for the remainder of the plan year;[54]
- 1 state is considering legislation that would ban step therapy in value-based care arrangements; and[55]
- 1 state is considering legislation that would prohibit a step therapy policy for a rare disease treatment from being more restrictive than the FDA-approved label.[56]

### Transparency

- 1 state is considering additional step therapy transparency requirements that would require plans to report the number of adverse decisions involving step therapy by zip code, race, ethnicity, gender, and age.[57]

The wide range of reforms underscores the urgent need for the patient, caregiver, and provider community to identify the broader types of step therapy reform necessary to ensure timely access to necessary medications. Moreover, this analysis reflects a growing trend among state legislatures to prohibit the use of step therapy altogether for certain conditions and symptoms associated with the underlying disease treatment.

In addition, novel and emerging issues within step therapy protocols warrant legislators' attention. For instance, health care providers may be required to prescribe a lower dosage of a medication than they believe is clinically necessary, forcing patients to fail on the lower dosage before gaining access to the recommended one. Such dosage limitations are common in the treatment of migraine disease and digestive conditions, often leaving patients to endure prolonged symptoms until the plan approves the appropriate dosage.[58]

Patients also face access challenges for certain types of treatments, such as long-acting treatments for hormone replacement therapy, ophthalmologic disorders, mental health, serious mental illnesses,[59] and most notably HIV prevention treatments ("PrEP").[60] Long-acting treatments offer a critical opportunity to address treatment, adherence challenges and improve patient outcomes, yet many step therapy policies require patients to first fail on shorter-acting alternatives. In some cases, health plans reject "treatment adherence" as a valid justification for switching to a long-acting medication. Notably, proposed and enacted legislation has not yet addressed these critical caps. As such, legislatures must recognize the unique challenges that step therapy presents for newer treatments and develop practical, sustainable solutions.

Given the evolving needs of consumers, the development of novel therapeutics, and the variety of approaches developing across states, Aimed Alliance identified the following opportunities and best practices:

- **Ensure a Fair Step Therapy Exception Process:** State legislators and regulators should require health plans to implement a fair and accessible exception process that allows consumers to bypass a step therapy protocol when the required treatment meets any of the following criteria:
  - Has been ineffective;
  - Is expected to be ineffective, and delaying effective treatment would lead to irreversible consequences;
  - Will cause, or is likely to cause, an adverse reaction to the individual;
  - Is expected to prevent the individual from performing daily activities or occupational responsibilities; or
  - The individual is stable on their current treatment.
- **Automatic Approval for Non-Compliance:** State legislators and regulators should ensure that if a health plan fails to comply with a step therapy law, exception request, or respond within a statutory timeframe, the exception is deemed automatically granted.
- **Prohibit Step Therapy for Serious and Progressive Conditions:** State legislatures should consider banning the use of step therapy for certain serious or progressive conditions, such as stage 4 or metastatic cancers and serious mental illnesses. Prohibitions should also apply to step therapy requirements for the treatment of side effects associated with the underlying condition or primary treatment.

- **Establish Step Therapy Guardrails:** State legislators should enact laws that create clear step therapy limitations to ensure policies are reasonable and clinically appropriate. Guardrails may include:
  - Prohibiting health plans from requiring consumers to fail on more than one treatment;
  - Prohibit health plans from requiring consumers to fail on treatments not approved by the Food and Drug Administration to treat the patient's condition;
  - Prohibiting health plans from imposing step therapy when a health care provider requests a different dosage based on medical necessity;
  - Limiting trial durations to no more than 30 days, or an alternative duration if supported by current evidence-based and peer-reviewed clinical guidelines;
  - Requiring step therapy protocols to be based on current evidence-based and peer-reviewed clinical guidelines;
  - Requiring health plans to consider treatment adherence a medically necessary justification for accessing long-acting treatments; and
  - Requiring health plans to accept a provider's attestation as *prima facie evidence* that a step therapy policy has been satisfied or previously failed.
- **Engage in Continuous Reviews and Oversight:** State legislators and regulators should develop an annual or bi-annual review process to assess step therapy regulations and identify opportunities for reform and improve consumer protections. This may include:
  - Requiring health plans to submit certain data to the insurance commissioner on step therapy usage, consumer impact, plan cost savings, and affected specialties; and
  - Assessing whether step therapy should be categorically prohibited for certain conditions or therapeutic classes, such as perimenopause and menopause, post-partum serious mental illnesses, and cardiovascular disorders.
- **Enhance Transparency:** State legislators and regulators should require health plans to include specific information in step therapy denial letters, including:
  - The rationale for denying the exception request;
  - Information on the alternative medication that is required to be failed; and
  - Information on how to file an internal appeal, external appeal, and consumer complaint with the state insurance authority.

# OVERSIGHT MECHANISMS

**A breakdown of all state approaches to oversight is available as Annex B of this report. Annex C of this report provides specific information regarding states that provide public reports and appeals data.**

State insurance commissioners have the authority to enforce consumer protection laws related to step therapy, prior authorization, copay accumulators, and other health insurance laws. However, the regulation of health plan compliance with these consumer protection laws is often dependent on individual consumers filing complaints. In most states, they must exhaust both internal and external appeals processes before the state insurance department may review the complaint. This can be burdensome and discouraging, creating barriers to timely resolutions.[61]

Recognizing this challenge, Aimed Alliance sought to assess how state insurance departments are otherwise ensuring compliance with state consumer protection laws. To do so, Aimed Alliance conducted a 50-state analysis of existing reporting requirements imposed on health plans relating to utilization management and internal and external appeals processes.

## State All-Payer Claims Databases

Twenty-five states have adopted All-Payer Claims Databases (APCDs), which are comprehensive systems designed to collect claims data relating to medical, pharmacy, dental, and eligibility requirements for both private and public payers.[62] These databases are intended to provide state governments with a more comprehensive view of health care costs and utilization. However, only 9 of the 25 states with APCDs currently accept data requests.[63] Moreover, access to this data is prohibitively expensive, with costs ranging from $500 to $50,000 for just one state.[64] Although APCD data holds significant potential for analyzing patient access to treatments and care, these high costs make it inaccessible for many non-profit and patient advocacy organizations.

## State-Based Oversight & Public Reporting Approaches

While state insurance commissioners and insurance departments generally have the authority to monitor and enforce compliance with state health insurance laws,[65] most rely on consumer complaints alleging a health plan has acted inconsistently with the plan's terms or in violation of state law.[66] This responsive approach limits proactive enforcement and makes it difficult to identify systematic issues or bad actors. To better understand how states are working to actively monitor plan compliance, particularly regarding the use of step therapy, internal appeals, and external appeals, Aimed Alliance reviewed state practices and identified the following approaches:

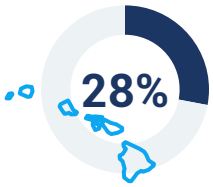
- 4 states require health plans to report specific data on the use of step therapy and prior authorization;[67]
- 24 states require health plans to report data related to internal appeals, external appeals, or both;[68]
- 17 states require that reported data be made available to the public through either an annual report or upon request;
  - 9 states publish annual reports that include this data;[69]
  - 8 states provide data upon request;[70]
- 3 states maintain consumer reports or databases related to grievances or complaints filed with the departments.[71]

When data related to internal and external appeals were available, we sought to determine how often appeals were overturned upon review. However, due to the inconsistencies in reporting timeframes and the types of information required across states, a direct comparison between states was not feasible. Despite this limitation, the available data indicates that external appeals were generally approved at least one-third of the time. For example,


**CALIFORNIA**
*2024 data showed:*
▸ **171 external appeals**
▸ **112 were overturned**
a 65% reversal rate.

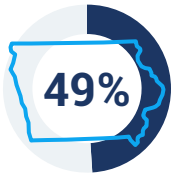

**CONNECTICUT**
*2024 data showed:*
▸ **626 external appeals**
▸ **212 were overturned**
a 33% reversal rate.


**DELAWARE**
*2024 data showed:*
▸ **29 external appeals**
▸ **8 were overturned**
a 27% reversal rate.

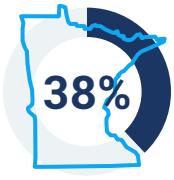



**HAWAII**
*2024 data showed:*
▸ **21 external appeals**
▸ **6 were overturned**
a 28% reversal rate.

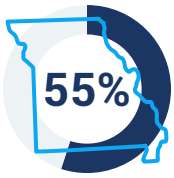

**INDIANA**
*2023 data showed:*
▸ **230 external appeals**
▸ **29 were overturned**
a 12% reversal rate.




**IOWA**
*Between Jan. 1, 2023, and Oct. 17, 2024, data showed:*
▸ **101 external appeals**
▸ **50 were overturned**
a 49% reversal rate.




**MINNESOTA**
*2023 data showed:*
▸ **213 external appeals**
▸ **81 were overturned**
a 38% reversal rate.[72]



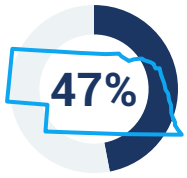

**MISSOURI**

*2024 data showed:*

▸ **60 external appeals**

▸ **33 were overturned**

a 55% reversal rate.[73]

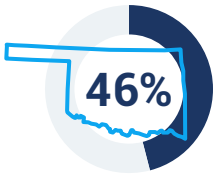



**NEBRASKA**

*Since 2014:*

▸ **786 cases have been overturned**

a 47% reversal rate.[74]



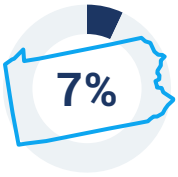

**OKLAHOMA**

*From Jan. 2023, to Jan. 2024, data showed:*

▸ **43 external appeals requests** that were eligible for review

▸ **20 were overturned**

a 46% reversal rate.




**PENNSYLVANIA**

*2023 data showed:*

▸ **54 external appeals**

▸ **4 were overturned**

a 7% reversal rate.


**UTAH**

*2023 data showed:*

▸ **181 external appeals** eligible for review

▸ **89 were overturned**

a 38% reversal rate.


**WISCONSIN**

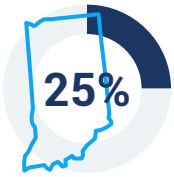
*2023 data showed:*

▸ **346 external appeals**

▸ **75 were overturned**

a 21% reversal rate.

Similarly, Indiana and Pennsylvania provide data on the use and outcomes of internal appeals. Although limited, the data shows that internal appeals are approved at a slightly higher rate than external appeals, with over 40% resulting in reversals in favor of the consumer.



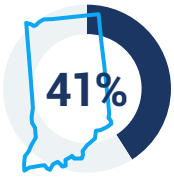

**INDIANA**

*2023 data showed:*

▸ **8,921 grievances were filed**

▸ **2,203 were overturned**

a 25% reversal rate.



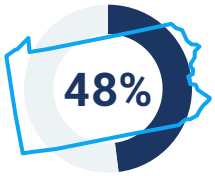

**INDIANA**

*2023 data showed:*

▸ **2,482 internal appeals**

▸ **1,029 were overturned**

a 41% reversal rate.




**PENNSYLVANIA**

*2023 data showed:*

▸ **3,156 internal appeals filed**

▸ **1,528 were overturned**

a 48% reversal rate.

Lastly, Pennsylvania's 2023 data revealed that out of the 2,135,041 denied claims, only 3,156 internal appeals were filed, which is less than 1% of all denials. This low rate of appeals highlights a significant limitation of relying on appeals and complaints as the primary tool for regulatory compliance. Wisconsin's annual insurance report also tracks the total number of grievances filed with the Department, but does not track the outcome of these grievances.[75] Ultimately, for consumers and advocates, this raises questions about why consumers and health care providers are not challenging denials more often, especially given that a substantial portion of appealed decisions are ultimately reversed.

