House File 2635 - Introduced

HOUSE FILE 2635
BY COMMITTEE ON HEALTH AND HUMAN SERVICES

(SUCCESSOR TO HF 2438)

A BILL FOR

An Act relating to health carriers and payment of claims, audits, and standards of conduct; prior authorizations and utilization review organizations; and providing civil penalties and including applicability provisions.

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

DIVISION I

HEALTH INSURANCE TRADE PRACTICES

Section 1. Section 507B.4, subsection 3, paragraph j, subparagraph (15), Code 2026, is amended to read as follows:

(15) Failing to comply with the procedures for auditing claims submitted by health care providers as set forth in section 507B.15 or as otherwise provided by rule of the commissioner. However, this subparagraph shall have no applicability to liability insurance, workers' compensation or similar insurance, automobile or homeowners' medical payment insurance, disability income, or long-term care insurance.

Sec. 2. Section 507B.4, subsection 3, Code 2026, is amended by adding the following new paragraphs:

NEW PARAGRAPH. *w. Standards of conduct.* Any violation of section 507B.16 by a health carrier.

NEW PARAGRAPH. *x. Prior authorization — peer review.* Any violation of section 514F.8A by a utilization review organization or a health carrier.

Sec. 3. Section 507B.4A, subsection 2, paragraph a, Code 2026, is amended by striking the paragraph and inserting in lieu thereof the following:

a. An insurer shall comply with all of the following:

(1) An insurer shall either accept and pay or deny a clean claim no later than thirty calendar days after the date the insurer receives an electronic claim submission, or no later than forty-five calendar days after the date the insurer receives a claim submitted on paper.

(2) After the date of payment of a clean claim, an insurer shall not retroactively deny, reduce, or recoup payment of the claim unless the insurer first provides written notice and evidence of any of the following to the health care provider that submitted the claim:

(a) The claim submission included a misrepresentation.

(b) The claim submission was fraudulent.

(c) The claim submission was a duplicate submission of a

claim for which the insurer previously paid.

Sec. 4. Section 507B.4A, subsection 2, Code 2026, is amended by adding the following new paragraph:

NEW PARAGRAPH. *0c.* For purposes of this subsection, *"insurer"* includes all of the following:

(1) An insurer providing accident and sickness insurance under chapter 509, 514, or 514A; a health maintenance organization; or another entity providing health insurance or health benefits subject to state insurance regulation.

(2) The medical assistance program under chapter 249A and the healthy and well kids in Iowa (Hawki) program under chapter 514I.

(3) A managed care organization acting pursuant to a contract with the department of health and human services to administer the medical assistance program under chapter 249A, or the healthy and well kids in Iowa (Hawki) program under chapter 514I.

Sec. 5. NEW SECTION. **507B.15 Health carriers —— audits and claim submissions.**

1. As used in this section, unless the context otherwise requires:

a. "Audit" means a review, investigation, or request for additional documentation by a health carrier before or after issuing payment on a clean claim to a health care provider.

b. "Clean claim" means a properly completed paper or electronic billing instrument containing all reasonably necessary information that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation, and that does not involve the existence of particular circumstances requiring special treatment that prevents a prompt payment from being made.

c. "Health care provider" means the same as defined in section 514J.102.

d. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject

to the jurisdiction of the commissioner, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. *"Health carrier"* includes the following:

(1) The medical assistance program under chapter 249A and the healthy and well kids in Iowa (Hawki) program under chapter 514I.

(2) A managed care organization acting pursuant to a contract with the department of health and human services to administer the medical assistance program under chapter 249A, or the healthy and well kids in Iowa (Hawki) program under chapter 514I.

2. If a health carrier conducts an audit of a clean claim submitted by a health care provider, the health carrier shall reimburse the health care provider for the reasonable administrative costs incurred and documented by the health care provider to respond to the audit, including but not limited to staff time, copying, and record retrieval.

