House File 2399 - Reprinted

HOUSE FILE 2399
BY COMMITTEE ON COMMERCE

(SUCCESSOR TO HSB 650)

(As Amended and Passed by the House February 24, 2022)

A BILL FOR

An Act relating to reimbursement for health care services provided after receipt of a prior authorization, and including applicability provisions.

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

Section 1. NEW SECTION. **514F.8 Prior authorizations —— reimbursement.**

1. For purposes of this section:

a. "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

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

c. "Health benefit plan" means the same as defined in section 514J.102.

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

e. "Health care provider" means a health care professional or a facility.

f. "Health care services" means services provided by a health care provider for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease. *"Health care services"* includes the provision of durable medical equipment. *"Health care services"* does not include prescription drugs or dental care services as that term is defined in section 514J.102.

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"* does not include the department of human services, or a managed care organization acting pursuant to a contract with the department of human services to administer the medical assistance program under chapter 249A or the healthy and well kids in Iowa (hawk-i) program under chapter 514I.

h. "Prior authorization" means a determination by a

utilization review organization that a specific health care service proposed by a health care provider for a covered person is medically necessary or medically appropriate, and the determination is made prior to the provision of the health care service to the covered person, and, if applicable, includes a utilization review organization's requirement that a covered person or a health care provider notify the utilization review organization prior to receiving or providing a specific health care service.

i. "Utilization review" means the same as defined in section 514F.4, subsection 3.

j. "Utilization review organization" means an entity that performs utilization review, including a health carrier that meets the requirements established for accreditation set by the utilization review accreditation commission or the national committee on quality assurance and that performs utilization review for the health carrier's health benefit plans.

2. *a.* A utilization review organization shall not revoke, or impose a limitation, condition, or restriction on, a prior authorization after the date on which a health care provider provides a health care service to a covered person per the prior authorization.

b. A health carrier shall reimburse a health care provider at the contracted reimbursement rate for a health care service provided by the health care provider to a covered person per a prior authorization.

c. Paragraphs *"a"* and *"b"* shall not apply in any of the following circumstances:

(1) The health care provider or the covered person committed fraud, waste, or abuse.

(2) The health care provider or the covered person provided inaccurate information that the utilization review organization relied on for the utilization review organization's prior authorization determination.

(3) On the date that the health care service was provided by

the health care provider to the covered person per the prior authorization, the health care service was no longer a benefit covered by the covered person's health benefit plan.

(4) On the date that the health care service was provided by the health care provider to the covered person per the prior authorization, the health care provider was no longer contracted with the health carrier that provides the covered person's health benefit plan.

(5) The health care provider failed to meet the health carrier's requirements related to timely filing of claims for submission of a claim for the health care service provided by the health care provider to the covered person per the prior authorization.

(6) Due to coordination of benefits, the health carrier does not have liability for a claim for the health care service provided by the health care provider to the covered person per a prior authorization.

(7) On the date that the health care service was provided by the health care provider to the covered person per the prior authorization, the covered person was no longer a participant in the health benefit plan in which the covered person participated on the date that the prior authorization was received by the health care provider.

3. A prior authorization for a specific health care service for a covered person shall be valid for the specific health care service for not less than ninety days from the date that the covered person's health care provider receives the prior authorization from a utilization review organization, provided that during the ninety days the covered person remains a participant in the same health benefit plan in which the covered person participated on the date the prior authorization was received by the health care provider.

4. The commissioner may adopt rules pursuant to chapter 17A as necessary to administer this chapter.

Sec. 2. APPLICABILITY. This Act applies January 1, 2023, to

health benefit plans that are delivered, issued for delivery, continued, or renewed in this state on or after that date.