Based on Aimed Alliance's research and analysis, the following states do not currently provide any publicly available reports of oversight mechanisms and activities: Alabama, Alaska, Colorado,[76] Florida,[77] Idaho, Illinois, Louisiana, Mississippi, Nevada, New Hampshire,[78] New Jersey, New Mexico,[79] North Carolina, North Dakota, Ohio,[80] Oklahoma,[81] Oregon, South Carolina, South Dakota, Texas, Vermont, Virginia,[82] West Virginia,[83] Wyoming.[84]

## Looking Forward

Transparency is critical to ensure health plans comply with state laws and to provide legislators and regulators with the information they need to enforce compliance or enact stronger consumer protections. While internal and external appeals processes are valuable tools to correct improper benefit decisions, these mechanisms are significantly underutilized by consumers. Based on the current state approaches, Aimed Alliance has identified the following opportunities and best practices:

- **Mandate Annual Reporting on Claims and Appeals:** State legislators and regulators should require health plans to report annually on the number of claim denials, internal appeals, external appeals, and appeal outcomes.
- **Require Detailed, Anonymized Claims and Appeals Data:** State legislators and regulators should require health plans to include anonymized data on claims and appeals, such as diagnosis (therapeutic and sub-diagnostic category), type of treatments under review (prescription drugs, imaging, testing, mental health treatment, residential treatment, etc.), and whether the claim was subject to a benefit utilization policy.[85]
- **Establish a Public, Searchable Claims Transparency Database:** State regulators should publish all aggregate data on a user-friendly public database, enabling the public to easily identify plans with high denials and overturn rates. This transparency would also support the public sector and governmental agencies in identifying potential bad actors.[86]
    - Requiring health plans to post this information on their own websites is less effective, as we found this information difficult for consumers to locate and interpret meaningfully.
- **Strengthen Benefit Denial Notices to Empower Consumers:** State legislators and regulators should require that a benefit denial letter include a specific rationale for the denial, information on alternative treatments covered by the health plan, and clear instructions on how to file internal appeals, external appeals, and consumer complaints with the state insurance agency.

# ARTIFICIAL INTELLIGENCE IN BENEFIT UTILIZATION

**A breakdown of all state laws is available as Annex D of this report.**

Artificial intelligence ("AI") refers to the use of machine learning to provide answers, insights, and informed decisions based on human-defined objectives, recommendations, and real or virtual environments.[88] AI is a powerful tool at the forefront of health care innovation, with the potential to transform the health care system by improving diagnosis, treatment, administrative efficiency, utilization management, and research and development.[89] However, without appropriate guardrails, AI may become a barrier to care, causing delays in timely access to the most appropriate treatments.

For example, in 2023, Cigna Healthcare faced a federal class-action lawsuit alleging that the company used AI to deny payment for thousands of claims.[90] Alarmingly, the lawsuit alleges that these denials occurred after only 1.2 seconds of consideration.[91] While this may be an efficient use of time, the complaint states that 80% of the initial denials were overturned on appeal, raising serious concerns about the reliability and fairness of the original AI decisions.[92]

Fortunately, various stakeholders have issued guidance on how state and federal regulators might oversee and regulate the use of AI in step therapy. The following analysis provides an overview of proposed and enacted reforms.

## NAIC Model Bulletin

The National Association of Insurance Commissioners ("NAIC") is a member-led organization composed of insurance regulators from all 50 U.S. states and six U.S. territories.[93] Its mission is to support insurance commissioners by providing expertise, data, and analysis to help them effectively regulate the insurance industry and protect consumers. The NAIC frequently publishes model laws, regulations, and bulletins intended to address emerging insurance issues. In 2023, the NAIC released a Model Bulletin ("Bulletin") on the use of AI by insurers.[94] While not legally binding, the Bulletin is intended to serve as a framework for states beginning to regulate the use of AI in insurance. It emphasizes the importance of responsible governance, effective risk management techniques, and clear procedures to promote fair and accurate consumer-centered outcomes.[95]

Specifically, the Bulletin outlines how insurance departments can govern the development and acquisition of AI tools, as well as how they may request information during an investigation into AI's use.[96] It builds upon the NAIC's 2020 Principles on AI, which underscore that AI must be fair and ethical, accountable, compliant, transparent, secure, safe, and robust.[97]

The Bulletin also identifies several existing laws and regulations, including the Unfair Trade Practices Model Act, the Unfair Claims Settlement Practices Model Act, the Corporate Governance Annual Disclosure Model Act, the Property and Casualty Model Rating Law, and the Market Conduct Surveillance Model Law, as potential tools that states can use to implement and enforce the Bulletin.[98]

Section 3 of the Bulletin clarifies that while insurers may use AI to assist in decision-making, they remain ultimately responsible for those decisions. Insurers must ensure that AI-driven determinations are not arbitrary, capricious, or unfairly discriminatory.[99] To support this, the Bulletin recommends insurers implement a formal AI program and policy that considers:

- The nature of the decisions made, informed, or supported using AI;
- Potential consumer harms resulting of AI;
- The role of human oversight in the final decision making process;
- How AI-driven decisions are communicated to consumers; and
- The extent to which predictive AI models rely on third-party systems.[100]

To achieve these objectives, the Bulletin recommends establishing clear governance and risk management policies, including human input at each stage of the AI deployment, defined escalation pathways for AI-related issues,  and data management procedures to track, retain, and address errors.[101]

From a regulatory oversight perspective, insurance commissioners are are encouraged to investigate and assess the adequacy of the insurers' AI programs, particularly in terms of consumer protection, fairness, and nondiscrimination. The Bulletin also outlines the types of questions and supplemental data that insurance commissioners may request from insurers to evaluate the adequacy of their AI-related policies and procedures. Lastly, the Bulletin recognizes that insurance commissioners may also need to request information from third parties working with insurers to manage AI systems. As such, insurers must conduct thorough due diligence with third parties to ensure their data, models, and AI systems align with regulatory standards. This requirement helps reinforce that insurers cannot shift accountability and liability to third party AI programmers.

Although the Bulletin does not specifically address the use of AI in benefit utilization, it establishes an important framework for enhancing transparency, oversight, and reporting requirements on the use of AI in health insurance. Since its adoption in December 2023, 22 states and the District of Columbia have implemented the Model Bulletin.[102]

In addition, California, Colorado, Texas, and New York have not adopted the Model Bulletin, but have issued their own insurance-specific AI bulletins or regulations. Notably, California's bulletin recognizes that improperly managed AI can perpetuate both conscious and unconscious biases, leading to discriminatory treatment of consumers.[103] It outlines how certain neutral data points, such as zip codes, can serve as proxies for race and must be carefully analyzed to prevent violations of existing consumer protection and antidiscrimination laws.[104] Interestingly, the California bulletin also includes examples of recent complaints received by the insurance commissioner concerning the use of AI, including:

- Insurers unfairly flagging or denying claims in certain zip codes, and then offering unreasonably low settlements, resulting in a disproportionately higher rate of claim delays and denials in socioeconomically disadvantaged communities;
- Insurers using biometric data to decide whether to deny or approve claims; and
- Insurers relying on biometric data to determine which products to underwrite for specific populations, based on race, gender, disability, and other protected classes.

Given these concerns, the California bulletin affirms that all health insurers are responsible for conducting their own due diligence to ensure the use of AI complies with existing consumer protection and anti-discrimination laws. This compliance analysis may be subject to review by the insurance commissioners during a complaint investigation.[105]

New York has taken a broader approach, stating that in addition to requiring compliance with all applicable state and federal laws, insurers must demonstrate that AI decision-making aligns with generally accepted standards. New York also mandates documentation on the frequency of testing to detect and eliminate discriminatory programming and to ensure human oversight. Moreover, New York requires plans to notify consumers when AI has been used in a benefit determination, including disclosing the data relied upon and other relevant information. Failure to provide this notice may constitute an unfair trade practice.[106] In this way, New York's bulletin is particularly notable for creating a potential avenue of liability for insurers when consumers are denied benefits based on the use of AI.

Lastly, Texas and Colorado have also issued AI-related bulletins, but Colorado's initial bulletin applied only to life insurance, however, the Division of Insurance is now considering expanding its scope to include health insurance.[107] Similarly, Texas' bulletin takes a broader stance, emphasizing that insurers are responsible for ensuring compliance with state law and for data and AI tools provided by third parties.[108]

## NAIC Consumer Representative Report

In November 2024, the NAIC Consumer Representatives published a report examining how health plans use AI in benefit utilization and identifying activities that pose the greatest risk for inappropriate or discriminatory denials of medically necessary care.[109] While the representatives recognized the value of AI's potential to reduce administrative burdens and improve patient outcomes, they expressed concern over the rapid implementation of AI tools and emphasized the need for regulatory measures to protect consumers' health and privacy.[110]

The report's recommendations closely align with the NAIC Model Bulletin, particularly in emphasizing the need for transparency, accountability and regulatory oversight.[111] Notably, the report recognizes that penalties for non-compliance must be "significant enough to have influence."[112] Despite the widespread adoption of the NAIC Model Bulletin, and states' assertions that existing health insurance and consumer protection statutes can be used to regulate AI, no state bulletin has yet established specific punitive consequences for non-compliance.

## Federal Regulation

As of May 2025, the federal government has not passed comprehensive legislation or regulations governing the use of AI in health care. However, existing legal authorities related to unfair trade practices, consumer protection, and health privacy may apply to the use of AI, even in the absence of new legislation or regulations.

In addition, on January 23, 2025, President Trump issued an executive order revoking the previous Administration's efforts to regulate the use of AI and implement safeguards against fraud, bias, discrimination, and privacy infringements.[113] The January 2025 Order instead directs all federal agencies to cease any efforts aimed at addressing those safeguards and instead pursue other non-regulatory approaches to fostering innovation and maintaining the United States' global leadership in AI.

## State Regulation

While many state departments of insurance have issued bulletins addressing the use of AI, only California, Colorado, and Nebraska have enacted laws codifying AI protections. Under California law, health plans that use AI in utilization management must adhere to strict safeguards, such as ensuring AI does not override a provider's clinical judgment, requiring decisions to be based on an individual patient's history and clinical records, and prohibiting AI from being the final decision-maker in any benefit determination.[114] Colorado's legislation takes a broader approach by directing the Division of Insurance to develop regulations that govern the use of AI and protect consumers from unintended discrimination. Lastly, Nebraska's law, passed during the 2025 session, prohibits AI from serving as the sole basis for any benefit decision.[116]

Although California, Colorado, and Nebraska are currently the only states with codified AI protections, 29 states are actively considering legislation to regulate AI in healthcare.[117] The most common proposals aim to ensure that AI is not the final decision-maker in benefit determinations and that a health care provider must review all benefit requests.[118] The second most common type of legislation, introduced in nine states, would require health plans to notify consumers when AI is used as part of a benefit decision.[119] In addition, seven states have considered bills mandating AI tools to base their decisions on individual patient data and clinical history to prevent reliance on group datasets in medical necessity assessments.[120] Additional legislative efforts focus on increasing consumer awareness of the use of AI, limiting the scope of on AI's use, and enhancing public transparency:

- 6 states considered legislation that would completely prohibit the use of AI in utilization management;[121]
- 4 states considered legislation that would require the disclosure of AI algorithms being used in utilization management;[122]
- 4 states considered legislation that would increase reporting requirements around the use of AI by health plans;[123]
- 3 states considered legislation that would create expert groups, taskforces, or institutions that could identify how AI should be used, regulated, and promoted;[124]
- 1 state considered legislation that would require enrollees to explicitly consent for their data to be used by AI in its development and validation;[125]
- 1 state considered legislation that would require clinics, hospitals, or any other health care facility to notify patients when AI is used in developing patient communications;[126]
- 1 state considered legislation that would prohibit the use of AI in the evaluation and determination of patient care to ensure AI could not make decisions about testing, medications, or necessary procedures;[127] and
- 1 state considered legislation that would require developers and deployers of AI to conduct evaluations and impact assessments to determine if AI was being used in a discriminatory manner.[128]

## Looking Forward

While AI is increasingly top of mind for the public, its use in health care and health insurance remains relatively new. Legislators and regulators must recognize the need to develop regulations and laws that address current challenges while remaining flexible to accommodate future developments in AI. Based on the analysis above, the most pressing concerns among consumers and regulators include the use of AI without human oversight, and the resulting risk of discrimination or improper denials of medically necessary care. As such, drawing from the reforms currently under consideration by states and regulators, Aimed Alliance has identified the following opportunities and best practices:

- **Adopt the NAIC Model Bulletin:**
  State insurance commissioners should adopt the NAIC's Model Bulletin as a foundational framework for regulating and overseeing AI in health care settings;
- **Enhance Public Transparency:**
  Legislators should consider measures that improve public transparency around the use of AI in health plans, thereby enabling more informed oversight and future regulatory action. These could include requirements for plans to:
  - Disclose the AI algorithm's strengths, limitations, and known biases (Arkansas);
  - Identify populations where the AI performs better or worse (Arkansas);
  - Share the criteria, training data (including bias mitigation), and the algorithm used by health plans (Arkansas);
  - Explain how it is used, expected outcomes, and any independent third-party validation (Arkansas);
  - Submit reports to the state department of insurance detailing AI use, along with comprehensive data on AI operations, including the number of claims and grievances broken down by demographic categories like race, ethnicity, gender, and age (Maryland);
  - Annually publish information on their websites about AI-driven decisions, including thresholds for human review, rates of decision overturn, misdiagnosis rates, and instances where AI suggestions might overlook patient-specific factors, such as preexisting conditions or care preferences (Maryland).
- **Require Human Oversight in Benefit Decisions:**
  Legislators should consider measures that ensure benefit requests are reviewed by a qualified health care provider, in the same or similar specialty. Legislation should also prohibit AI from serving as the sole decision-maker in any request for benefits or coverage.

