Senate File 2421 - Introduced

SENATE FILE 2421
BY COMMITTEE ON HEALTH AND HUMAN SERVICES

(SUCCESSOR TO SSB 3118)

A BILL FOR

An Act relating to utilization review organizations' use of artificial intelligence, prior authorization determinations and exemptions, and audits, and including applicability provisions.

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

DIVISION I

PRIOR AUTHORIZATION ── USE OF ARTIFICIAL INTELLIGENCE AND PEER REVIEW

Section 1. Section 514F.8, subsection 1, Code 2026, is amended by adding the following new paragraph:

NEW PARAGRAPH. *0b. "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.

Sec. 2. Section 514F.8, Code 2026, is amended by adding the following new subsection:

NEW SUBSECTION. 2A. A utilization review organization may use an artificial intelligence-based algorithm to provide an initial review of a request for prior authorization, except that, for a prior authorization request for a health care service based on medical necessity, a utilization review organization shall not use an artificial intelligence-based algorithm as the sole basis for the utilization review organization's decision to deny, delay, or downgrade the prior authorization request.

Sec. 3. 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 the same as defined in section 514F.8.

h. "Physician" means a licensed doctor of medicine and surgery or a licensed doctor of osteopathic medicine and surgery licensed under chapter 148.

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, 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, board certifications, specialty expertise, and educational background.

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

Sec. 4. APPLICABILITY. This division of this Act applies to all of the following:

1. Requests for prior authorization made before January 1, 2027, if the request has not been finally determined on or before that date.

2. Requests for prior authorization made on or after January 1, 2027.

DIVISION II

PRIOR AUTHORIZATION —— CANCER-RELATED EXEMPTIONS

Sec. 5. NEW SECTION. **514F.8B Prior authorizations —— exemptions for cancer-related screenings.**

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 a cancer-related screening if the screening 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.

3. The director of health and human services shall adopt rules pursuant to chapter 17A to administer this section, including but not limited to rules relating to all of the following:

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

b. 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.

4. The commissioner of insurance may adopt rules pursuant to chapter 17A to administer this section, except as otherwise provided in subsection 3.

Sec. 6. 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 cancer-related screening if the screening 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, the request is made before January 1, 2027, and the request has not been finally determined on or before that date.

3. Requests for prior authorization for a cancer-related screening, if the screening 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, made on or after January 1, 2027.

DIVISION III

PRIOR AUTHORIZATION —— LIFE-THREATENING HEALTH CONDITIONS

Sec. 7. NEW SECTION. **514F.8C Prior authorizations —— exemptions for life-threatening health conditions.**

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 the same as defined in section 514F.8.

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

DIVISION IV

UTILIZATION REVIEW ORGANIZATIONS —— PREPAYMENT AUDITS

Sec. 9. NEW SECTION. **514F.10 Utilization review organizations —— prepayment audits.**

1. For purposes of this section:

a. "Audit" means a review, investigation, or request for additional documentation by a health carrier or utilization review organization on behalf of the health carrier prior to or after issuing payment on a claim to a health care provider.

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

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

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

2. A health carrier or utilization review organization that conducts an audit shall notify the health care provider that submitted the claim of the initiation of the audit no later than fifteen calendar days after the date the health carrier selects the claim for audit.

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

4. A health care provider that submitted a claim that is the subject of an audit by a health carrier or utilization review organization, and that receives an adverse determination regarding the claim, may appeal the adverse determination no later than thirty calendar days after the date the health care provider receives the audit determination.

5. A health carrier or utilization review organization shall consider an appeal under subsection 4, and issue a final

determination on the claim that is the subject of the appeal, no later than fourteen calendar days after that date the health carrier or utilization review organization receives notice of the appeal.

6. If a health carrier or utilization review organization violates this section, the claim shall be automatically approved by the health carrier or utilization review organization and promptly paid pursuant to section 507B.4A, subsection 2.

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

Sec. 10. APPLICABILITY. This division of this Act applies to audits initiated on or after January 1, 2027.

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' use of artificial intelligence, prior authorization determinations and exemptions, and audits.

DIVISION I —— PRIOR AUTHORIZATION —— USE OF ARTIFICIAL INTELLIGENCE AND PEER REVIEW. Under the bill, a utilization review organization (URO) may use an artificial intelligence-based algorithm to provide an initial review of a request for prior authorization (authorization), except that, for a request for a health care service (service) based on medical necessity, a URO shall not use an artificial intelligence-based algorithm as the sole basis for a decision to deny, delay, or downgrade the authorization request. "Downgrade" is defined in the bill.

A URO shall not deny or downgrade a request for authorization unless the decision is made by a qualified reviewer or clinical peer and the URO provides the health care provider (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 (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, the qualified reviewer or clinical peer shall consider the known clinical aspects of the services under review.

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

This division of the bill applies to requests for authorization made before January 1, 2027, if the request has not been finally determined on or before that date, and requests for authorization made on or after January 1, 2027.

DIVISION II —— PRIOR AUTHORIZATION —— CANCER-RELATED EXEMPTIONS. A health carrier (carrier) shall not require authorization for, or impose additional utilization review requirements on, a person for a cancer-related screening (screening) if the screening is recommended by the person's health care professional (professional) based on the most recently updated national comprehensive cancer network clinical practice guidelines in oncology. The director of health and human services shall adopt rules, and the commissioner may adopt rules, to administer this division of the bill as detailed in the bill.

This division of the bill applies to health benefit plans (plans) delivered, issued for delivery, continued, or renewed on or after January 1, 2027, and requests for authorization for a screening recommended by a person's professional if the request is made before January 1, 2027, and has not been finally determined on or before that date. The bill also applies to such requests made on or after January 1, 2027.

DIVISION III —— PRIOR AUTHORIZATION —— LIFE-THREATENING HEALTH CONDITIONS. A carrier shall not require authorization for, or impose additional utilization review requirements on, a person for diagnosis and treatment of a health condition (condition) that develops or becomes evident while the person is receiving treatment at an inpatient facility and is reasonably determined by a professional to be a life-threatening condition unless the person receives immediate assessment and treatment. The commissioner may adopt rules to administer this division of the bill.

This division of the bill applies to plans delivered, issued for delivery, continued, or renewed on or after January 1, 2027, and requests for authorization for diagnosis and treatment of a condition that develops or becomes evident in a person while receiving treatment at an inpatient facility if the condition is life-threatening unless the person receives immediate assessment and treatment, the request is made before January 1, 2027, and the request has not been finally determined on or before that date.

DIVISION IV —— UTILIZATION REVIEW ORGANIZATIONS —— AUDITS. A carrier or URO that conducts an audit shall notify the provider that submitted the claim of the initiation of the audit no later than 15 days after the carrier selects the claim for audit. "Audit" is defined in the bill. A carrier or URO shall complete an audit and issue a determination to the provider no later than 45 days after the carrier or URO receives all documentation regarding the claim from the provider.

A provider who submitted a claim that is the subject of an audit and who receives an adverse determination regarding the claim may appeal it no later than 30 days after the provider receives the determination. A carrier or URO shall consider an appeal and issue a final determination no later than 14 days after receiving notice of an appeal. If a carrier or URO violates the bill, the claim shall be automatically approved by

the carrier or URO and promptly paid, including interest.

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

This division of the bill applies to audits initiated on or after January 1, 2027.