Senate File 562 - Introduced

SENATE FILE 562
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A BILL FOR

An Act relating to utilization review organizations, prior authorizations and exemptions, medical billing, and independent review organizations.

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

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Section 1. NEW SECTION. **514F.2A Utilization review —— use of artificial intelligence.**

1. For the purposes of this section:

a. "*Artificial intelligence*" means an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input the system receives how to generate outputs that can influence physical or virtual environments.

b. "*Covered person*" means the same as defined in section 51F.8.

c. "*Health care provider*" means the same as defined in section 514F.8.

d. "*Health carrier*" means the same as defined in section 514F.8.

e. "*Utilization review*" means the same as defined in section 514F.7.

2. A health carrier that uses artificial intelligence, an algorithm, or other software tool for the purpose of utilization review, based in whole or in part on medical necessity, or that contracts with or otherwise works through an entity that uses artificial intelligence, an algorithm, or other software tool for the purpose of utilization review, based in whole or in part on medical necessity, shall ensure all of the following:

a. The artificial intelligence, algorithm, or other software tool bases its determination on the following information, as applicable:

(1) A covered person's medical or other clinical history.

(2) Individual clinical circumstances as presented by the requesting health care provider.

(3) Other relevant clinical information contained in the covered person's medical or other clinical record.

b. The artificial intelligence, algorithm, or other software tool's criteria and guidelines comply with this chapter and applicable state and federal law.

c. The artificial intelligence, algorithm, or other software

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tool does not supplant health care provider decision making.

d. The use of the artificial intelligence, algorithm, or other software tool does not discriminate, directly or indirectly, against covered persons in violation of state or federal law.

e. The artificial intelligence, algorithm, or other software tool is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the federal department of health and human services.

f. The artificial intelligence, algorithm, or other software tool is open to inspection for audit or compliance reviews by the division and the department of health and human services pursuant to applicable state and federal law.

g. Disclosures pertaining to the use and oversight of the artificial intelligence, algorithm, or other software tool are contained in written policies and procedures maintained by the health carrier.

h. The artificial intelligence, algorithm, or other software tool's performance, use, and outcomes are periodically reviewed and revised to maximize accuracy and reliability.

i. Patient data is not used beyond its intended and stated purpose, consistent with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

j. The artificial intelligence, algorithm, or other software tool does not directly or indirectly cause harm to a covered person.

3. Notwithstanding subsection 2, the artificial intelligence, algorithm, or other software tool shall not deny, delay, or modify health care services based, in whole or in part, on medical necessity. A determination of medical necessity shall be made only by a health care provider competent to evaluate the specific clinical issues involved in the health care services requested by the health care provider by reviewing and considering the requesting health care provider's recommendation, the covered person's medical or other clinical history, as

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applicable, and individual clinical circumstances.

Sec. 2. Section 514F.8, Code 2025, is amended by adding the following new subsections:

NEW SUBSECTION. 1A. *a.* A utilization review organization shall respond 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.

NEW SUBSECTION. 2A. 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.

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

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subsection shall not be considered public records for purposes of chapter 22.

Sec. 3. NEW SECTION. **514F.8A Prior authorizations —— statistics.**

1. For purposes of this section:

a. "Covered person" means the same as defined in section 514F.8.

b. "Health benefit plan" means the same as defined in section 514J.102.

c. "Health care provider" means the same as defined in section 514F.8.

d. "Health care services" means the same as defined in 514F.8.

e. "Health carrier" means the same as defined in 514F.8.

f. "Prior authorization" means the same as defined in 514F.8.

g. "Utilization review" means the same as defined in section 514F.7.

h. "Utilization review organization" means the same as defined in 514F.8.

