

# Senate File 562 - Introduced

SENATE FILE 562

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## A BILL FOR

1 An Act relating to utilization review organizations, prior  
2 authorizations and exemptions, medical billing, and  
3 independent review organizations.  
4 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

1     Section 1. NEW SECTION. 514F.2A Utilization review — use  
2 of artificial intelligence.

3     1. For the purposes of this section:

4     *a. "Artificial intelligence"* means an engineered or  
5 machine-based system that varies in its level of autonomy and  
6 that can, for explicit or implicit objectives, infer from the  
7 input the system receives how to generate outputs that can  
8 influence physical or virtual environments.

9     *b. "Covered person"* means the same as defined in section  
10 51F.8.

11    *c. "Health care provider"* means the same as defined in  
12 section 514F.8.

13    *d. "Health carrier"* means the same as defined in section  
14 514F.8.

15    *e. "Utilization review"* means the same as defined in section  
16 514F.7.

17    2. A health carrier that uses artificial intelligence,  
18 an algorithm, or other software tool for the purpose of  
19 utilization review, based in whole or in part on medical  
20 necessity, or that contracts with or otherwise works through  
21 an entity that uses artificial intelligence, an algorithm, or  
22 other software tool for the purpose of utilization review,  
23 based in whole or in part on medical necessity, shall ensure  
24 all of the following:

25    *a.* The artificial intelligence, algorithm, or other software  
26 tool bases its determination on the following information, as  
27 applicable:

28       (1) A covered person's medical or other clinical history.

29       (2) Individual clinical circumstances as presented by the  
30 requesting health care provider.

31       (3) Other relevant clinical information contained in the  
32 covered person's medical or other clinical record.

33    *b.* The artificial intelligence, algorithm, or other software  
34 tool's criteria and guidelines comply with this chapter and  
35 applicable state and federal law.

1     *c.* The artificial intelligence, algorithm, or other software  
2 tool does not supplant health care provider decision making.

3     *d.* The use of the artificial intelligence, algorithm,  
4 or other software tool does not discriminate, directly or  
5 indirectly, against covered persons in violation of state or  
6 federal law.

7     *e.* The artificial intelligence, algorithm, or other software  
8 tool is fairly and equitably applied, including in accordance  
9 with any applicable regulations and guidance issued by the  
10 federal department of health and human services.

11    *f.* The artificial intelligence, algorithm, or other software  
12 tool is open to inspection for audit or compliance reviews by  
13 the division and the department of health and human services  
14 pursuant to applicable state and federal law.

15    *g.* Disclosures pertaining to the use and oversight of the  
16 artificial intelligence, algorithm, or other software tool are  
17 contained in written policies and procedures maintained by the  
18 health carrier.

19    *h.* The artificial intelligence, algorithm, or other software  
20 tool's performance, use, and outcomes are periodically reviewed  
21 and revised to maximize accuracy and reliability.

22    *i.* Patient data is not used beyond its intended and  
23 stated purpose, consistent with the federal Health Insurance  
24 Portability and Accountability Act of 1996, Pub. L. No.  
25 104-191.

26    *j.* The artificial intelligence, algorithm, or other software  
27 tool does not directly or indirectly cause harm to a covered  
28 person.

29     3. Notwithstanding subsection 2, the artificial  
30 intelligence, algorithm, or other software tool shall not  
31 deny, delay, or modify health care services based, in whole  
32 or in part, on medical necessity. A determination of medical  
33 necessity shall be made only by a health care provider  
34 competent to evaluate the specific clinical issues involved  
35 in the health care services requested by the health care

1 provider by reviewing and considering the requesting health  
2 care provider's recommendation, the covered person's medical or  
3 other clinical history, as applicable, and individual clinical  
4 circumstances.

5 Sec. 2. Section 514F.8, Code 2025, is amended by adding the  
6 following new subsections:

7 NEW SUBSECTION. 1A. a. A utilization review organization  
8 shall respond to a request for prior authorization from a  
9 health care provider as follows:

10 (1) Within forty-eight hours after receipt for urgent  
11 requests.

