

House File 2635 - Introduced

HOUSE FILE 2635
BY COMMITTEE ON HEALTH AND
HUMAN SERVICES

(SUCCESSOR TO HF 2438)

A BILL FOR

1 An Act relating to health carriers and payment of claims,
2 audits, and standards of conduct; prior authorizations
3 and utilization review organizations; and providing civil
4 penalties and including applicability provisions.
5 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

DIVISION I

HEALTH INSURANCE TRADE PRACTICES

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2
3 Section 1. Section 507B.4, subsection 3, paragraph j,
4 subparagraph (15), Code 2026, is amended to read as follows:

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

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

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

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

19 Sec. 3. Section 507B.4A, subsection 2, paragraph a, Code
20 2026, is amended by striking the paragraph and inserting in
21 lieu thereof the following:

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

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

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

33 (a) The claim submission included a misrepresentation.

34 (b) The claim submission was fraudulent.

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

1 claim for which the insurer previously paid.

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

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

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

10 (2) The medical assistance program under chapter 249A and
11 the healthy and well kids in Iowa (Hawki) program under chapter
12 514I.

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

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

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

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

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

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

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

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

8 (1) The medical assistance program under chapter 249A and
9 the healthy and well kids in Iowa (Hawki) program under chapter
10 514I.

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

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

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

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

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

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

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

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

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

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

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

24 5. The commissioner shall adopt rules pursuant to chapter
25 17A to administer and enforce this section.

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

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

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

32 1. As used in this section:

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

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

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

9 (1) The medical assistance program under chapter 249A and
10 the healthy and well kids in Iowa (Hawki) program under chapter
11 514I.

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

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

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

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

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

1 lower-level health care service.

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

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

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

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

17 (1) The medical assistance program under chapter 249A and
18 the healthy and well kids in Iowa (Hawki) program under chapter
19 514I.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35 a. Between the health care provider and a qualified

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

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

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

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

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

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

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

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

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

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

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

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

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

9 1. For purposes of this section:

10 a. "Covered person" means the same as defined in section
11 514F.8.

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

14 c. "Health care professional" means the same as defined in
15 section 514J.102.

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

25 (1) The medical assistance program under chapter 249A and
26 the healthy and well kids in Iowa (Hawki) program under chapter
27 514I.

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

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

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

1 514F.4, subsection 3.

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

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

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

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

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

21 1. Health benefit plans delivered, issued for delivery,
22 continued, or renewed in this state on or after January 1,
23 2027.

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

27 EXPLANATION

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

30 This bill relates to health carriers and payment of claims,
31 audits, and standards of conduct, prior authorizations, and
32 utilization review organizations.

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

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

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

16 A carrier that conducts an audit shall notify the provider
17 of the initiation of the audit no later than 15 days after
18 selecting the clean claim for audit. A carrier shall complete
19 an audit and issue a determination on the clean claim within
20 45 days of receiving all requested documentation from the
21 provider. A provider that submitted a clean claim subject
22 to an audit, and that receives an adverse determination, may
23 appeal the determination within 30 days. A carrier shall
24 consider an appeal and issue a final determination on the clean
25 claim no later than 14 days after receiving notice of the
26 appeal. If a carrier violates the audit timeline requirements,
27 the clean claim shall be automatically approved and promptly
28 paid, including interest at the rate of 10 percent per annum.

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

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

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

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

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

19 The bill makes conforming changes to Code sections
20 507B.4(3)(j)(15) and 507B.4(3).

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

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

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

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

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

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

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

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