3. *a.* A health carrier that conducts an audit shall notify the health care provider that submitted the clean claim of the initiation of the audit no later than fifteen calendar days after the date the health carrier selects the clean claim for audit.

b. A health carrier shall complete an audit of a clean claim and issue a determination on the clean claim to the health care provider that submitted the clean claim no later than forty-five calendar days after the date that the health carrier receives all requested documentation regarding the clean claim from the health care provider.

c. A health care provider that submitted a clean claim that is the subject of an audit by a health carrier, and that receives an adverse determination regarding the clean claim,

may appeal the adverse determination no later than thirty calendar days after the date the health care provider receives the audit determination.

d. A health carrier shall consider an appeal under subparagraph "*c*", and issue a final determination on the clean claim that is the subject of the appeal, no later than fourteen calendar days after the date the health carrier receives notice of the appeal.

e. If a health carrier violates this subsection, the clean claim shall be automatically approved by the health carrier and promptly paid, including interest at the rate of ten percent per annum.

4. *a.* A violation of this section by a health carrier shall constitute an unfair method of competition or unfair or deceptive act or practice under section 507B.4.

b. A health carrier that violates this section shall be subject to civil penalties under section 505.7A.

c. In any action brought by a health care provider for a violation of this section, the health care provider shall be entitled to recover costs of litigation, including reasonable attorney fees and other litigation expenses incurred by the health care provider, regardless of whether the health care provider prevails in such action.

5. The commissioner shall adopt rules pursuant to chapter 17A to administer and enforce this section.

6. *a.* This section shall not apply to a claim that is under active fraud investigation by a state or federal authority.

b. This section shall not apply to a federal program where audits are mandated by federal law.

Sec. 6. NEW SECTION. **507B.16 Health carriers —— standards of conduct.**

1. As used in this section:

a. "*Health care provider*" means the same as defined in section 514J.102.

b. "*Health carrier*" means an entity subject to the

insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. *"Health carrier"* includes the following:

(1) The medical assistance program under chapter 249A and the healthy and well kids in Iowa (Hawki) program under chapter 514I.

(2) A managed care organization acting pursuant to a contract with the department of health and human services to administer the medical assistance program under chapter 249A, or the healthy and well kids in Iowa (Hawki) program under chapter 514I.

2. A health carrier shall not impose on a health care provider, directly or indirectly, any financial penalty, reimbursement reduction, or administrative fee, or terminate a health care provider's participation in the health carrier's network, based on the health care provider's referral to, or affiliation with, an out-of-network health care provider.

3. A health carrier shall not interfere with, or participate in any capacity in, a health care provider's decisions regarding staffing and referral, except as otherwise provided by law.

4. A health carrier shall not offer, attempt to enforce, or enforce an agreement, or an amendment to an agreement, with a health care provider without providing an opportunity for negotiation. A contract term that imposes an unreasonable or unconscionable obligation on a health care provider shall be void and unenforceable.

5. *a.* A violation of this section by a health carrier shall constitute an unfair method of competition or unfair or deceptive act or practice under section 507B.4.

b. A health carrier that violates this section shall be subject to civil penalties according to section 505.7A.

c. In any action brought by a health care provider against a health carrier for a violation of this section, the health care provider shall be entitled to recover costs of litigation, including reasonable attorney fees and other expenses incurred by the health care provider in the course of the litigation, regardless of whether the health care provider prevails in such action.

6. The commissioner shall adopt rules pursuant to chapter 17A to administer and enforce this section.

DIVISION II

PRIOR AUTHORIZATIONS

Sec. 7. NEW SECTION. **514F.8A Prior authorizations —— peer review.**

1. For purposes of this section:

a. *"Clinical peer"* means a health care professional that meets all of the following requirements:

(1) The health care professional practices in the same or similar specialty as the health care provider that requested a prior authorization.

