Senate Study Bill 1016 - Introduced

SENATE FILE _____
BY (PROPOSED COMMITTEE ON HEALTH AND HUMAN SERVICES BILL BY CHAIRPERSON KLIMESH)

A BILL FOR

An Act relating to prior authorizations and exemptions by health benefit plans 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 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 subsection shall not be considered public records for purposes of

chapter 22.

Sec. 2. 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 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 prior authorizations and exemptions by health benefit plans and utilization review organizations.

The bill requires a utilization review organization (organization) to respond 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 annually review all health care services for which authorization is required 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.

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. Complaints received under the bill shall not be considered public records.

The bill requires, on or before January 15, 2026, all health carriers (carriers) that deliver, issue for delivery, continue, or renew a health benefit plan (plan) in this state on or after January 1, 2026, and that require prior authorizations, to implement a pilot program that exempts a subset of participating providers, including primary health care 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 exemption 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 exemption program or a provider's eligibility for the exemption program.

On or before January 15, 2027, each carrier required to implement an authorization exemption program (program) under the bill shall submit to the commissioner of insurance a report 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.