# ANNEX A: STEP THERAPY LAWS

## ALABAMA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| No step therapy law in place. | NA | NA |

## ALASKA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| No step therapy law in place. | NA | NA |

## ARIZONA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>AZ Rev Stat § 20-3654 (2024) | Requires an exception to a step therapy protocol be granted when:<br>(1) a required drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient;<br>(2) a required drug is expected to be ineffective;<br>(3) the patient has tried and failed previously on the drug;<br>(4) it is not in the best interest of the patient because it is expected to cause a barrier to treatment adherence, negative impact on comorbid conditions, clinically predictable negative drug interaction, or a decrease in patient's ability to achieve or maintain a reasonably functional ability to perform daily activities; or<br>(5) the patient is stable on current medication.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours in an emergency. | All state-regulated health plans |

## ARKANSAS

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>AR Code § 23-99-1114 (2024) | Prohibits step therapy for the treatment of:<br>(1) psychosis or a serious mental illness through antipsychotic prescription drugs; and<br>(2) metastatic cancer. | All state-regulated health plans and Medicaid |
| Yes.<br>AR Code § 23-79-2104 (2024) | Requires an exception to a step therapy protocol be granted when:<br>(1) a required drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient;<br>(2) a required drug is expected to be ineffective;<br>(3) the patient has tried and failed previously on the drug;<br>(4) it is not in the best interest of the patient; or<br>(5) the patient is stable on current medication.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours in an emergency. | All state-regulated health plans and Medicaid |

## CALIFORNIA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>CA Health & Safety Code § 1367.206 (2024) | Requires an exception to a step therapy protocol be granted when:<br>(1) a required drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient;<br>(2) a required drug is expected to be ineffective;<br>(3) the patient has tried and failed previously on the drug;<br>(4) it is not in the best interest of the patient because it is expected to cause a barrier to treatment adherence, negative impact on comorbid conditions, clinically predictable negative drug interaction, or a decrease in patient's ability to achieve or maintain a reasonably functional ability to perform daily activities; or<br>(5) the patient is stable on current medication.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours in an emergency. | All state-regulated health plans |
| Yes.<br>CA Ins Code § 10123.1935 (2024) | Requires that health plans provide access to at least one drug in the following categories without utilization management, including step therapy:<br>(1) Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.<br>(2) Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.<br>(3) A long-acting buprenorphine product.<br>(4) A long-acting injectable naltrexone product. | All state-regulated health plans |

## COLORADO

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>CO Rev Stat § 10-16-145 (2022) | Requires an exception to a step therapy protocol be granted when:<br>(1) a required drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient;<br>(2) a required drug is expected to be ineffective;<br>(3) the patient has tried and failed previously on the drug; or<br>(4) the patient is stable on their current medication.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours in an emergency.<br>Requires a step therapy protocol to be based on clinical practice guidelines. | All state-regulated plans |
| Yes.<br>CO Rev Stat § 10-16-145.5 (2022) | Prohibits step therapy for the treatment of stage IV metastatic cancer.<br>Prohibits step therapy for at least one atypical opioid for pain management. | All state-regulated plans |

## CONNECTICUT

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>CT Gen Stat § 38a-510. (2024) | Requires an exception to a step therapy protocol be granted when a required drug:<br>(1) has previously been ineffective;<br>(2) is expected to be ineffective based on known medical criteria;<br>(3) will or is likely to cause an adverse reaction or physically harm the patient; or<br>(4) is not in the best interest of the patient based on medical necessity. | All state-regulated plans |
| Yes.<br>PA 23-204 §§ 225 & 226 (2024) | Prohibits step therapy for drugs used to treat schizophrenia, major depressive disorder, bipolar disorder, or metastatic cancer.<br>This ban is from January 1, 2024 to January 1, 2027. | All state-regulated plans |

## DELAWARE

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>18 DE Code § 3381 (2024) | Requires an exception to a step therapy protocol be granted when:<br>(1) a required drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient;<br>(2) a required drug is expected to be ineffective;<br>(3) the patient has tried and failed previously on the drug;<br>(4) it is not in the best interest of the patient because it is expected to cause a barrier to treatment adherence, negative impact on comorbid conditions, clinically predictable negative drug interaction, or a decrease in a patient's ability to achieve or maintain a reasonably functional ability to perform daily activities; or<br>(5) the patient is stable on current medication.<br>The plan must respond to an exception request within 48 hours in a non-emergency and 24 hours in an emergency.<br>Failure to respond during these time frames deems the exception automatically granted. | All state-regulated plans |

## FLORIDA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>FL Stat § 627.42393 (2023) | Prohibits step therapy if a patient has already tried and failed on the drug, or if the plan has previously paid for the drug within the last 90 days. | All state-regulated plans |

## GEORGIA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>GA Code § 33-24-59.25 (2024) | Requires an exception to a step therapy protocol be granted when:<br>(1) a required drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient;<br>(2) a required drug is expected to be ineffective;<br>(3) the patient has tried and failed previously on the drug; or<br>(4) the patient is stable on current medication.<br>The plan must respond to an exception request within 48 hours in a non-emergency and 24 hours in an emergency.<br>Failure to respond during these time frames deems the exception automatically granted. | All state-regulated plans |

## HAWAII

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| No step therapy law in place. | NA | NA |

## IDAHO

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| No step therapy law in place. | NA | NA |

## ILLINOIS

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes. Public Act 103-0650 | Prohibits all use of step therapy. | All state-regulated plans and Medicaid |

## INDIANA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>IN Code § 27-8-5-30 (2024) | Requires an exception to the step therapy protocol be granted when:<br>(1) a drug is contraindicated or will likely cause an adverse reaction, mental or physical harm;<br>(2) a drug is known to be ineffective;<br>(3) a drug has been previously tried and failed;<br>(4) it is not in the best interest of the patient because it would worsen a comorbid condition or decrease the insured's ability to achieve or maintain reasonable functional ability in performing daily activities.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours in an emergency. | All state-regulated plans |

## IOWA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>IA Code § 514F.7 (2024) | Requires an exception to a step therapy protocol be granted when a drug:<br>(1) is likely to cause an adverse reaction;<br>(2) is likely to decrease the ability of a covered person to achieve or maintain a reasonable functional ability in performing daily activities;<br>(3) is likely to cause physical or mental harm to a covered person;<br>(4) is expected to be ineffective due to adherence; or<br>(5) the patient has previously tried and failed. | All state-regulated plans |

## KANSAS

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| No step-therapy law in place. | NA | NA |

## KENTUCKY

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>KY Rev Stat § 304.17A-163 (2018) | Requires an exception to a step therapy protocol be granted when a drug:<br>(1) is already found to be ineffective; or<br>(2) is expected or likely to be ineffective based on the known conditions of the patient.<br>Limits step therapy to no more than 30 days, but can be extended by an additional 7 days if supported by sound clinical evidence.<br>The plan must respond to an exception request within 48 hours.<br>Requires a step therapy protocol to be based on clinical practice guidelines.<br>Requires the clinical review criteria and step therapy policy to be posted on the health plan's website and provided to health care professionals upon written request. | All state-regulated plans and Medicaid |

## LOUISIANA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>LA Rev Stat § 22:1053 (2024) | Requires an exception to a step therapy protocol be granted when:<br>(1) a drug has already been proven ineffective;<br>(2) a drug is reasonably expected to be ineffective based on patient history;<br>(3) a drug is contraindicated or will likely cause an adverse reaction, physical or mental harm to the patient;<br>(4) the patient is currently stable on their treatment; or<br>(5) it is not in the best interest of the patient.<br>Prohibits step therapy for stage-four metastatic cancer, and its associated conditions, or for treatment of postpartum depression.<br>Prohibits step therapy for ventilators when the ventilator requires frequent or substantial servicing, or there is clinical evidence that suggests alternative treatments will be less effective or cause an adverse reaction.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours in an emergency. Failure to respond within these timelines deems the request automatically granted.<br>Requires step therapy policies to be limited to a time period sufficient to demonstrate clinical effectiveness.<br>Requires step therapy protocol be based on high quality studies, research, peer-reviewed publications and medical practice.<br>A step therapy exception request denial letter must include the reason for the denial, an alternative covered medication, and information regarding the procedure for submitting an appeal. Information regarding alternative medication must include a list of comparable medications that are covered on the formulary. Simply referencing the formulary is insufficient.<br>Prohibits a step therapy protocol from being longer than the time necessary to determine clinical effectiveness. | All state-regulated plans |
| Yes.<br>LA Rev Stat § 22:988 (2024) | Prohibits the use of prior authorization or step therapy for the care or treatment of perimenopause and menopause. | All state-regulated health plans and Medicaid |

## MASSACHUSETTS

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>MA Gen L ch 176o § 12a (2023) | Requires an exception to a step therapy protocol be granted when:<br>(1) a drug is contraindicated or will likely cause an adverse reaction, physical, or mental harm to the patient;<br>(2) a drug is expected to be ineffective;<br>(3) a drug has previously been tried and failed; or<br>(4) if the patient is currently stable on their treatment and switching would cause an adverse reaction, physical or mental harm.<br>The plan must respond to an exception request within 3 business days in a non-emergency and 24 hours in an emergency. | All state-regulated plans |

## MAINE

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>24-A ME Rev Stat § 4320-N (2023) | Requires an exception to a step therapy protocol be granted when:<br>(1) a drug is contraindicated or will likely cause an adverse reaction, or physical or mental harm to the patient;<br>(2) a drug is expected to be ineffective;<br>(3) the patient has previously failed on the drug;<br>(4) it is not in the best interest of the patient;<br>(5) the patient is stable on their current medication; or<br>(6) the drug is intended to treat a serious mental illness.<br>The plan must respond to an exception request within 72 hours, or 2 business days, whichever is less, in a non-emergency and within 24 hours in an emergency. | All state-regulated plans |
| Yes.<br>24-A ME Rev Stat § 4317-D (2023) | Prohibits step therapy for any HIV prevention drug. | All state-regulated plans |

## MARYLAND

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>MD Insurance Code § 15-142 (2024) | Requires an exception to a step therapy protocol be granted when the drug:<br>(1) has not been approved by the FDA for the medical condition being treated; or<br>(2) was ordered within the last 180 days and effective in treating the patient's condition.<br>Prohibits the use of step therapy for a drug used to treat stage-four advanced metastatic cancer, if the drug is consistent with National Comprehensive Cancer Network guidance and peer-reviewed literature.<br>Requires an exception to a step therapy protocol be granted when the drug:<br>(1) is contraindicated or will likely cause an adverse reaction;<br>(2) is expected to be ineffective; or<br>(3) if the patient is stable on their current treatment;<br>(4) the patient has previously tried and failed on a drug in the same pharmacologic class. | All state-regulated health plans |

## MICHIGAN

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| No step therapy law in place. | NA | NA |

## MINNESOTA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>MN Stat § 62Q.184 (2024) | Requires an exception to a step therapy protocol be granted when the drug:<br>(1) is contraindicated or an adverse event has previously occurred;<br>(2) may decrease the ability of the enrollee to achieve or maintain reasonable functional ability in performing daily; or is likely to cause physical or mental harm;<br>(3) has been previously tried and failed; or<br>(4) the individual is currently stable on their treatment.<br>The plan must respond to an exception request within 5 days in a non-emergency and 72 hours in an emergency. | All state-regulated health plans |

