Senate File 231 - Introduced

SENATE FILE 231
BY COMMITTEE ON HEALTH AND HUMAN SERVICES

(SUCCESSOR TO SSB 1016)

A BILL FOR

An Act relating to prior authorization and utilization review organizations.

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

Section 1. Section 514F.8, Code 2025, is amended by adding the following new subsections:

NEW SUBSECTION. 1A. *a.* A utilization review organization shall provide a determination to a request for prior authorization from a health care provider as follows:

(1) Within forty-eight hours after receipt for urgent requests.

(2) Within ten calendar days after receipt for nonurgent requests.

(3) Within fifteen calendar days after receipt for nonurgent requests if there are complex or unique circumstances or the utilization review organization is experiencing an unusually high volume of prior authorization requests.

b. Within twenty-four hours after receipt of a prior authorization request, the utilization review organization shall notify the health care provider of, or make available to the health care provider, a receipt for the request for prior authorization.

c. A utilization review organization shall conduct an annual review and submit the findings in a report to the commissioner pursuant to the reporting procedures and deadlines established by the commissioner. The annual report shall include all of the following:

(1) The total number of, and percentage of, urgent prior authorization requests that the utilization review organization approved, aggregated for all health care services and items.

(2) The total number of, and percentage of, urgent prior authorization requests that the utilization review organization denied, aggregated for all health care services or items.

(3) The total number of, and percentage of, nonurgent prior authorization requests that the utilization review organization approved, aggregated for all health care services or items.

(4) The total number of, and percentage of, nonurgent prior authorization requests that the utilization review organization denied, aggregated for all health care services or items.

(5) The total number of, and percentage of, nonurgent prior authorization requests that were complex or involved unique circumstances that the utilization review organization approved, aggregated for all health care services or items.

(6) The average and median time that elapsed between the submission of a prior authorization request and a determination by the utilization review organization for the prior authorization request, aggregated for all health care services or items.

(7) The average and median time that elapsed between the submission of an urgent prior authorization request and a determination by the utilization review organization for the urgent prior authorization request, aggregated for all health care services or items.

(8) The average and median time that elapsed between the submission of a nonurgent prior authorization request and a determination by the utilization review organization for the urgent prior authorization request, aggregated for all health care services or items.

NEW SUBSECTION. 2A. *a.* A utilization review organization shall, at least annually, review all health care services for which the health benefit plan requires prior authorization and shall eliminate prior authorization requirements for health care services for which prior authorization requests are routinely approved with such frequency as to demonstrate that the prior authorization requirement does not promote health care quality, or reduce health care spending, to a degree sufficient to justify the health benefit plan's administrative costs to require the prior authorization.

b. (1) A utilization review organization shall submit an annual report containing the findings of the review conducted under paragraph "*a*" to the commissioner pursuant to the reporting procedures and deadlines established by the commissioner. The annual report shall include all of the following:

(a) The total number of prior authorizations the utilization

review organization evaluated as part of the annual review.

(b) The number of prior authorizations the utilization review organization eliminated as a result of the annual review, and the reason for the elimination.

(c) A list of prior authorizations that had at least eighty percent of requests approved in the previous twelve months for a specific health care service covered by a health benefit plan, but which prior authorizations were retained due to medical or scientific evidence, as defined in section 514J.102, that justified continuing such requirement.

(d) The total number of prior authorization requests submitted in the previous twelve months for each eliminated prior authorization, and the total number of health care providers that submitted a request for prior authorization in the previous twelve months for each eliminated prior authorization requirement.

(e) For each health care service for which prior authorization was eliminated under subparagraph division (b), the report shall include data regarding any increase or decrease of ten percent or greater in the average number of claims submitted per health care provider for that health care service compared to the twelve months immediately preceding the elimination of the prior authorization.

(2) The commissioner shall submit an annual report to the general assembly that includes a summary and analysis of the information reported under this paragraph and the information reported under subsection 1A, paragraph "c".

NEW SUBSECTION. 3A. Complaints regarding a utilization review organization's compliance with this chapter may be directed to the insurance division. The insurance division shall notify a utilization review organization of all complaints regarding the utilization review organization's noncompliance with this chapter. All complaints received pursuant to this subsection shall not be considered public records for purposes of chapter 22.

EXPLANATION

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

This bill relates to prior authorization and utilization review organizations.

The bill requires a utilization review organization (organization) to provide a determination to a request for prior authorization (authorization) from a health care provider (provider) within 48 hours after receipt for urgent requests or within 10 calendar days for nonurgent requests, unless there are complex or unique circumstances, or the organization is experiencing an unusually high volume of authorization requests, then an organization must respond within 15 calendar days. Within 24 hours after receipt of an authorization request, the organization shall notify a provider of, or make available, a receipt for the authorization request.

The bill requires an organization to conduct an annual review and submit the findings in a report to the commissioner of insurance (commissioner). The requirements for the report are detailed in the bill. The bill also requires an organization to annually review all health care services for which a health benefit plan (plan) requires an authorization, and to eliminate authorization requirements for health care services for which authorization requests are so routinely approved that the authorization requirement is not justified as it does not promote health care quality or reduce health care spending. An organization shall submit an annual report containing the findings of both reviews to the commissioner, and shall include all of the information detailed in the bill. The commissioner shall submit an annual report to the general assembly containing a summary and analysis of the information in the reports.

Complaints regarding an organization's compliance with the bill may be directed to the insurance division, and the insurance division shall notify an organization of all complaints received regarding the organization. Complaints received under the bill

1 shall not be considered public records.