(2) The health care professional has experience managing the specific medical condition or administering the health care service that is the subject of the prior authorization request.

(3) The health care professional is employed by or contracted with the utilization review organization or health carrier to which a health care provider submitted a request for prior authorization.

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

c. *"Downgrade"* means a decision by a health carrier or utilization review organization to change an expedited or urgent request for prior authorization to a standard determination, or otherwise modify a health care service that is the subject of a request for prior authorization to a

lower-level health care service.

d. "Health care professional" means the same as defined in section 514J.102.

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

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

g. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. *"Health carrier"* includes the following:

(1) The medical assistance program under chapter 249A and the healthy and well kids in Iowa (Hawki) program under chapter 514I.

(2) A managed care organization acting pursuant to a contract with the department of health and human services to administer the medical assistance program under chapter 249A, or the healthy and well kids in Iowa (Hawki) program under chapter 514I.

h. "Physician" means a doctor of medicine and surgery, or a doctor of osteopathic medicine and surgery, licensed in this state.

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

j. "Qualified reviewer" means a physician that meets all of the following requirements:

(1) The physician practices in the same or a similar specialty as the health care provider that requested a prior authorization.

(2) The physician has the training and expertise to treat

the specific medical condition that is the subject of a request for prior authorization, including sufficient knowledge to determine whether the health care service that is the subject of the request is medically necessary or clinically appropriate.

(3) The physician is employed by or contracted with the utilization review organization or health carrier to which a health care provider submitted a request for prior authorization.

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

2. A utilization review organization shall not deny or downgrade a request for prior authorization unless all of the following requirements are met:

a. The decision to deny or downgrade the request is made by either of the following:

(1) A qualified reviewer, if the health care provider requesting prior authorization is a physician.

(2) A clinical peer, if the health care provider requesting prior authorization is not a physician.

b. The utilization review organization provides the health care provider that requested the prior authorization all of the following:

(1) A written statement that cites the specific reasons for the denial or downgrade, including any coverage criteria or limits, or clinical criteria, that the utilization review organization considered or that was the basis for the denial or downgrade. The written statement shall be signed by either of the following:

(a) The qualified reviewer that made the denial or downgrade determination, if the health care provider that requested prior authorization is a physician.

(b) The clinical peer that made the denial or downgrade determination, if the health care provider that requested prior authorization is not a physician.

(2) A written explanation of the utilization review organization's appeals process. The utilization review organization shall also provide the written explanation to the covered person for whom prior authorization was requested.

(3) A written attestation that is either of the following:

(a) If the health care provider that requested prior authorization is a physician, a written attestation that the qualified reviewer who made the denial or downgrade determination practices in the same or a similar specialty as the health care provider, and has the requisite training and expertise to treat the medical condition that is the subject of the request for prior authorization, including sufficient knowledge to determine whether the health care service is medically necessary or clinically appropriate. The attestation shall include the qualified reviewer's name, national provider identifier, state medical license number, board certifications, specialty expertise, and educational background.

(b) If the health care provider that requested prior authorization is not a physician, a written attestation that the clinical peer who made the denial or downgrade determination practices in the same or a similar specialty as the health care provider, and the clinical peer has experience managing the specific medical condition or administering the health care service that is the subject of the request for prior authorization. The attestation shall include the clinical peer's name, national provider identifier, state medical license number, board certifications, specialty expertise, and educational background.

3. At the request of the requesting health care provider, a utilization review organization that denies a request for prior authorization shall, no later than seven business days after the date that the utilization review organization notifies the requesting health care provider of the denial, conduct a consultation either in person or remotely, as follows:

a. Between the health care provider and a qualified

reviewer, if the health care provider requesting prior authorization is a physician.

b. Between the health care provider and a clinical peer, if the health care provider requesting prior authorization is not a physician.

4. *a.* If a utilization review organization's decision to deny or downgrade a request for prior authorization is appealed by the requesting health care provider or covered person, the appeal shall be conducted by either of the following:

(1) A qualified reviewer, if the health care provider requesting prior authorization is a physician.

