

Senate File 2421 - Introduced

SENATE FILE 2421
BY COMMITTEE ON HEALTH AND
HUMAN SERVICES

(SUCCESSOR TO SSB 3118)

A BILL FOR

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

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

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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. *Ob.* “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

1 carrier to which a health care provider submitted a request for
2 prior authorization.

3 *b. "Covered person"* means the same as defined in section
4 514F.8.

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

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

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

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

17 *g. "Health carrier"* means the same as defined in section
18 514F.8.

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

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

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

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

29 (2) The physician has the training and expertise to treat
30 the specific medical condition that is the subject of a
31 request for prior authorization, including sufficient knowledge
32 to determine whether the health care service that is the
33 subject of the request is medically necessary or clinically
34 appropriate.

35 (3) The physician is employed by or contracted with

1 the utilization review organization or health carrier to
2 which a health care provider submitted a request for prior
3 authorization.

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

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

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

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

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

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

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

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

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

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

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

35 (a) If the health care provider that requested prior

1 authorization is a physician, a written attestation that
2 the qualified reviewer who made the denial or downgrade
3 determination practices in the same or a similar specialty as
4 the health care provider, and has the requisite training and
5 expertise to treat the medical condition that is the subject
6 of the request for prior authorization, including sufficient
7 knowledge to determine whether the health care service is
8 medically necessary or clinically appropriate. The attestation
9 shall include the qualified reviewer's name, national provider
10 identifier, board certifications, specialty expertise, and
11 educational background.

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

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

29 a. Between the health care provider and a qualified
30 reviewer, if the health care provider requesting prior
31 authorization is a physician.

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

35 4. a. If a utilization review organization's decision to

1 deny or downgrade a request for prior authorization is appealed
2 by the requesting health care provider or covered person, the
3 appeal shall be conducted by either of the following:

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

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

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

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

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

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

24 1. Requests for prior authorization made before January
25 1, 2027, if the request has not been finally determined on or
26 before that date.

27 2. Requests for prior authorization made on or after January
28 1, 2027.

29 **DIVISION II**

30 **PRIOR AUTHORIZATION — CANCER-RELATED EXEMPTIONS**

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

33 1. For purposes of this section:

34 *a.* "*Covered person*" means the same as defined in section
35 514F.8.

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

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

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

14 (1) The medical assistance program under chapter 249A and
15 the healthy and well kids in Iowa (Hawki) program under chapter
16 514I.

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

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

24 *f. "Utilization review"* means the same as defined in section
25 514F.4, subsection 3.

26 2. A health carrier shall not require prior authorization
27 for, or impose additional utilization review requirements on, a
28 covered person for a cancer-related screening if the screening
29 is recommended by the covered person's health care professional
30 based on the most recently updated national comprehensive
31 cancer network clinical practice guidelines in oncology.

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

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

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

5 *d. "Health carrier"* means the same as defined in section
6 514F.8.

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

9 *f. "Utilization review"* means the same as defined in section
10 514F.4, subsection 3.

11 2. A health carrier shall not require prior authorization
12 for, or impose additional utilization review requirements
13 on, a covered person for diagnosis and treatment of a health
14 condition that develops or becomes evident in a covered person
15 while the covered person is receiving treatment at an inpatient
16 facility, and the health condition is reasonably determined by
17 a health care professional to be a life-threatening condition
18 unless the covered person receives immediate assessment and
19 treatment.

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

22 Sec. 8. APPLICABILITY. This division of this Act applies
23 to all of the following:

24 1. Health benefit plans delivered, issued for delivery,
25 continued, or renewed in this state on or after January 1,
26 2027.

27 2. Requests for prior authorization for diagnosis and
28 treatment of a health condition that develops or becomes
29 evident in a covered person while the covered person
30 is receiving treatment at an inpatient facility if the
31 health condition is reasonably determined by a health care
32 professional to be a life-threatening condition unless the
33 covered person receives immediate assessment and treatment, the
34 request is made before January 1, 2027, and the request has not
35 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

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

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

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

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

14 EXPLANATION

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

17 This bill relates to utilization review organizations' use
18 of artificial intelligence, prior authorization determinations
19 and exemptions, and audits.

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

30 A URO shall not deny or downgrade a request for authorization
31 unless the decision is made by a qualified reviewer or clinical
32 peer and the URO provides the health care provider (provider)
33 requesting authorization a written statement citing the
34 reasons for the decision, explaining the appeals process, and
35 a written attestation as described by the bill. If a request

1 for authorization is denied, the URO shall notify the provider
2 within seven days and conduct a consultation as described by
3 the bill. "Clinical peer" and "qualified reviewer" are defined
4 in the bill.

5 If a URO's decision to deny or downgrade a request for
6 authorization is appealed by the requesting provider or covered
7 person (person), the appeal shall be conducted by a qualified
8 reviewer or clinical peer who was not involved in the initial
9 denial or downgrade. When conducting an appeal, the qualified
10 reviewer or clinical peer shall consider the known clinical
11 aspects of the services under review.

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

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

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

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

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

11 This division of the bill applies to plans delivered,
12 issued for delivery, continued, or renewed on or after January
13 1, 2027, and requests for authorization for diagnosis and
14 treatment of a condition that develops or becomes evident in a
15 person while receiving treatment at an inpatient facility if
16 the condition is life-threatening unless the person receives
17 immediate assessment and treatment, the request is made
18 before January 1, 2027, and the request has not been finally
19 determined on or before that date.

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

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

1 the carrier or URO and promptly paid, including interest.

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

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