12 (2) Within ten calendar days after receipt for nonurgent  
13 requests.

14 (3) Within fifteen calendar days after receipt for  
15 nonurgent requests if there are complex or unique circumstances  
16 or the utilization review organization is experiencing an  
17 unusually high volume of prior authorization requests.

18 b. Within twenty-four hours after receipt of a prior  
19 authorization request, the utilization review organization  
20 shall notify the health care provider of, or make available to  
21 the health care provider, a receipt for the request for prior  
22 authorization.

23 NEW SUBSECTION. 2A. A utilization review organization  
24 shall, at least annually, review all health care services for  
25 which the health benefit plan requires prior authorization and  
26 shall eliminate prior authorization requirements for health  
27 care services for which prior authorization requests are  
28 routinely approved with such frequency as to demonstrate that  
29 the prior authorization requirement does not promote health  
30 care quality, or reduce health care spending, to a degree  
31 sufficient to justify the health benefit plan's administrative  
32 costs to require the prior authorization.

33 NEW SUBSECTION. 3A. Complaints regarding a utilization  
34 review organization's compliance with this chapter may be  
35 directed to the insurance division. The insurance division

1 shall notify a utilization review organization of all  
2 complaints regarding the utilization review organization's  
3 noncompliance with this chapter. All complaints received  
4 pursuant to this subsection shall not be considered public  
5 records for purposes of chapter 22.

6     Sec. 3. NEW SECTION. 514F.8A Prior authorizations —  
7 statistics.

8     1. For purposes of this section:

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

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

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

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

17    e. "*Health carrier*" means the same as defined in 514F.8.

18    f. "*Prior authorization*" means the same as defined in  
19 514F.8.

20    g. "*Utilization review*" means the same as defined in section  
21 514F.7.

22    h. "*Utilization review organization*" means the same as  
23 defined in 514F.8.

24    2. A health carrier that utilizes prior authorization  
25 shall make statistics available regarding prior authorization  
26 approvals and denials on the health carrier's internet site  
27 in a readily accessible format. Following each immediately  
28 preceding calendar year, the statistics shall be updated  
29 annually by March 31, and shall include all of the following  
30 information:

31    a. A list of all health care services, including  
32 medications, that are subject to prior authorization.

33    b. The percentage of standard prior authorization requests  
34 that were approved, aggregated for all items and services.

35    c. The percentage of standard prior authorization requests

1 that were denied, aggregated for all items and services.

2     *d.* The percentage of prior authorization requests that were  
3 approved after appeal, aggregated for all items and services.

4     *e.* The percentage of prior authorization requests for which  
5 the time frame for review was extended, and the request was  
6 approved, aggregated for all items and services.

7     *f.* The percentage of expedited prior authorization requests  
8 that were approved, aggregated for all items and services.

9     *g.* The percentage of expedited prior authorization requests  
10 that were denied, aggregated for all items and services.

11     *h.* The average and median time that elapsed between the  
12 submission of a request and a determination by the health  
13 carrier or utilization review organization, for standard prior  
14 authorization, aggregated for all items and services.

15     *i.* The average and median time that elapsed between the  
16 submission of a request and a decision by the health carrier  
17 or utilization review organization for expedited prior  
18 authorizations, aggregated for all items and services.

19     *j.* Any other information the division determines  
20 appropriate.

21     Sec. 4. NEW SECTION. 514F.10 **Medical billing.**

22     1. For purposes of this section:

23         *a.* "*Commissioner*" means the commissioner of insurance.

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

26         *c.* "*Health carrier*" means the same as defined in section  
27 514F.9.

28         *d.* "*Health maintenance organization*" means health  
29 maintenance organization as defined in section 514B.1.

30     2. Health carriers, hospital and medical service  
31 corporations, health maintenance organizations, and health care  
32 providers shall comply with the requirements of Tit. I of the  
33 federal No Surprises Act, Pub. L. No. 116-260, Division BB, as  
34 amended.