2. A health carrier that utilizes prior authorization shall make statistics available regarding prior authorization approvals and denials on the health carrier's internet site in a readily accessible format. Following each immediately preceding calendar year, the statistics shall be updated annually by March 31, and shall include all of the following information:

a. A list of all health care services, including medications, that are subject to prior authorization.

b. The percentage of standard prior authorization requests that were approved, aggregated for all items and services.

c. The percentage of standard prior authorization requests that were denied, aggregated for all items and services.

d. The percentage of prior authorization requests that were approved after appeal, aggregated for all items and services.

e. The percentage of prior authorization requests for which the time frame for review was extended, and the request was

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approved, aggregated for all items and services.

f. The percentage of expedited prior authorization requests that were approved, aggregated for all items and services.

g. The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.

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

i. The average and median time that elapsed between the submission of a request and a decision by the health carrier or utilization review organization for expedited prior authorizations, aggregated for all items and services.

j. Any other information the division determines appropriate.

Sec. 4. NEW SECTION. **514F.10 Medical billing.**

1. For purposes of this section:

a. *"Commissioner"* means the commissioner of insurance.

b. *"Health care provider"* means the same as defined in section 514F.8.

c. *"Health carrier"* means the same as defined in section 514F.9.

d. *"Health maintenance organization"* means health maintenance organization as defined in section 514B.1.

2. Health carriers, hospital and medical service corporations, health maintenance organizations, and health care providers shall comply with the requirements of Tit. I of the federal No Surprises Act, Pub. L. No. 116-260, Division BB, as amended.

3. The commissioner shall enforce this section to the extent permitted under state and federal law. The commissioner may refer cases of noncompliance to the federal department of health and human services under the terms of a collaborative enforcement agreement, or to the attorney general.

Sec. 5. Section 514J.114, subsection 1, paragraph b, unnumbered paragraph 1, Code 2025, is amended to read as follows:

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Each independent review organization required to maintain written records pursuant to this section shall annually submit to the commissioner~~, upon request,~~ a report in the format specified by the commissioner. The report shall include in the aggregate by state and by health carrier all of the following:

Sec. 6. Section 514J.114, subsection 1, Code 2025, is amended by adding the following new paragraph:

NEW PARAGRAPH. *d.* The commissioner shall make the independent review organization reports required under this subsection publicly accessible on the division's internet site.

Sec. 7. Section 514J.114, subsection 2, paragraph b, unnumbered paragraph 1, Code 2025, is amended to read as follows:

Each health carrier required to maintain written records of requests for external review pursuant to this subsection shall annually submit to the commissioner~~, upon request,~~ a report in the format specified by the commissioner. The report shall include in the aggregate by state and by type of health benefit plan offered all of the following:

Sec. 8. Section 514J.114, subsection 2, Code 2025, is amended by adding the following new paragraph:

NEW PARAGRAPH. *d.* The commissioner shall make the health carrier reports required under this subsection publicly accessible on the division's internet site.

Sec. 9. PRIOR AUTHORIZATION EXEMPTION PROGRAM.

1. On or before January 15, 2026, all health carriers that deliver, issue for delivery, continue, or renew a health benefit plan in this state on or after January 1, 2026, and that require prior authorizations, shall implement a pilot program that exempts a subset of participating health care providers, at least some of whom shall be primary health care providers, from certain prior authorization requirements.

2. Each health carrier shall make available on the health carrier's internet site for each health benefit plan that the health carrier delivers, issues for delivery, continues, or renews in this state, details about the health benefit plan's

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prior authorization exemption program, including all of the following information:

a. The health carrier's criteria for a health care provider to qualify for the exemption program.

b. The health care services that are exempt from prior authorization requirements for health care providers who qualify under paragraph "a".

c. The estimated number of health care providers who are eligible for the program, including the health care providers' specialties, and the percentage of the health care providers that are primary care providers.

d. Contact information for the health benefit plan for consumers and health care providers to contact the health benefit plan about the exemption program, or about a health care provider's eligibility for the exemption program.

3. On or before January 15, 2027, each health carrier required to implement a prior authorization exemption program pursuant to subsection 1 shall submit a report to the commissioner of insurance that contains all of the following:

a. The results of the exemption program, including an analysis of the costs and savings of the exemption program.

b. The health benefit plan's recommendations for continuing or expanding the exemption program.

c. Feedback received by each health benefit plan from health care providers and other interested parties regarding the exemption program.

d. An assessment of the administrative costs incurred by each of the health carrier's health benefit plans to administer and implement prior authorization requirements under the exemption program.

