House File 2488 - Introduced

HOUSE FILE 2488
BY COMMITTEE ON COMMERCE

(SUCCESSOR TO HSB 641)

A BILL FOR

1 An Act relating to prior authorizations and exemptions by
2 health benefit plans and utilization review organizations.
3 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1 Section 1. Section 514F.8, Code 2024, is amended by adding
2 the following new subsections:
3 NEW SUBSECTION. 1A. *a.* A utilization review organization
4 shall respond to a request for prior authorization from a
5 health care provider as follows:
6 (1) Within forty-eight hours after receipt for urgent
7 requests.
8 (2) Within ten calendar days after receipt for nonurgent
9 requests.
10 (3) Within fifteen calendar days after receipt for
11 nonurgent requests if there are complex or unique circumstances
12 or the utilization review organization is experiencing an
13 unusually high volume of prior authorization requests.
14 *b.* Within twenty-four hours after receipt of a prior
15 authorization request, the utilization review organization
16 shall notify the health care provider of, or make available to
17 the health care provider, a receipt for the request for prior
18 authorization.
19 NEW SUBSECTION. 2A. A utilization review organization
20 shall, at least annually, review all health care services for
21 which the health benefit plan requires prior authorization and
22 shall eliminate prior authorization requirements for health
23 care services for which prior authorization requests are
24 routinely approved with such frequency as to demonstrate that
25 the prior authorization requirement does not promote health
26 care quality, or reduce health care spending, to a degree
27 sufficient to justify the health benefit plan's administrative
28 costs to require the prior authorization.
29 NEW SUBSECTION. 3A. Complaints regarding a utilization
30 review organization's compliance with this chapter may be
31 directed to the insurance division. The insurance division
32 shall notify a utilization review organization of all
33 complaints regarding the utilization review organization's
34 noncompliance with this chapter. All complaints received
35 pursuant to this subsection shall not be considered public

1 records for purposes of chapter 22.
2 Sec. 2. PRIOR AUTHORIZATION EXEMPTION PROGRAM.
3 1. On or before January 15, 2025, all health carriers
4 that deliver, issue for delivery, continue, or renew a health
5 benefit plan in this state on or after January 1, 2025,
6 shall implement a pilot program that exempts a subset of
7 participating health care providers, at least some of whom
8 shall be primary health care providers, from certain prior
9 authorization requirements.
10 2. Each health carrier shall make available on the health
11 carrier's internet site for each health benefit plan that the
12 health carrier delivers, issues for delivery, continues, or
13 renews in this state, details about the health benefit plan's
14 prior authorization exemption program, including all of the
15 following information:
16 a. The health carrier's criteria for a health care provider
17 to qualify for the exemption program.
18 b. The health care services that are exempt from prior
19 authorization requirements for health care providers who
20 qualify under paragraph "a".
21 c. The estimated number of health care providers who are
22 eligible for the program, including the health care providers'
23 specialties, and the percentage of the health care providers
24 that are primary care providers.
25 d. Contact information for the health benefit plan for
26 consumers and health care providers to contact the health
27 benefit plan about the exemption program, or about a health
28 care provider's eligibility for the exemption program.
29 3. On or before January 15, 2026, each health carrier
30 required to implement a prior authorization exemption
31 program pursuant to subsection 1 shall submit a report to the
32 commissioner of insurance that contains all of the following:
33 a. The results of the exemption program, including an
34 analysis of the costs and savings of the exemption program.
35 b. The health benefit plan's recommendations for continuing

1 or expanding the exemption program.
2 c. Feedback received by each health benefit plan from
3 health care providers and other interested parties regarding
4 the exemption program.
5 d. An assessment of the administrative costs incurred by
6 each of the health carrier's health benefit plans to administer
7 and implement prior authorization requirements under the
8 exemption program.

9 EXPLANATION

10 The inclusion of this explanation does not constitute agreement with
11 the explanation's substance by the members of the general assembly.

12 This bill relates to prior authorizations and exemptions by
13 health benefit plans and utilization review organizations.
14 The bill requires a utilization review organization
15 (organization) to respond to a request for prior authorization
16 (authorization) from a health care provider (provider) within
17 48 hours after receipt for urgent requests or within 10
18 calendar days for nonurgent requests, unless there are complex
19 or unique circumstances, or the organization is experiencing
20 an unusually high volume of authorization requests, then an
21 organization must respond within 15 calendar days. Within
22 24 hours after receipt of an authorization request, the
23 organization shall notify a provider of, or make available, a
24 receipt for the authorization request.
25 The bill requires an organization to annually review all
26 health care services for which authorization is required and to
27 eliminate authorization requirements for health care services
28 for which authorization requests are so routinely approved that
29 the authorization requirement is not justified as it does not
30 promote health care quality or reduce health care spending.
31 Complaints regarding an organization's compliance with
32 the bill may be directed to the insurance division, and
33 the insurance division shall notify an organization of all
34 complaints. Complaints received under the bill shall not be
35 considered public records.

1 The bill requires, on or before January 15, 2025, all health
2 carriers (carriers) that deliver, issue for delivery, continue,
3 or renew a health benefit plan (plan) in this state on or after
4 January 1, 2025, to implement a pilot program that exempts a
5 subset of participating providers, including primary health
6 care providers, from certain authorization requirements. Each
7 carrier shall make available for each plan details about the
8 plan's authorization exemption requirements on the carrier's
9 internet site, including the carrier's criteria for a provider
10 to qualify for the exemption program, the health care services
11 that are exempt from authorization requirements, the estimated
12 number of providers who are eligible for the program, including
13 the providers' specialties and the percentage of the providers
14 that are primary care providers, and contact information for
15 consumers and providers to contact the plan about the exemption
16 program or a provider's eligibility for the exemption program.
17 On or before January 15, 2026, each carrier required to
18 implement an authorization exemption program (program) under
19 the bill shall submit to the commissioner of insurance a
20 report containing the results of the program, including an
21 analysis of the costs and savings of the program, the plan's
22 recommendations for continuing or expanding the program,
23 feedback received by each plan, and an assessment of the
24 administrative costs incurred by each of the carrier's plans
25 to administer and implement authorization requirements under
26 the program.