35     3. The commissioner shall enforce this section to the extent

1 permitted under state and federal law. The commissioner may  
2 refer cases of noncompliance to the federal department of  
3 health and human services under the terms of a collaborative  
4 enforcement agreement, or to the attorney general.

5 Sec. 5. Section 514J.114, subsection 1, paragraph b,  
6 unnumbered paragraph 1, Code 2025, is amended to read as  
7 follows:

8 Each independent review organization required to maintain  
9 written records pursuant to [this section](#) shall annually submit  
10 to the commissioner, ~~upon request~~, a report in the format  
11 specified by the commissioner. The report shall include in the  
12 aggregate by state and by health carrier all of the following:

13 Sec. 6. Section 514J.114, subsection 1, Code 2025, is  
14 amended by adding the following new paragraph:

15 NEW PARAGRAPH. *d.* The commissioner shall make the  
16 independent review organization reports required under this  
17 subsection publicly accessible on the division's internet site.

18 Sec. 7. Section 514J.114, subsection 2, paragraph b,  
19 unnumbered paragraph 1, Code 2025, is amended to read as  
20 follows:

21 Each health carrier required to maintain written records of  
22 requests for external review pursuant to [this subsection](#) shall  
23 annually submit to the commissioner, ~~upon request~~, a report in  
24 the format specified by the commissioner. The report shall  
25 include in the aggregate by state and by type of health benefit  
26 plan offered all of the following:

27 Sec. 8. Section 514J.114, subsection 2, Code 2025, is  
28 amended by adding the following new paragraph:

29 NEW PARAGRAPH. *d.* The commissioner shall make the health  
30 carrier reports required under this subsection publicly  
31 accessible on the division's internet site.

32 Sec. 9. PRIOR AUTHORIZATION EXEMPTION PROGRAM.

33 1. On or before January 15, 2026, all health carriers  
34 that deliver, issue for delivery, continue, or renew a health  
35 benefit plan in this state on or after January 1, 2026, and

1 that require prior authorizations, shall implement a pilot  
2 program that exempts a subset of participating health care  
3 providers, at least some of whom shall be primary health care  
4 providers, from certain prior authorization requirements.

5 2. Each health carrier shall make available on the health  
6 carrier's internet site for each health benefit plan that the  
7 health carrier delivers, issues for delivery, continues, or  
8 renews in this state, details about the health benefit plan's  
9 prior authorization exemption program, including all of the  
10 following information:

11 a. The health carrier's criteria for a health care provider  
12 to qualify for the exemption program.

13 b. The health care services that are exempt from prior  
14 authorization requirements for health care providers who  
15 qualify under paragraph "a".

16 c. The estimated number of health care providers who are  
17 eligible for the program, including the health care providers'  
18 specialties, and the percentage of the health care providers  
19 that are primary care providers.

20 d. Contact information for the health benefit plan for  
21 consumers and health care providers to contact the health  
22 benefit plan about the exemption program, or about a health  
23 care provider's eligibility for the exemption program.

24 3. On or before January 15, 2027, each health carrier  
25 required to implement a prior authorization exemption  
26 program pursuant to subsection 1 shall submit a report to the  
27 commissioner of insurance that contains all of the following:

28 a. The results of the exemption program, including an  
29 analysis of the costs and savings of the exemption program.

30 b. The health benefit plan's recommendations for continuing  
31 or expanding the exemption program.

32 c. Feedback received by each health benefit plan from  
33 health care providers and other interested parties regarding  
34 the exemption program.

35 d. An assessment of the administrative costs incurred by



1 each of the health carrier's health benefit plans to administer  
2 and implement prior authorization requirements under the  
3 exemption program.

4 EXPLANATION

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

7 This bill relates to utilization review organizations, prior  
8 authorizations and exemptions, medical billing, and independent  
9 review organizations.