(2) A clinical peer, if the health care provider requesting prior authorization is not a physician.

b. A qualified reviewer or clinical peer involved in the initial denial or downgrade determination of a request for prior authorization that is the subject of an appeal shall not conduct the appeal.

c. When conducting an appeal of a request for prior authorization, the qualified reviewer or clinical peer shall consider the known clinical aspects of the health care services under review, including but not limited to medical records relevant to the covered person's medical condition that is the subject of the health care services for which prior authorization is requested, and any relevant medical literature submitted by the health care provider as part of the appeal.

5. *a.* A violation of this section by a utilization review organization or a health carrier shall constitute an unfair method of competition or unfair or deceptive act or practice under section 507B.4.

b. A utilization review organization or a health carrier that violates this section shall be subject to civil penalties according to section 505.7A.

c. In any action brought by a health care provider against a utilization review organization or a health carrier for a violation of this section, the health care provider shall be

entitled to recover costs of litigation, including reasonable attorney fees and other expenses incurred by the health care provider in the course of the litigation, regardless of whether the health care provider prevails in such action.

6. The commissioner of insurance may adopt rules pursuant to chapter 17A to administer this section.

Sec. 8. NEW SECTION. **514F.8B Prior authorizations —— exemptions.**

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 professional" means the same as defined in section 514J.102.

d. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, including an insurance company offering sickness and accident plans, a health maintenance organization, a nonprofit health service corporation, a plan established pursuant to chapter 509A for public employees, or any other entity providing a plan of health insurance, health care benefits, or health care services. *"Health carrier"* includes the following:

(1) The medical assistance program under chapter 249A and the healthy and well kids in Iowa (Hawki) program under chapter 514I.

(2) A managed care organization acting pursuant to a contract with the department of health and human services to administer the medical assistance program under chapter 249A, or the healthy and well kids in Iowa (Hawki) program under chapter 514I.

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

f. "Utilization review" means the same as defined in section

514F.4, subsection 3.

2. A health carrier shall not require prior authorization for, or impose additional utilization review requirements on, a covered person for any of the following:

a. A cancer-related screening or cancer-related preventative health care service if the cancer-related screening or cancer-related service is recommended by the covered person's health care professional based on the most recently updated national comprehensive cancer network clinical practice guidelines in oncology.

b. Diagnosis and treatment of a health condition that develops or becomes evident in a covered person while the covered person is receiving treatment at an inpatient facility, and the health condition is reasonably determined by a health care professional to be a life threatening condition unless the covered person receives immediate assessment and treatment.

3. The commissioner of insurance may adopt rules pursuant to chapter 17A to administer this section.

Sec. 9. APPLICABILITY. This division of this Act applies to all of the following:

1. Health benefit plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2027.

2. Requests for prior authorization for a health care service, if the request is made before January 1, 2027, and the request has not been finally determined on or before that date.

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 health carriers and payment of claims, audits, and standards of conduct, prior authorizations, and utilization review organizations.

DIVISION I —— HEALTH INSURANCE TRADE PRACTICES. Under current law, an insurer shall either accept and pay or deny a clean claim. Under the bill, an insurer shall either

accept and pay or deny a clean claim no later than 30 days after receiving an electronic claim submission, or 45 days after receiving a claim submitted on paper. After paying a clean claim, the insurer shall not retroactively deny, reduce, or recoup payment of the claim, except if the claim submission included a misrepresentation, was fraudulent, or was a duplicate submission, and the insurer first provides written notice including evidence to the health care provider (provider) that submitted the claim of the misrepresentation, fraud, or duplicate submission.

If a health carrier (carrier) conducts an audit of a clean claim, the carrier shall reimburse the provider for the reasonable administrative costs incurred by the provider to respond to the audit. "Audit" and "clean claim" are defined in the bill.