## MISSISSIPPI

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>MS Code § 83-9-36 (2024) | Requires an exception to a step therapy protocol be granted when the drug:<br>(1) has previously been failed on; or<br>(2) the provider can demonstrate based on sound clinical evidence or medical and scientific evidence that the preferred treatment is likely to be ineffective or will likely cause an adverse reaction or physical or mental harm.<br>Limits step therapy to 30 days. May be extended up to 7 days.<br>Prohibits step therapy for advanced metastatic cancer and the symptoms and side effects of advanced cancer or its treatment. Limited duration from April 2024 to June 30, 2026. | All state-regulated health plans |

## MISSOURI

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>MO Rev Stat § 376.2034 (2024) | Requires an exception to a step therapy protocol be granted when the drug:<br>(1) has previously been tried and failed; or<br>(2) is necessary to save the life of the patient. | All state-regulated health plans |

## MONTANA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| No step therapy law in place. | NA | NA |

## NEBRASKA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>NE Code § 44-7,115 (2024) | Requires an exception to a step therapy protocol be granted when the drug:<br>(1) is contraindicated based on manufacturer prescribing information; or is likely to:<br>(2) cause an adverse reaction;<br>(3) decrease the ability of the covered individual to achieve or maintain reasonable functional ability in performing daily activities;<br>(4) cause physical or mental harm to patient; or<br>(5) is known to be ineffective based on characteristics as described in peer-reviewed clinical criteria, provider's medical judgment, or patient's documented experience with drug; or<br>(6) has previously been tried or failed.<br>The plan must respond to an exception request within 5 days in a non-emergency and 72 hours in an emergency. | All state-regulated health plans |

## NEVADA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>NV Rev Stat § 695C.16947 (2024)[129] | Prohibits the use of step therapy for FDA-approved drugs used to treat psychiatric conditions. | All state-regulated health plans |
| Yes.<br>NV Rev Stat § 689A.04043 (2024) | Requires an exception to a step therapy protocol be granted when:<br>(1) a drug is contraindicated or will likely cause an adverse reaction, or physical or mental harm;<br>(2) a drug is expected to be ineffective based on the known clinical characteristics;<br>(3) a drug has been previously tried and failed;<br>(4) it is not in the best interest of the patient based on medical necessity; or<br>(5) the patient is stable on their current treatment.<br>The plan must respond to an exception request within 48 hours in a non-emergency and 24 hours in an emergency. | All state-regulated health plans |
| Yes.<br>NV Rev Stat § 689A.04041 (2024)[130] | Requires an exemption to a step therapy protocol if an insured has been diagnosed with stage 3 or 4 cancer. | All state-regulated health plans |
| Yes.<br>NV Rev Stat § 689A.04048 (2024)[131] | Prohibits step therapy for a covered drug that is approved by the FDA that is prescribed to treat a psychiatric condition if:<br>(1) The drug has been approved by the FDA with indications for the psychiatric condition of the insured; and<br>(2) If the drug is prescribed by:<br>(a) A psychiatrist;<br>(b) A physician assistant under the supervision of a psychiatrist;<br>(c) An advanced practice registered nurse who has the psychiatric training and experience prescribed by the State Board of Nursing;<br>(d) A primary care provider that is providing care to an insured in consultation with a practitioner listed in subparagraphs 1-3 above;<br>(e) The practitioner listed in paragraph (2) who prescribed the drug knows or reasonably expects each alternative drug required to be used earlier in the step therapy protocol to be ineffective. | All individual health plans |

## NEW HAMPSHIRE

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>NH Rev Stat § 420-J:7-b (2024) | Prohibits plans from requiring patients to try and fail on a medication more than once if continuously enrolled in the plan. | All state-regulated health plans |

## NEW JERSEY

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>AB 1825 (2025) | Requires a step therapy policy use clinical review criteria, relying on objective data, developed and endorsed by a multidisciplinary team experts.<br>Requires an exception to a step therapy protocol be granted when the drug:<br>(1) is contraindicated or likely to cause an adverse reaction or physical or mental harm to the patient;<br>(2) is expected to be ineffective;<br>(3) has previously been tried and failed.<br>Requires step therapy exception request be upheld for at least 180 days, or the duration of therapy if less than 190 days.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours in an emergency.<br>Managed care organizations under the Medicaid program must make statistics available regarding the step therapy exception requests, approvals, and denials on its website in a readily accessible format. | All state-regulated health plans and Medicaid |

## NEW MEXICO

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>NM Stat § 59A-47-47.1 (2024) | Requires an exception to a step therapy protocol be granted when the drug:<br>(1) is contraindicated or likely to cause an adverse reaction or physical or mental harm to the patient;<br>(2) is expected to be ineffective;<br>(3) has previously been tried and failed;<br>(4) is not in the best interest of the patient because it is expected to cause a barrier to treatment adherence, worsen a comorbid condition, or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities.<br>Requires a step therapy exception to be upheld for the duration of treatment.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours in an emergency.<br>Requires a step therapy policy to be based on clinical practice guidelines, developed by a panel of experts, based on high-quality studies, research, and medical practice. | Individual and small group plans |

## NEW YORK

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>NY Ins L § 4903 (2024) | Requires an exception to a step therapy protocol be granted when:<br>(1) a drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to patient;<br>(2) a drug is expected to be ineffective based on clinical history;<br>(3) a drug has previously been tried and failed;<br>(4) not in the best interest of the patient because it could pose a significant barrier to adherence, worsen a comorbid condition, or likely decreased the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or<br>(5) the patient is stable on their current treatment.<br>Requires that a step therapy denial letter be provided in writing and include:<br>(1) the reasons for the determination, including the clinical rationale, if any;<br>(2) instructions on how to file both a standard and expedited appeal;<br>(3) notice of the availability of the clinical review criteria relied upon to make such determination;<br>(4) information on any applicable alternative prescription drug subject to the step therapy protocol of the utilization review agent.<br>Failure to respond to a step therapy exception request within the statutory period will be deemed an approval of the override request. | All state-regulated health plans |
| Yes.<br>NY Ins L § 4902 (2024)<br>*Effective Jan. 1, 2026* | Prohibits a step therapy policy from requiring:<br>(1) failure on an FDA-approved drug that is not approved to treat the medical condition being treated;<br>(2) trial and failure on more than two drugs approved to treat the medical condition; and<br>(3) failure for more than 30 days or a duration of treatment supported by current evidence-based guidelines.<br>Prohibits imposing step therapy:<br>(1) if a therapeutic equivalent is not available or if it has been previously failed on within the last 365 days;<br>(2) a newly enrolled individual has previously completed a step therapy protocol for that drug under a previous plan or in the last 365 days;<br>(3) if a drug has been previously approved for coverage by the current health plan, unless an evidence-based safety concern exists.<br>Requires a health care provider's attestation that a patient has previously failed on a drug be accepted as evidence of previous failure. | All state-regulated health plans |

## NORTH CAROLINA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>NC Gen Stat § 58-3-221 (2023) | Requires protocols to be based on a review of new evidence, research and newly developed treatments.<br>Requires the plan provide access to a non-formulary drug when the:<br>(1) enrollee has tried and failed on alternative drugs while under the current or previous plan;<br>(2) drug is expected to be ineffective;<br>(3) drug is expected to cause harmful or adverse clinical reaction; or<br>(4) provider attests the patient has previously failed on alternative treatment or is likely to be detrimental to the enrollee's health.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours in an emergency. | All state-regulated health plans |

## NORTH DAKOTA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>ND Century Code § 19-02.1-16.3 (2024) | Prohibits step therapy for the treatment of metastatic cancer and requires the policy to be based on peer-reviewed medical literature. | All state-regulated health plans |

## OHIO

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>OH Rev Code § 3901.832 (2024) | Requires an exception to a step therapy protocol be granted when:<br>(1) a drug is contraindicated for the condition being treated;<br>(2) a drug has been previously tried and failed by the patient under the current or previous plan; or<br>(3) when the patient is stable on their current treatment.<br>The plan must respond to an exception request within 10 business days in a non-emergency and 48 hours for urgent care services.<br>If the plan does not respond within the statutory period, the exemption request is automatically deemed granted. | All state-regulated health plans |

## OKLAHOMA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>63 OK Stat § 7330 (2024) | Requires an exception to a step therapy protocol be granted when:<br>(1) other treatments have been shown to be as effective as other available treatment options based on peer-reviewed evidence;<br>(2) it would cause a delay that would lead to severe or irreversible consequence and the drug is reasonably expected to be less effective;<br>(3) a drug is contraindicated or is likely to cause an adverse action or other physical harm;<br>(4) a drug will prevent the patient from achieving or maintaining reasonable and safe functional ability in performing occupational responsibilities or daily living activities, or if<br>(5) the patient's disease is classified as life-threatening.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours for emergencies. | All state-regulated health plans |

## OREGON

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>OR Rev Stat § 743B.602 (2023) | Requires a health plan to post on its website clear explanations, that are easily accessible, written in plain language and understandable to providers and beneficiaries, on:<br>(1) clinical criteria used for each step therapy policy and the criteria for approving an exception request;<br>(2) the procedure to request an exemption and medical rationale required; and<br>(3) documentation necessary to demonstrate appropriateness.<br>Requires an exception to a step therapy protocol be granted when:<br>(1) a drug is contraindicated or will cause the patient to experience an adverse reaction;<br>(2) is expected to be ineffective;<br>(3) has previously been tried and failed;<br>(4) the patient is stable on their current treatment for at least 90 days;<br>(5) it is not in the best interest of the patient based on medical necessity. | All-state regulated health plans |

## PENNSYLVANIA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>1921 Act 284 Ch. 21 Sec. 56 | Requires an exception to a step therapy protocol request, to consider:<br>(1) any contraindications, including severe reactions;<br>(2) clinical effectiveness of prerequisite prescription drugs;<br>(3) past clinical outcomes on prerequisite prescription drugs;<br>(4) expected clinical outcomes;<br>(5) if the patient has previously tried and failed on the drug previously. | All state-regulated health plans and Medicaid |
| Yes.<br>1921 Act 284 Ch. 21 Sec. 55 | The plan must respond to an exception request within 48 hours in a non-emergency, but no longer than 72 hours; and 24 hours for emergencies. | All state-regulated health plans and Medicaid |

## RHODE ISLAND

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| No step therapy law in place. | NA | NA |

## SOUTH CAROLINA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| No step therapy law in place. | NA | NA |

## SOUTH DAKOTA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>SD Codified L § 58-17H-53 (2024) | Requires health plans to provide the evidence-based and peer-reviewed clinical criteria to the covered person upon written request. | All state-regulated health plans |
| Yes.<br>SD Codified L § 58-17H-55 (2024) | Requires an exception to a step therapy protocol to be granted when:<br>(1) a drug is contraindicated or when the enrollee has previously tried and failed on the drug;<br>(2) a drug is likely to cause an adverse reaction;<br>(3) a drug is likely to decrease the ability of a covered person to achieve or maintain reasonable functional ability in performing daily activities;<br>(4) a drug is likely to cause physical or mental harm to the patient;<br>(5) a drug is expected to be ineffective based on clinical characteristic, adherence or compliance challenges;<br>(6) the patient has previously tried and failed on the drug; or<br>(7) the patient is currently stable on their current treatment.<br>The plan must respond to an exception request within 5 days in a non-emergency, and 72 hours for emergencies. | All state-regulated health plans |

## TENNESSEE

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>TN Code § 56-7-3502 (2024) | Requires an exception to a step therapy protocol to be granted when:<br>(1) a drug is contraindicated or will likely cause an adverse reaction, physical or mental harm due to a documented adverse event with a previous use;<br>(2) a drug is expected to be ineffective;<br>(3) it is not in the best interest of the patient because it will cause a significant barrier to patient adherence, worsen a comorbid condition, or decrease patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or<br>(4) the patient is currently stable on their current treatment. | All state-regulated health plans |
| Yes.<br>TN Code § 56-6-705 (2024) | Requires a denial letter to include the principal reason for the determination and the procedures to initiate an appeal. | All state-regulated health plans |