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 utilization review organizations, prior authorizations and exemptions, medical billing, and independent

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review organizations.

Under the bill, a health carrier (carrier) that uses an artificial intelligence, algorithm, or other software tool (artificial intelligence) for the purpose of utilization review, or that contracts with or works through an entity that uses an artificial intelligence for the purpose of utilization review, shall ensure that (1) the artificial intelligence bases its determination on the information described in the bill; (2) the artificial intelligence does not base its determination solely on a group dataset; (3) the artificial intelligence's criteria and guidelines comply with Code chapter 514F and applicable state and federal law; (4) the artificial intelligence does not supplant health care provider (provider) decision making; (5) the use of the artificial intelligence does not discriminate against covered persons; (6) the artificial intelligence is fairly and equitably applied; (7) the artificial intelligence is open to inspection for audit or compliance reviews by the insurance division (division) and the department of health and human services; (8) disclosures pertaining to the use and oversight of the artificial intelligence are contained in written policies and procedures; (9) the artificial intelligence's performance, use, and outcomes are periodically reviewed and revised; (10) patient data is not used beyond its intended and stated purpose; and (11) the artificial intelligence does not cause harm to a covered person. "Artificial intelligence" is defined in the bill. The artificial intelligence shall not deny, delay, or modify health care services (services) based on medical necessity, and a determination of medical necessity shall be made only by a competent provider.

The bill requires a utilization review organization (organization) to respond to a request for prior authorization (authorization) from a 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

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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 annually review all services for which authorization is required and to eliminate authorization requirements for 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. Complaints regarding an organization's compliance with the bill may be directed to the division, and the division shall notify an organization of all complaints. Complaints received under the bill shall not be considered public records.

Under the bill, a carrier that utilizes authorization shall make statistics available regarding authorization approvals and denials on the carrier's internet site in a readily accessible format. Following each calendar year, the statistics shall be updated annually by March 31, and shall include all of the information detailed in the bill.

Under the bill, carriers, hospital and medical service corporations, health maintenance organizations, and providers shall comply with the requirements of Tit. I of the federal No Surprises Act, Pub. L. No. 116-260, Division BB, as may be amended, and the commissioner of insurance (commissioner) shall enforce such compliance. The commissioner may refer cases of noncompliance to the federal department of health and human services under the terms of a collaborative enforcement agreement, or to the attorney general.

Under current law, an independent review organization (IRO) required to maintain written records shall submit a report to the commissioner upon request. Under the bill, an IRO required to maintain written records shall annually submit a report to the commissioner. The commissioner shall make the IRO reports publicly accessible on the division's internet site.

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Under current law, each carrier required to maintain written records of requests for external review shall submit a report to the commissioner upon request. Under the bill, each carrier required to maintain written records of requests for external review shall annually submit a report to the commissioner. The commissioner shall make the carrier reports publicly accessible on the division's internet site.

The bill requires, on or before January 15, 2026, all carriers that deliver, issue for delivery, continue, or renew a health benefit plan (plan) in this state on or after January 1, 2026, to implement an authorization exemption pilot program (program) that exempts a subset of participating providers, including primary providers, from certain authorization requirements. Each carrier shall make available for each plan details about the plan's authorization exemption requirements on the carrier's internet site, including the carrier's criteria for a provider to qualify for the program, the health care services that are exempt from authorization requirements, the estimated number of providers who are eligible for the program, including the providers' specialties and the percentage of the providers that are primary care providers, and contact information for consumers and providers to contact the plan about the program or a provider's eligibility for the program. On or before January 15, 2027, each carrier required to implement a program under the bill shall submit a report to the commissioner containing the results of the program, including an analysis of the costs and savings of the program, the plan's recommendations for continuing or expanding the program, feedback received by each plan, and an assessment of the administrative costs incurred by each of the carrier's plans to administer and implement authorization requirements under the program.

Unofficial