A carrier that conducts an audit shall notify the provider of the initiation of the audit no later than 15 days after selecting the clean claim for audit. A carrier shall complete an audit and issue a determination on the clean claim within 45 days of receiving all requested documentation from the provider. A provider that submitted a clean claim subject to an audit, and that receives an adverse determination, may appeal the determination within 30 days. A carrier shall consider an appeal and issue a final determination on the clean claim no later than 14 days after receiving notice of the appeal. If a carrier violates the audit timeline requirements, the clean claim shall be automatically approved and promptly paid, including interest at the rate of 10 percent per annum.

The audit requirements shall not apply to a claim that is under active fraud investigation by a state or federal authority, or to a federal program where audits are mandated by federal law.

Under the bill, a carrier shall not: (1) impose on a provider any financial penalty, reimbursement reduction, or administrative fee, or terminate a provider's participation

in the carrier's network, based on the provider's referral to or affiliation with an out-of-network provider; (2) interfere with, or participate in any capacity in, a provider's decisions regarding staffing and referral, except as otherwise provided by law; and (3) offer, attempt to enforce, or enforce an agreement or amendment to an agreement with a provider without providing an opportunity for negotiation, and a contract term that violates the bill shall be void and unenforceable.

A violation of this division of the bill by a carrier shall constitute an unfair method of competition or unfair or deceptive act or practice. The carrier shall be subject to civil penalties. In any action brought by a provider against a carrier, the provider shall be entitled to recover costs of litigation, including reasonable attorney fees and other expenses, regardless of whether the provider prevails in such action.

The commissioner shall adopt rules to administer and enforce this division.

The bill makes conforming changes to Code sections 507B.4(3)(j)(15) and 507B.4(3).

DIVISION II —— PRIOR AUTHORIZATIONS. A utilization review organization (URO) shall not deny or downgrade a request for authorization unless: (1) the decision is made by a qualified reviewer or clinical peer; and (2) the URO provides the provider requesting authorization a written statement citing the reasons for the decision, explaining the appeals process, and a written attestation as described by the bill. If a request for authorization is denied, the URO shall notify the provider within seven days and conduct a consultation as described by the bill. "Clinical peer" and "qualified reviewer" are defined in the bill.

If a URO's decision to deny or downgrade a request for authorization is appealed by the requesting provider or covered person, the appeal shall be conducted by a qualified reviewer or clinical peer who was not involved in the initial denial

or downgrade. When conducting an appeal of a request for authorization, the qualified reviewer or clinical peer shall consider the known clinical aspects of the health care services (services) under review, including but not limited to medical records relevant to the medical condition and any relevant medical literature submitted by the provider.

A violation of the bill's requirements for denial or downgrade of an authorization by a URO or a carrier shall constitute an unfair method of competition or unfair or deceptive act or practice. The carrier shall be subject to civil penalties. In any action brought by a provider against a carrier, the provider shall be entitled to recover costs of litigation, including reasonable attorney fees and other expenses, regardless of whether the provider prevails in such action.

The commissioner may adopt rules to administer this division of the bill.

A carrier shall not require authorization for, or impose additional utilization review requirements on, a covered person for: (1) a cancer-related screening or cancer-related preventative service recommended by the covered person's professional based on the national comprehensive cancer network clinical practice guidelines in oncology; or (2) the diagnosis and treatment of a health condition that develops or becomes evident in a covered person while receiving treatment at an inpatient facility, and the health condition is reasonably determined by a professional to be a life threatening condition unless the covered person receives immediate assessment and treatment.

This division of the bill applies to health benefit plans delivered, issued for delivery, continued, or renewed on or after January 1, 2027, and requests for prior authorization for a cancer-related screening or cancer-related preventative health care service if the screening or service is recommended by the covered person's professional, the request is made

before January 1, 2027, and the request has not been finally determined on or before that date.