## TEXAS

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>TX Ins Code § 1369.0545 (2024) | Requires health plans to base step therapy protocols on clinical practice guidelines, developed and endorsed by a multidisciplinary panel of experts; based on high-quality studies, research, and medical practice; and created by an explicit and transparent process. | All state-regulated health plans |
| Yes.<br>TX Ins Code § 1369.0546 (2024) | Requires an exception to a step therapy protocol to be granted when:<br>(1) a drug is contraindicated;<br>(2) a drug will likely cause an adverse reaction, physical or mental harm to the patient;<br>(3) a drug is expected to be ineffective based on clinical characteristics;<br>(4) a drug has previously been tried and failed by the patient;<br>(5) it is not in the best interest of the patient because the drug is expected to cause a significant barrier to adherence, worsen a comorbid condition, or decrease a patient's ability to achieve or maintain reasonable functional ability in performing daily activities; or<br>(6) the patient is stable on their current treatment and received coverage under their previous plan.<br>The plan must respond to an exception request within 72 hours in a non-emergency, and 24 hours for emergencies. Failure to comply with the statutory response periods deems the requests automatically granted. | All state-regulated health plans |
| Yes.<br>TX Ins Code § 1369.0547 (2024) | Prohibits a health plan from imposing more than one step in a step therapy policy for the treatment of a serious mental illness. | All state-regulated health plans |

## UTAH

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| No step therapy law in place. | NA | NA |

## VERMONT

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>VT Act 111 of 2024 | Requires an exception to a step therapy protocol to be granted when:<br>(1) a drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;<br>(2) a drug is expected to be ineffective;<br>(3) a drug has been previously tried and failed; or<br>(4) the patient is currently stable on their treatment;<br>(5) it is not in the best interest of the patient because it will pose a barrier to adherence; likely worsen a comorbid condition; likely decrease the patient's ability to achieve or maintain reasonable functional ability. | All state-regulated health plans |
| Yes.<br>18 VT Stats § 9418b<br>*VT step therapy law subject to same time requirements as VT prior authorization statute referenced within step therapy law* | The plan must respond to an exception request within 48 hours in a non-emergency, and 24 hours for emergencies. Failure to comply with the statutory response periods deems the requests automatically granted. | All state-regulated health plans |

## VIRGINIA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>VA Code § 38.2-3407.9:05 (2019) | Requires step therapy policies to be based on peer-reviewed research and medical practice guidelines.<br>Requires an exception to a step therapy protocol to be granted when:<br>(1) a drug is contraindicated;<br>(2) a drug is expected to be ineffective;<br>(3) a drug has previously been tried and failed; or<br>(4) the patient is stable on their current treatment.<br>The plan must respond to an exception request within 72 hours in a non-emergency, and 24 hours for emergencies. | All state-regulated health plans |

## WASHINGTON

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>WA Rev Code § 48.43.420 (2024) | Requires an exception to a step therapy protocol be granted when:<br>(1) a drug is contraindicated or likely to cause an adverse reaction;<br>(2) a drug is expected to be ineffective;<br>(3) the patient has already tried and failed on the drug;<br>(4) the patient is stable on their current treatment;<br>(5) it is not in the best interest of the patient by creating a barrier to adherence, negatively impacting a comorbid condition, causing predictable negative drug interaction, or decreasing the patient's ability to perform daily activities.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours in an emergency. | All state-regulated plans. |

## WEST VIRGINIA

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>WV Code § 33-24-7p (2023) | Requires an exception to a step therapy protocol be granted when:<br>(1) a drug is contraindicated or will likely cause an adverse reaction, or physical or mental harm to the patient;<br>(2) a drug is expected to be ineffective;<br>(3) a drug has previously been tried and failed by the patient;<br>(4) it is not in the best interest of the patient; or<br>(5) the patient is stable on their current treatment. | All state-regulated plans. |

## WISCONSIN

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>WI Stat § 632.866 (2024) | Requires step therapy policies to be based on peer-reviewed research and medical practice guidelines.<br>Health plan must describe on its website the process and criteria used for selecting and evaluating clinical practice guidelines used to develop step therapy protocol.<br>Requires an exception to a step therapy protocol be granted when:<br>(1) a drug is contraindicated;<br>(2) a drug has previously caused an adverse reaction;<br>(3) a drug is likely to cause a serious adverse reaction;<br>(4) a drug is likely to likely decrease the ability to achieve or maintain reasonable functional ability in performing daily activities;<br>(5) a drug is likely to cause physical or psychiatric harm to the patient;<br>(6) a drug is expected to be ineffective;<br>(7) a drug has previously been tried and failed; or<br>(8) the patient is stable on their current treatment.<br>The plan must respond to an exception request within 72 hours in a non-emergency and 24 hours in an emergency. | All state-regulated health plans |

## WYOMING

| STATE LAW | LANGUAGE | APPLICABLE PLANS |
|---|---|---|
| Yes.<br>WY Stat § 26-55-111 (2024) | Prohibits health plans from requiring a patient to repeat step therapy if already completed under a previous health plan. | All state-regulated health plans |

# ANNEX B: OVERSIGHT

## ALABAMA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## ALASKA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## ARIZONA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## ARKANSAS

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| The All-Payer Claims Database includes reporting for "denials." However, due to cost, this data was not reviewed. The legislature also requires that health plans publish statistics regarding approvals and denials on their website, including the reason for denial.[5] Based on Aimed Alliance's review, health plans are not completely complying with this because some do not include the reason for the denials. | Arkansas All-Payer Claims Database |

## CALIFORNIA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Publishes an online database that tracks independent claim reviews. This database includes claim information on the reason for appeal (medical necessity, experimental, etc.), outcome of appeal, diagnosis category, the item or service requested, and the age and gender identity of the appellant. | California's All Payer Claims Database |

## COLORADO

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Publishes annual report which includes data on total number of health insurance complaints received. | Colorado All Payer Claims Database |

## CONNECTICUT

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Publishes an annual consumer report that includes savings derived from utilization management per individual, and utilization review requests, denials, appeals and outcome of appeals. Report requires plans to disclose why the benefit was denied: (1) not a covered benefit; (2) not medically necessary; (3) not an eligible enrollee; (4) incomplete submission; (5) duplicate submission; or (6) all other miscellaneous. | Connecticut All-Payer Claims Database |

## DELAWARE

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| In a response to Aimed Alliance's letter, the department stated it does not collect data on denials and internal appeals, and only monitors external appeals. In 2024, the Department received 29 external review requests, of which, 21 were denied and 8 were overturned. | Delaware Health Care Claims Database |

## FLORIDA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | Florida All Payer Claims Database |

## GEORGIA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## HAWAII

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Publishes an annual report to the state legislature that includes the number of external reviews conducted, types of cases reviewed, summary of cases, and the outcomes of the cases. The 2024 report found 21 external reviews were conducted, of which, 11 related to denials in coverage, 6 involved policy coverage, 3 involved claims appeals, and 1 related to par-non-par. Of the 21 claims, 6 were overturned.<br>*4 cases were withdrawn; 5 cases were upheld; 6 were dismissed on statutory grounds.* | Hawaii All-Payer Claims Database |

## IDAHO

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## ILLINOIS

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## INDIANA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Does not track any specific data relating to step therapy, but does publish annual grievance and appeals statistics. In 2023, 8,921 grievances were filed with the department of insurance, and 2,203 were overturned. In addition, 2,482 internal appeals were filed and 1,029 were overturned on appeal. Lastly, 230 external appeals were filed and 29 were overturned on appeal. | Indiana All-Payer Claims Database |

## IOWA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| In response to Aimed Alliance's letter, the division stated it does not track specific data relating to step therapy or internal appeals, but does track external appeals data. From January 1, 2023 to October 17, 2024, the Department received 101 external appeals, of which, 50 were overturned in the consumers' favor, and 51 were upheld. The justifications for external review outcomes are considered confidential under Iowa law. | NA |

## KANSAS

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Collects information on internal and external appeals but does not post this data publicly on its website.<br>*Aimed Alliance staff met with Kansas Department of Insurance staff on Nov. 7, 2024.* | Kansas Data Analytic Interface |

## KENTUCKY

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| In response to Aimed Alliance's letter, the Department stated it collects information on the number of step therapy exception requests received; the type of health care providers or medical specialties of health care providers that submitted requests; the number of exceptions that were denied and approved, and those that were initially denied, then appealed and reversed on appeal; and the medical conditions for which insurers were granted exceptions due to the likelihood that the drug would cause an adverse reaction. The first set of data was submitted to the Department in March 2024 and is available via a public records request. | NA |

## LOUISIANA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## MAINE

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Published a report in February 2025 on 2021-2023 prior authorization data, including the total number of prior authorization requests received under standard and expedited requests, the outcome of requests, and average and median wait times for decision outcomes. In addition, plans are also required to submit annual data on the number of complaints received, adverse decisions, appeals, and appeal outcomes. This data is not available on the website or in a report. | Maine All Payer Claims Data Base |

## MARYLAND

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Publishes an annual report to the state legislature on appeals and grievances in health insurance. The report provides plan-specific information on adverse decisions, appeals, grievances, and outcomes. The report also breaks down adverse decisions by service type. As of January 1, 2025, plans will also be required to report whether the adverse decision involved step therapy or prior authorization; the number of adverse decision reconsideration requests it received; and the number of formulary exception requests made and outcome. | Maryland Medical Care Data Base |

## MASSACHUSETTS

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Requires plans to annually report the number of step therapy exception requests received by exception type; the type of health care providers or the medical specialties of the health care providers submitting step therapy exception requests; the number of step therapy exception requests, by exception, that were denied and the reasons for the denials; the number of step therapy exception requests by exception that were approved; the medical conditions for which patients are granted exceptions due to the likelihood that switching from the prescription drug will likely cause an adverse reaction in or physical or mental harm to the insured; the number of step therapy exception requests, by exception, that were initially denied and then appealed; and the number of step therapy exception requests by exception that were initially denied and then subsequently reversed by internal appeals or external reviews. | Massachusetts All-Payer Claims Database |

## MICHIGAN

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Publishes all individual complaint decisions on its website. | NA |

## MINNESOTA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Collects data on external appeals, including item descriptions and case outcomes. Data for 2022 and 2023 was provided to Aimed Alliance upon request. In 2022, 221 external appeals (118 upheld, 98 overturned, 5 no responses); 2023, 213 external appeals (132 upheld, 81 overturned).<br>*The Minnesota Commerce Department shared this data with Aimed Alliance on October 31, 2024.* | Minnesota All Payer Claims Database |

## MISSISSIPPI

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## MISSOURI

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| In response to Aimed Alliance's letter, the Department stated it collects data on external appeals and case outcomes. Data was provided to Aimed Alliance upon request. | Midwest Health Initiative Commercial Claims Database |

## MONTANA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Montana Code 33-32-421 requires an external review organization to annually report in aggregate the total number of requests for external review, the outcome of requests, and average length of time for resolution, a summary of cases, and coverage types. The insurance commissioner also has the authority to request that additional information be included annually. This information is not published. | NA |

## NEBRASKA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Nebraska Revised Statute 44-1315 requires plans report data on external appeals outcomes, available upon request. | NA |

## NEVADA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | Nevada All-Payer Claims Database |

## NEW HAMPSHIRE

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | New Hampshire Comprehensive Health Care Information System |

## NEW JERSEY

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | New Jersey All-Payer Claims Database |

## NEW MEXICO

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| The New Mexico Human Services Department publishes an annual report on Medicaid managed care plans which scores plans on their grievance and appeals processes. | New Mexico All-Payer Claims Database |

## NEW YORK

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Maintains a public interactive and searchable database that includes appeal data broken down by diagnosis, treatment, health plan (including Medicaid and CHIP), and appeals outcomes. | New York All Payer Claims Database |

## NORTH CAROLINA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## NORTH DAKOTA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## OHIO

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## OKLAHOMA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| In response to Aimed Alliance's letter, the Department shared data on internal and external appeals. | NA |

## OREGON

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | Oregon All Payer Claims Reporting Program |

## PENNSYLVANIA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Publishes an annual report titled "Transparency in Coverage", that provides data on the number of claim requests, denials, internal, and external appeals, and outcomes. The report provides aggregate data and insurer-specific data. | NA |

## RHODE ISLAND

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Requires health plans to report aggregate claim data quarterly. Data is broken down by item or service, internal and external appeals, and outcomes. Data is available upon request.<br>*The Department shared this information with Aimed Alliance on November 12, 2024.* | Rhode Island All-Payer Claims Database |

## SOUTH CAROLINA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## SOUTH DAKOTA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## TENNESSEE

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Tennessee Code §56-6-704 requires health plans to annually report the number of internal and external grievances, outcomes, and any corrective actions the plan took. This information is not publicly available. | NA |

## TEXAS

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | Texas All-Payor Claims Database |

## UTAH

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

## VERMONT

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | Vermont Health Care Uniform Reporting and Evaluation System |

## VIRGINIA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | Virginia All-Payer Claims Database |

## WASHINGTON

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Publishes an annual report to the state legislature on prior authorization for the top 10 prescription drugs, inpatient and outpatient care, durable medical devices, and diabetes supplies. The report includes information on denials, approvals, appeals, and appeal outcomes. | Washington State All-Payer Claims Database |

## WISCONSIN

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| Maintains a public database of all grievances as reported to the Office by health insurance companies, including aggregate data related to grievances filed and reasoning for denials. | NA |

## WEST VIRGINIA

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | West Virginia Health Care Authority Database |

## WYOMING

| DENIALS AND APPEALS TRANSPARENCY | ALL PAYERS CLAIMS DATABASE |
|---|---|
| NA | NA |

# ANNEX C: STATE-SPECIFIC REPORTING REQUIREMENTS AND APPEALS DATA

| STATE | Do they collect data on step therapy or PA? | Do they collect data on internal and external appeals? | Is this data available publicly? | How often are appeals filed? | How often are appeals overturned? |
|---|---|---|---|---|---|
| ARKANSAS | No. | Yes. | No. | NA | NA |
| CALIFORNIA | No. | Yes. | Yes. | 2024<br>171 | 2024<br>112 (65%) |
| COLORADO | No. | No. | Annual consumer report lists total number of consumer complaints filed related to health insurance. | NA | NA |
| CONNECTICUT | No. | Yes. | Yes. Each insurer is required to post this information. | 2024<br>On average, 626 appeals filed. | 2024<br>212 (33%) |
| DELAWARE | No. | Yes, external appeals only. | Yes, upon request. | 2024<br>29 | 2024<br>8 (27%) |
| HAWAII | No. | Yes, external appeals only. | Yes, annual report. | 2024<br>21 | 2024<br>6 (28%) |
| INDIANA | No. | Yes, grievances and appeals. | Yes, annual report. | 2023 data<br>8,921 grievances<br>2,482 internal appeals<br>230 external appeals | 2023 data<br>2,203 grievances overturned (25%)<br>1,029 internal appeals overturned (41%)<br>29 external appeals overturned (12%) |
| IOWA | No. | Yes, external appeals data only. | Yes, upon request. | Jan. 1 2023 to Oct. 17, 2024<br>101 external appeals | 50 overturned in consumer's favor (49%) |
| KANSAS | No. | Yes, internal and external appeals data. | No. | NA | NA |
| KENTUCKY | Yes, step therapy data. | Yes. | Yes, upon request. | NA | NA |
| MAINE | Yes, prior authorization data. | Yes. | No. | NA | NA |
| MASSACHUSETTS | Yes, step therapy data. | No. | No. | NA | NA |

| STATE | Do they collect data on step therapy or PA? | Do they collect data on internal and external appeals? | Is this data available publicly? | How often are appeals filed? | How often are appeals overturned? |
|---|---|---|---|---|---|
| MARYLAND | Yes, beginning in 2025, for step therapy and prior authorization. | Yes. | No. | NA | NA |
| MICHIGAN | No. | Yes, publishes all complaints online. | Yes, all individual complaint decisions are posted on their website. | NA | NA |
| MINNESOTA | No. | Yes, internal and external appeals data. | Yes, upon request. | 2022<br>221 external appeals<br>2023<br>213 external appeals | 2022<br>98 overturned (44%)<br>2023<br>81 overturned (38%) |
| MISSOURI | No. | Yes, external appeals data. | Yes, upon request. | 2021<br>89 external appeals<br>2022<br>48 external appeals<br>2023<br>57 external appeals<br>2024<br>60 external appeals | 2021<br>38 overturned (42%)<br>2022<br>20 overturned (41%)<br>2023<br>31 overturned (54%)<br>2024<br>33 overturned (55%) |
| MONTANA | No. | Yes. | No. | NA | NA |
| NEBRASKA | No. | Yes, external appeals data only. | Yes, upon request. | On average, conducts approximately 250 reviews each year. | Since 2014, 786 cases have been overturned (47%). |
| NEW YORK | No. | Yes. | Yes, there is a public database on their website. | NA | NA |
| OKLAHOMA | No. | Yes. | Yes, upon request. | Jan 2023-January 2024<br>60 exemption requests; 17 were ineligible for review due to not exhausting internal and external appeals.<br>Only 43 were eligible for review. | 20 overturned (46%) |
| PENNSYLVANIA | No. | Yes, internal and external appeals. | Yes, annual report. | 2023<br>2,135,041 claim denials (.1% filed appeals)<br>3156 internal appeals filed<br>54 external appeals filed | 2023<br>1,528 internal appeals overturned (48%)<br>4 external appeals overturned (7%) |
| RHODE ISLAND | No. | Yes. | Yes, upon request. | NA | NA |
| TENNESSEE | No. | Yes, internal and external appeals data. | No. | NA | NA |

| STATE | Do they collect data on step therapy or PA? | Do they collect data on internal and external appeals? | Is this data available publicly? | How often are appeals filed? | How often are appeals overturned? |
|---|---|---|---|---|---|
| **UTAH** | No. | Yes, internal and external appeals data. | Yes, annual Market Report. | 2023<br>233 external appeals (181 eligible for review) | 2023<br>89 external appeals overturned (38%) |
| **WASHINGTON** | No. | Yes, only related to the top 10 most utilized prescription drugs, medical devices, and diabetes supplies. | Yes, annual report. | NA | NA |
| **WISCONSIN** | No. | Yes. | Maintains a public website that tracks the total number of grievances filed with the department and the reasons for grievances. | 2023<br>346 external reviews<br>2023<br>12,194 grievances filed<br>2024<br>14,581 grievances filed | 2023<br>75 external appeals overturned (21%)<br>Outcome data for grievances is not tracked. |

# ANNEX D: ARTIFICIAL INTELLIGENCE

## ALABAMA

| ENACTED | PROPOSED |
|---|---|
| NA | NA |

## ALASKA

| ENACTED | PROPOSED |
|---|---|
| NA | NA |

## ARIZONA

| ENACTED | PROPOSED |
|---|---|
| NA | Proposed bill would mandate that a health care provider or medical director individually review each claim that involves medical necessity, experimental status, or requires medical judgment before a denial can be issued (AZ HB2175). |

## ARKANSAS

| ENACTED | PROPOSED |
|---|---|
| NA | Proposed bill would require state-funded plans to disclose details about AI algorithms used in utilization review through an applied model card. This includes:<br>• The algorithm's strengths, limitations, and known biases<br>• Populations where the AI performs better or worse<br>• The criteria, training data (including bias mitigation), and the algorithm itself<br>• How it is used, expected outcomes, and any independent third-party validation<br>Additionally, insurers would be required to ensure:<br>• Use of federated data-sharing models to protect privacy<br>• Compliance with national interoperability standards (e.g., FHIR, USCDI)<br>• Alignment with privacy/security standards like the Trusted Exchange Framework<br>• Explicit enrollee consent is documented for use of their health data in AI development and validation.<br>(AR HB1287) |

## CALIFORNIA

| ENACTED | PROPOSED |
|---|---|
| California enacted a law requiring health plans that use AI in utilization review to follow strict safeguards. Under the law, AI tools cannot override a provider's clinical judgment or make final decisions regarding medical necessity. They must base their assessments on the patient's individual medical history, provider input, and clinical records, not solely on group data. Only a licensed physician or qualified health care professional may ultimately determine whether a service is medically necessary (SB 1120). | Would require any health facility, clinic, physician's office or group practice office using AI to generate patient communications to include a disclaimer notifying the patient that the communication was AI-generated and provide clear instructions for contacting a human healthcare provider (CA AB3030).<br>Requires that a denial, delay, or modification of healthcare services based on medical necessity must be made by a licensed physician or other healthcare provider competent to evaluate the specific clinical issues involved in the healthcare services requested by the provider and with the same or similar specialty as the requesting provider. This bill would require algorithms, AI and other software tools used for utilization review or utilization management decisions of a healthcare service plan to comply with specified requirements, including that they be fairly and equitably applied (CA SB1120). |

## COLORADO

| ENACTED | PROPOSED |
|---|---|
| Colorado passed legislation to ensure use of algorithms and predictive models, including AI, in all types of insurance does not lead to discrimination. The law directs the Colorado Division of Insurance to develop regulations that establish a reasonable period of time for insurers to correct any unfairly discriminatory impact identified in external data sources. It also authorizes insurers to use external data sources that have been previously reviewed and approved by the Division as not unfairly discriminatory (SB21-169). | No. |

## CONNECTICUT

| ENACTED | PROPOSED |
|---|---|
| No. | Bill proposed to prohibit health carriers from using AI in the evaluation and determination of patient care to safeguard patient access to testing, medications and procedures (CT. No.447). |

## DELAWARE

| ENACTED | PROPOSED |
|---|---|
| The Delaware Department of Insurance issued a bulletin reminding insurance carriers operating in the state that any decisions affecting consumers made using advanced technologies, including AI, must comply with all insurance laws, particularly those prohibiting unfair trade practices and discrimination. The bulletin outlines the department's expectations for how insurers should manage and oversee the development, acquisition, and use of AI technologies. | No. |

## FLORIDA

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would require that insurers' decisions to deny claims or any portion of a claim be made by a qualified human professional; prohibit using algorithms, artificial intelligence, or machine learning systems as the sole basis for determining whether to adjust or deny a claim; and require insurers to include certain information in denial communications to claimants (FL SB794). |

## GEORGIA

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would require developers and deployers of AI systems to conduct thorough evaluations and impact assessments to identify and mitigate potential discriminatory effects across various consequential decision areas, including healthcare (GA SB167). |

## HAWAII

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would require that if AI or an automated decision system initiates a denial, that denial must be reviewed and co-signed by a board-certified specialist in the relevant field before being finalized; and patients and providers shall be notified in writing when AI is used at any stage of the coverage determination (HI HB194).<br>Proposed bill would establish an AI institute to facilitate interdisciplinary research and development in AI with a focus on areas relevant to the state, including health care advancements and equitable delivery of patient care (HI HB546). |

## IDAHO

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## ILLINOIS

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would prohibit insurers from issuing an adverse consumer outcome concerning the denial, reduction, or termination of insurance plans or benefits that results solely from the use or application of any AI system or predictive model and require that any decision-making process for the denial, reduction, or termination of insurance plans or benefits that results from the use of AI systems or predictive models shall be meaningfully reviewed by an individual with authority to override the AI systems and determinations (IL HB0035). |

## INDIANA

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would require an insurer to disclose to an insured the use of AI to make or inform any decision involved in the provision of the coverage to the insured or generate any part of a communication to the insured regarding the coverage (IN HB1620). |

## IOWA

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would require health carriers using AI for reviewing medical services to base determinations on individual patient history, clinical circumstances, and relevant medical records, and prohibit AI from replacing healthcare provider decision-making or discriminating against patients (IA SF562). |

## KANSAS

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## KENTUCKY

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would establish the Commonwealth Artificial Intelligence Consortium Task Force to serve as a collaborative platform to bring together various stakeholders, including healthcare providers to identify needs, collect data, develop AI solutions, foster innovation and competitiveness, promote AI literacy, and ensure trusted AI development and governance (KY SCR412). |

## LOUISIANA

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## MAINE

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would prohibit health insurance carriers from denying coverage or claims for services under a health plan solely based on the use of AI (ME LD955).<br>Proposed bill would require health insurance carriers that use AI to make medical review or utilization review determinations relating to the approval, denial, delay, modification or adjustment of coverage for services under a health plan to be based on an individual's specific medical history and clinical circumstances; avoid discriminating against enrollees based on personal characteristics like race, age, or disability; be applied fairly and equitably; and be transparent with policies open to inspection (ME LD1301). |

## MARYLAND

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would require health insurance carriers in Maryland to submit reports to the insurance commissioner about their use of AI and would mandate more comprehensive data about their operations, including the number of claims and grievances broken down by demographic categories like race, ethnicity, gender, and age (MD HB 697).<br>Proposed bill would prohibit AI from denying, delaying or modifying health care services (MD HB820).<br>Proposed bill would require that AI cannot be designed solely to reduce costs at the expense of patient care quality. It would also require that carriers annually post detailed information on their websites about AI-driven decisions, including thresholds for human review, rates of decision overturn, misdiagnosis rates, and instances where AI suggestions might disregard patient-specific factors like preexisting conditions or care preferences (MD HB1240). |

## MASSACHUSETTS

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would require that carriers and utilization review organizations using such technological tools ensure their AI systems base determinations on individual patient medical history, clinical circumstances, and relevant medical records, and not solely on group datasets and mandates that these AI tools cannot replace healthcare provider decision-making, must not discriminate against patients, and must be applied fairly and equitably (MA S46).<br>Proposed bill would require health insurance carriers to disclose the use of AI algorithms or automated decision tools in their claims review process, including a summary of what tools are being used and how (MA H1210).<br>Proposed bill would require annual impact assessments, implementation of risk management programs aligned with national standards, and robust consumer protections, such as notifying individuals when AI influences consequential decisions (MA H94).<br>Proposed bill would require entities to implement risk management policies, conduct impact assessments, and provide consumers with clear notifications when AI systems are used to make important decisions (MA H97). |

## MICHIGAN

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## MINNESOTA

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would prohibit the use of AI in the utilization review process for health insurance in Minnesota (MN HF1838).<br>Proposed bill would prohibit health insurance carriers from using algorithms or AI programs when reviewing and making decisions about prior authorization requests (MN HF2500). |

## MISSISSIPPI

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## MISSOURI

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## MONTANA

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would require that AI tools used for medical necessity determinations be based on individual patient clinical history, cannot rely solely on group datasets, and must not replace healthcare provider decision-making (MT HB556). |

## NEBRASKA

| ENACTED | PROPOSED |
|---|---|
| Enacted bill would prohibit an AI-based algorithm from being the sole basis of a utilization review entity's decision to deny, delay, or modify health care services based, in whole or in part, on medical necessity (NE LB77). | No. |

## NEVADA

| ENACTED | PROPOSED |
|---|---|
| No. | Non-companion bills that would ban the use of AI to deny a request for prior authorization (NV AB290). |

## NEW HAMPSHIRE

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## STATE

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## NEW JERSEY

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would require insurance carriers to disclose, in a clear and conspicuous location on the carrier's Internet website, whether or not the carrier uses an automated utilization management system and how many claims were reviewed using the automated utilization management system in the previous year (NJ A3858/S3298). |

## NEW MEXICO

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would mandate that consumers be informed when they are interacting with an AI system and given opportunities to understand and appeal adverse decisions (NM HB60). |

## NEW YORK

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would impose requirements for the use of artificial intelligence, algorithm, or other software tools in utilization review and management (NY A3991).<br>Proposed bill would establish the New York Artificial Intelligence Bill of Rights, which provides comprehensive protections for residents against potential harmful impacts of automated systems (NY A3265).<br>Proposed bill would establish comprehensive regulations for AI systems in New York State, including mandating that companies using high-risk AI systems notify users at least five business days before making consequential decisions, allow users to opt-out of automated processes, provide appeal mechanisms for AI-assisted decisions, and maintain robust risk management policies (NY S1169). |

## NEW CAROLINA

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would prohibit insurers from using AI as the sole basis for denying healthcare services and ensures that prior authorizations remain valid for certain periods, such as 90 days when a person switches health plans or six months for chronic condition treatments (NC S315). |

## NEW DAKOTA

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## OHIO

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would prohibit health insurers from making care decisions solely based on AI results and mandates that medical necessity determinations must be made by a licensed physician or qualified provider who considers the patient's individual clinical circumstances and the requesting provider's recommendation, and any decision to deny, delay, or modify health care services using an AI algorithm must be accompanied by a clear explanation of the rationale (OH SB164). |

## OKLAHOMA

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## OREGON

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would establish AI commission, whose focus would include ethics and bias in health care (OR HB3592). |

## PENNSYLVANIA

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## RHODE ISLAND

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would prohibit insurers from relying exclusively on AI or automated decision tools to deny, reduce, or alter coverage or claims for medically necessary care and require that adverse determinations be reviewed by physicians or other licensed healthcare professionals who are qualified in the appropriate specialties, without conflicts of interest or incentives to confirm adverse determinations, and who have the authority to reverse adverse determinations based on their clinical judgment (RI H5172).<br><br>Proposed bill would require insurers to publicly disclose how they use AI to manage claims and coverage, including details about underlying algorithms and data, and mandates that insurers cannot rely exclusively on AI to deny or reduce coverage for medically necessary care. Insurers must maintain documentation of AI decisions for five years and provide clear appeal processes when AI is used to make adverse determinations (RI S0013). |

## SOUTH CAROLINA

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would prohibit health plans from making coverage decisions that have been made based solely on results derived from the use or application of AI or the use of automated decision tools and require that health care professionals supervise and meaningfully review any coverage decisions made using automated decision-making tools when those tools are used to inform decisions to modify or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to insureds (SC S443). |

## SOUTH DAKOTA

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## TENNESSEE

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would require that AI tools base determinations on individual patient clinical history, individual clinical circumstances, and relevant medical records, and prohibit decisions made solely on group datasets, and stipulates that medical necessity determinations must be made exclusively by licensed physicians or healthcare professionals, not by AI systems (TN HB1382). |

## TEXAS

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would prohibit a utilization review agent from using AI as the sole basis of a decision to wholly or partly deny, delay, or modify health care services for an enrollee on the basis of medical necessity or appropriateness of health care items and services (TX HB2922).<br><br>Proposed bill would require organizations to publicly disclose on their websites and in writing whether they use AI-based algorithms in their utilization review processes (TX SB1822).<br><br>Proposed bill prohibits discrimination based on race, color, national origin, gender, age, vaccination status, or disability when using clinical AI algorithms (TX SB1411).<br><br>Proposed bill would require plans, when issuing a denial, to provide a clear notification that the claim denial was based on an AI determination and an explanation of the basis for the AI's decision (TX HB4635).<br><br>Proposed bill would require that AI determinations are based on individual patient clinical information, do not rely solely on group datasets, comply with existing laws, do not override healthcare provider decisions, avoid discrimination, are applied fairly, are subject to periodic review and revision, protect patient information, and do not cause harm to patients (TX HB4018). |

## UTAH

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## VERMONT

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## VIRGINIA

| ENACTED | PROPOSED |
|---|---|
| No. | Vetoed bill would have required any person using a "high-risk" AI system (intended to autonomously make, or be a substantial factor in making, a consequential decision) to make a "consequential decision" (any decision that has a material legal, or similarly significant, effect on the provision or denial to any consumer of specified services, including access to health care services), unless they have designed and implemented a risk management policy and program for such system (VA HB2094).<br><br>Proposed bill would prohibit any public body from using a "high-risk" AI system (intended to autonomously make, or be a substantial factor in making, a consequential decision) to make a "consequential decision" (any decision that has a material legal, or similarly significant, effect on the provision or denial to any consumer of, or the cost or terms specified services, including health care services), unless the deployer has designed and implemented a risk management policy and program for such high-risk AI system (VA HB2046/VA SB2046). |

## WASHINGTON

| ENACTED | PROPOSED |
|---|---|
| No. | Proposed bill would require that plans using AI for prior authorization decisions to be based on medical necessity to ensure the AI tool considers individual clinical data, complies with all relevant laws, avoids discrimination, is transparently and fairly applied, subject to audit, and regularly reviewed for accuracy and reliability (WA HB1566).<br><br>Proposed bill would require developers and deployers of AI systems to complete annual impact assessments detailing the AI tool's purpose, outputs, data collected from individuals, how it is used or monitored in making "consequential decisions" (those with significant legal, material, or personal impact on areas such as health care, insurance, or access to essential services) (WA HB1951). |

## WEST VIRGINIA

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## WISCONSIN

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

## WYOMING

| ENACTED | PROPOSED |
|---|---|
| No. | No. |

# REFERENCES


1. Aimed Alliance, *Step Therapy*, https://aimedalliance.org/step-therapy/.
2. States can regulate health insurance practices for all individual, small group, and fully-insured large group plans, as well as the state Medicaid programs. Meanwhile, self-insured large group plans and Medicare plans are only regulated by federal law.
4. Arkansas, Connecticut, Florida, Illinois, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, Ohio, Oklahoma, and Texas.
5. Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Maine, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. Maryland also allows for an exception if the drug has been tried and failed within the last 180 days.
6. Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Indiana, Iowa, Louisiana, Massachusetts, Maine, Maryland, Minnesota, Mississippi, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin.
7. Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Maine, Maryland, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Oklahoma, Oregon, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin.
8. Arizona, Arkansas, California, Colorado, Delaware, Georgia, Louisiana, Massachusetts, Maryland, Minnesota, Nevada, New York, Ohio, Oregon, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, West Virginia, and Wisconsin.
9. Maryland and Oklahoma.
10. Oklahoma.
11. Pennsylvania.
12. Arizona, Arkansas, California, Colorado, Indiana, Louisiana, Maine, New Jersey, New Mexico, North Carolina, Oklahoma, Pennsylvania, Texas, Virginia, Washington, and Wisconsin.
13. Delaware, Georgia, Nevada, and Vermont.
14. Massachusetts.
15. Minnesota, Nebraska, and South Dakota.
16. Ohio.
17. Aimed Alliance, *Executive Summary: New York Step Therapy Alliance Roundtable Discussion* (2022), https://aimedalliance.org/wp-content/uploads/2022/11/New-York-Step-Therapy-Alliance-Roundtable-Executive-Summary.pdf.
18. Laura Joszt, *How Prior Authorization, Step Therapy Results in Medication Discontinuation and Worse Outcomes* (Nov. 12, 2019), https://www.ajmc.com/view/how-prior-authorization-step-therapy-result-in-medication-discontinuation-and-worse-outcomes.
19. John O' Connor, *Pritzker signs law banning health insurance companies' predatory tactics,' including step therapy* (July 10, 2024), Associated Press, https://apnews.com/article/health-insurance-law-illinois-step-therapy-97d8a8845645f2ce4ad8be01fa153003.
20. Arkansas, Colorado, Louisiana, Maryland, Mississippi, Nevada, and North Carolina.
21. Arkansas, Connecticut, Maine, and Nevada.
22. Texas.
23. Kentucky, Mississippi, and New York.
24. Louisiana.
25. New York.
26. New Jersey and New Mexico.
27. Arkansas, Kansas, Kentucky, Louisiana, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, Ohio, Oklahoma, and Texas.
28. Arkansas, Connecticut, Kansas, Louisiana, Massachusetts, Nevada, New Jersey, New Mexico, Ohio, Oklahoma, and Texas.
29. Arkansas, Connecticut, Florida, Kansas, Kentucky, Louisiana, Massachusetts, New Jersey, New Mexico, Oklahoma, and Texas.
30. Arkansas, Kansas, Massachusetts, Nevada, Ohio, and Oklahoma.
31. Arkansas, Connecticut, and Oklahoma.
32. Florida.
33. Arkansas, Texas, and Florida, if the treatment was approved for coverage within the last 12 months.
34. Arkansas and Nevada.
35. Arkansas, Kansas, Massachusetts, New Jersey, New Mexico, Oklahoma, and Pennsylvania.
36. Nevada.
37. Kentucky.
38. Ohio.
39. Ohio and Oklahoma.
40. New Mexico.
41. Nevada.
42. Connecticut.
43. Kentucky, New Jersey, and New Mexico.
44. Hawaii (SB226/HB216); Montana (SB449/SB483); New Jersey (S3533/A1825); South Carolina (S531/H4562); Rhode Island (H5119/S116); and Vermont (SB30).
45. Hawaii (SB226/HB216) and New Jersey (S308/A2010).
46. Alaska (SB113/HB144); Connecticut (SB10); Indiana (HB1062); Iowa (SF197); Maine (LD178); Maryland (SB646); Maryland (SB921/HB1087); North Dakota (SB2248 and side effects); and Oregon (HB2536 and associated symptoms).
47. Alabama (SB191); Indiana (SB522); and Mississippi (SB2868/SB2874).
48. Connecticut (SB10); Massachusetts (H1129); Maryland (SB111/HB382); New Jersey (S1192/A4838); New York (S4867/A7522); Texas SB959/HB2674; Rhode Island (H5320/S786); Washington (HB1425 only psychotropic medications); and Wisconsin (SB83/AB54).
49. Connecticut (SB10) and Connecticut (SB813).
50. New Jersey (HB570) and New Mexico (HB570/SB477).
51. Rhode Island (SB117/H5463) and Rhode Island (SB221/H5429).
52. Connecticut (SB10) and Mississippi (SB2609).
53. Florida (SB264/HB721).
54. Florida (SB264/HB721).
55. Maryland (SB475).
56. Oklahoma (SB1064).
57. Maryland (HB697).
58. Colorado (SB25-301).
59. NAMI, *Long-Acting Injectables (LAIs)*, https://www.nami.org/about-mental-illness/treatments/mental-health-medications/long-acting-injectables-lais/.

60. World Health Organization, *New WHO guidelines advise countries to deliver long-acting cabotegravir as part of comprehensive approach to HIV prevention* (July 28, 2022), https://www.who.int/news/item/28-07-2022-who-recommends-long-acting-cabotegravir-for-hiv-prevention.
61. While some emergency circumstances may allow consumers to circumvent the internal procedures, this is not the primary pathway for raising concerns with state regulators.
62. Agency for Healthcare Research and Quality, *All-Payer Claims Databases,* https://www.ahrq.gov/data/apcd/index.html.
63. All-Payer Claims Database, *Claims Data Release Rules,* https://www.apcdcouncil.org/state-efforts/claims-data-release-rules (Colorado, Massachusetts, Maine, Minnesota, New Hampshire, Oregon, Utah, Vermont, and Washington).
64. Center for Improving Value in Health Care, *Colorado APCD Data Access & Licensing Fees,* https://civhc.org/wp-content/uploads/2017/08/CO-APCD-Data-Access-and-Licensing-Fees_8.2017-1.pdf.
65. Missouri, Oklahoma, Tennessee, Texas, and Wyoming have deferred some of their enforcement authority under the Patient Protection and Affordable Care Act (ACA) to the Centers for Medicaid and Medicare Services, CMS, *Compliance and Enforcement: Ensuring Compliance with the Public Health Service Act,* https://www.cms.gov/marketplace/private-health-insurance/consumer-protections-enforcement.
66. CoverageRights.org.
67. Kentucky, Maine, Massachusetts, and Maryland beginning in January 2025.
68. Arkansas, California, Connecticut, Delaware, Hawaii, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, New York, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Utah, Washington, and Wisconsin.
69. California, Connecticut, Hawaii, Indiana, New York, Pennsylvania, Utah, Washington, and Wisconsin.
70. Delaware, Iowa, Kentucky, Minnesota, Missouri, Nebraska, Oklahoma, and Rhode Island.
71. Colorado, Michigan, and Wisconsin.
72. Minnesota also shared 2022 data, which showed of 221 external appeals, 98 were overturned, a 44% reversal rate.
73. Missouri also shared data from 2021, 2022, and 2023. In 2021, of 89 external appeals, 38 were overturned, a 42% reversal rate. In 2022, of 48 external appeals, 20 were overturned, a 41% reversal rate. In 2023, of 57 external appeals, 31 were overturned, a 54% reversal rate.
74. This data was provided by the Nebraska Department of Insurance.
75. Wisconsin Office of the Commissioner of Insurance, 2023 Wisconsin Insurance Report, https://oci.wi.gov/Documents/AboutOCI/2023_WIR_Final_Web.pdf
76. The Colorado Division of Insurance produces an annual report that provides data on the total number of consumer complaints received by the department related to health insurance. From July 2023 - July 2024, the department received 1,716 health insurance complaints. Colorado, *Complaints Against Insurers,* https://drive.google.com/drive/folders/0BwguXutc4vbpfllReWFZdTQ0ejFrYmwxU2V6QzI0Qk9jUkdBaE5zZlVCLWEtcjFlaVhwNUE?resourcekey=0-8BEngghaQ0tGiuhN3XPmCw
77. Requires PBMs to report every 90 days the total number of pharmacy appeals and denials by PBMs. However, this information is not publicized; Florida Office of Insurance Regulation, *Pharmacy Benefit Managers,* https://floir.com/life-health/pbm.
78. The New Hampshire Insurance Department has statutory authority to collect data and impose statutory reporting requirements for claims, denials, and utilization management policies. However, the Department has announced it will not enforce these requirements for 2025 and 2026. New Hampshire Insurance Department, *New Hampshire Insurance Department Announces Temporary Suspension of Certain Filing Requirements to Streamline Regulatory Compliance* (Mar. 18, 2025), https://www.insurance.nh.gov/news-and-media/new-hampshire-insurance-department-announces-temporary-suspension-certain-filing.
79. The New Mexico Human Services Department publishes an annual report on quality reviews for the Medicaid Managed Care Programs. This Report does not include appeals data. New Mexico Human Services Department, *New Mexico Medicaid Managed Care Centennial Care 2.0 program* (Apr. 2025), https://api.realfile.rtsclients.com/PublicFiles/6c91aefc960e463485b3474662fd7fd2/f6f14d6a-0d7b-4a12-89b6-d49276bb2fb1/EQRO-IPRO%20Annual%20Technical%20Report%202023.
80. Aimed Alliance, *Ohio Response to Aimed Alliance 2024 Letter* (Jan. 27, 2025), https://aimedalliance.org/wp-content/uploads/2025/05/OHIO_Aimed-Alliance-Response.pdf.
81. Data related to external appeals and decision outcomes is available upon request.
82. Step Therapy transparency legislation was passed in March 2025. A report to the legislature on step therapy will include information on (i) the aggregate number of step therapy exception requests, acceptances, denials, appeals, and reversals; (ii) the percentages of reversals of step therapy exception request denials; (iii) the timeframe for responses, reconsiderations, and final decisions regarding step therapy exception requests; (iv) the number of step therapy protocols that are introduced, revised, or removed each quarter; and (v) data on the specialties of step therapy protocols, such as those used specifically for oncology, rheumatology, ophthalmology, orthopedics, or neurosurgery. Virginia State Legislative Information System, *Chapter 256,* https://lis.virginia.gov/bill-details/20251/HB2258/text/CHAP0256.
83. West Virginia does not track commercial appeals data but does publish an annual report on its managed care programs. West Virginia Department of Human Services, *Bureau for Medical Services Managed Care Programs 2023 External Quality Review Annual Technical Report* (Apr. 2024), https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOreports/Documents/WV%202023%20ATR_FINAL%20508.pdf.
84. Aimed Alliance staff met with the Department of Insurance on Nov. 5, 2024. The Department shared that in 2024, only 22 external appeal requests were filed. External appeals are based on medical necessity. The Department does not track the total number of coverage claims, approved, or denied.
85. The California Department of Insurance, *Interactive Independent Medical Review Statistics,* https://interactive.web.insurance.ca.gov/apex_extprd/f?p=192:1:12831202701089.
86. California, Hawaii, Indiana, Pennsylvania, and New York. Massachusetts will also produce a step-therapy data report beginning on January 1, 2025. This may be an alternative for states to consider if they are trying to understand how step therapy protocols are impacting consumers and how current exception laws are applied.
88. Food and Drug Administration, *Artificial Intelligence and Machine Learning in Software as a Medical Device,* https://www.fda.gov/medical-devices/software-medical-device-samd/artificial-intelligence-and-machine-learning-software-medical-device#whatis.

89. Food and Drug Administration, *Artificial Intelligence and Machine Learning in Software as a Medical Device,* https://www.fda.gov/medical-devices/software-medical-device-samd/artificial-intelligence-and-machine-learning-software-medical-device#whatis.
90. Ryan Heath, *AI lawsuits spread to health,* Axios (July 25, 2023), https://www.axios.com/2023/07/25/ai-lawsuits-health-cigna-algorithm-payment-denial.
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92. *Id.*
93. National Association of Insurance Commissioners, *About,* https://content.naic.org/about.
94. National Association of Insurance Commissioners, *NAIC Members Approve Model Bulletin on Use of AI by Insurers* (Dec. 4, 2023), https://content.naic.org/article/naic-members-approve-model-bulletin-use-ai-insurers.
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96. National Association of Insurance Commissioners, *NAIC Model Bulletin: Use of Artificial Intelligence Systems by Insurers* (Dec. 2, 2023), https://content.naic.org/sites/default/files/2023-12-4%252520Model%252520Bulletin_Adopted_0.pdf.
97. National Association of Insurance Commissioners, *Principles on Artificial Intelligence (AI),* https://content.naic.org/sites/default/files/committee_related_documents/AI%2520principles%2520as%2520Adopted%2520by%2520the%2520TF_0807.pdf.
98. *Id.* at 2.
99. *Id.* at 3.
100. *Id.*
101. *Id.* at 5-6.
102. National Association of Insurance Commissioners, *Implementation of NAIC Model Bulletin: Use of Artificial Intelligence Systems by Insurers* (May 2, 2025), https://content.naic.org/sites/default/files/cmte-h-big-data-artificial-intelligence-wg-ai-model-bulletin.pdf.pdf.
103. California Insurance Commissioner, *Bulletin 2022-5* (Jun. 30, 2022), https://www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/BULLETIN-2022-5-Allegations-of-Racial-Bias-and-Unfair-Discrimination-in-Marketing-Rating-Underwriting-and-Claims-Practices-by-the-Insurance-Industry.pdf .
104. *Id.*
105. *Id.*
106. Department of Financial Services, *Proposed Insurance Circular Letter* (Jan. 17, 2024), https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2024_nn_proposed.
107. Colorado Division of Insurance, *Proposed Amended Regulation 10-1-1,* https://drive.google.com/file/d/1Wd60KO1wIlcsYtsA2eOy7p46imaG-KTZ/view.
108. Texas Department of Insurance, *Commissioner's Bulletin # B-0036-20* (Nov. 30, 2020), https://www.tdi.texas.gov/bulletins/2020/B-0036-20.html.
109. NAIC Consumer Representatives, *Artificial Intelligence in Health Insurance: The Use and Regulation of AI in Utilization Management* (Nov. 2024), https://content.naic.org/sites/default/files/national_meeting/Final-CR-Report-AI-and-Health-Insurance-11.14.24.pdf.
110. *Id.*
111. *Id.*
112. *Id.* at 4.
113. Executive Office of the President, *Safe Secure, and Trustworthy Development and Use of Artificial Intelligence* (Oct. 30, 2023), https://www.federalregister.gov/documents/2023/11/01/2023-24283/safe-secure-and-trustworthy-development-and-use-of-artificial-intelligence.
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115. Colorado Department of Regulatory Agencies: Division of Insurance, *SB21-169 – Protecting Consumers from Unfair Discrimination in Insurance Practices,* https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1120.
116. Nebraska (NE LB77).
117. Arizona, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Montana, Nebraska, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, and Texas.
118. Arizona, California, Florida, Hawaii, Illinois, Maine, Montana, North Carolina, Ohio, Rhode Island, South Carolina, Tennessee, and Texas.
119. Florida, Hawaii, Indiana, Maryland, Massachusetts, New Mexico, New York, Ohio, and Texas.
120. Iowa, Massachusetts, Montana, Ohio, Tennessee, Texas, and Washington.
121. Minnesota, Maryland, Nebraska, Nevada, and Virginia.
122. Arkansas, New Jersey, Rhode Island, and Texas.
123. Illinois, Maryland, Massachusetts, New Jersey, and Washington.
124. Hawaii, Kentucky, and Oregon.
125. Arkansas.
126. California.
127. Connecticut.
128. Georgia.
129. NV Rev Stat § 689B.0307, NV Rev Stat § 689C.1681, NV Rev Stat § 695A.258, NV Rev Stat § 695B.19047, NV Rev Stat § 695C.17095, NV Rev Stat § 695G.1705 to NV Rev Stat § 689A.04043.
130. NV Rev Stat § 689B.0305 (2024), NV Rev. Stat § 689C.1684 (2024), NV Rev. Stat §R 695A.259 (2024), NV Rev Stat § 695B.19085 (2024), NV Rev Stat § 695C.17333 (2024), NV Rev Stat § 695G.1675 (2024).
131. NV Rev Stat § 689B.03765, NV Rev Stat § 689C.1682, NV Rev Stat § 695A.256, NV Rev Stat § 695B.19046, NV Rev Stat § 695C.16947, NV Rev Stat § 695F.159, NV Rev Stat § 695G.1702


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