10 Under the bill, a health carrier (carrier) that uses an  
11 artificial intelligence, algorithm, or other software tool  
12 (artificial intelligence) for the purpose of utilization  
13 review, or that contracts with or works through an entity that  
14 uses an artificial intelligence for the purpose of utilization  
15 review, shall ensure that (1) the artificial intelligence  
16 bases its determination on the information described in  
17 the bill; (2) the artificial intelligence does not base its  
18 determination solely on a group dataset; (3) the artificial  
19 intelligence's criteria and guidelines comply with Code  
20 chapter 514F and applicable state and federal law; (4) the  
21 artificial intelligence does not supplant health care provider  
22 (provider) decision making; (5) the use of the artificial  
23 intelligence does not discriminate against covered persons;  
24 (6) the artificial intelligence is fairly and equitably  
25 applied; (7) the artificial intelligence is open to inspection  
26 for audit or compliance reviews by the insurance division  
27 (division) and the department of health and human services;  
28 (8) disclosures pertaining to the use and oversight of the  
29 artificial intelligence are contained in written policies and  
30 procedures; (9) the artificial intelligence's performance,  
31 use, and outcomes are periodically reviewed and revised;  
32 (10) patient data is not used beyond its intended and stated  
33 purpose; and (11) the artificial intelligence does not cause  
34 harm to a covered person. "Artificial intelligence" is defined  
35 in the bill. The artificial intelligence shall not deny,

1 delay, or modify health care services (services) based on  
2 medical necessity, and a determination of medical necessity  
3 shall be made only by a competent provider.

4     The bill requires a utilization review organization  
5 (organization) to respond to a request for prior authorization  
6 (authorization) from a provider within 48 hours after receipt  
7 for urgent requests or within 10 calendar days for nonurgent  
8 requests, unless there are complex or unique circumstances,  
9 or the organization is experiencing an unusually high volume  
10 of authorization requests, then an organization must respond  
11 within 15 calendar days. Within 24 hours after receipt of an  
12 authorization request, the organization shall notify a provider  
13 of, or make available, a receipt for the authorization request.  
14 The bill requires an organization to annually review all  
15 services for which authorization is required and to eliminate  
16 authorization requirements for services for which authorization  
17 requests are so routinely approved that the authorization  
18 requirement is not justified as it does not promote health care  
19 quality or reduce health care spending. Complaints regarding  
20 an organization's compliance with the bill may be directed to  
21 the division, and the division shall notify an organization of  
22 all complaints. Complaints received under the bill shall not  
23 be considered public records.

24     Under the bill, a carrier that utilizes authorization shall  
25 make statistics available regarding authorization approvals and  
26 denials on the carrier's internet site in a readily accessible  
27 format. Following each calendar year, the statistics shall  
28 be updated annually by March 31, and shall include all of the  
29 information detailed in the bill.

30     Under the bill, carriers, hospital and medical service  
31 corporations, health maintenance organizations, and providers  
32 shall comply with the requirements of Tit. I of the federal  
33 No Surprises Act, Pub. L. No. 116-260, Division BB, as may  
34 be amended, and the commissioner of insurance (commissioner)  
35 shall enforce such compliance. The commissioner may refer

1 cases of noncompliance to the federal department of health and  
2 human services under the terms of a collaborative enforcement  
3 agreement, or to the attorney general.

4 Under current law, an independent review organization (IRO)  
5 required to maintain written records shall submit a report to  
6 the commissioner upon request. Under the bill, an IRO required  
7 to maintain written records shall annually submit a report to  
8 the commissioner. The commissioner shall make the IRO reports  
9 publicly accessible on the division's internet site.

10 Under current law, each carrier required to maintain written  
11 records of requests for external review shall submit a report  
12 to the commissioner upon request. Under the bill, each carrier  
13 required to maintain written records of requests for external  
14 review shall annually submit a report to the commissioner. The  
15 commissioner shall make the carrier reports publicly accessible  
16 on the division's internet site.

17 The bill requires, on or before January 15, 2026, all  
18 carriers that deliver, issue for delivery, continue, or renew a  
19 health benefit plan (plan) in this state on or after January  
20 1, 2026, to implement an authorization exemption pilot program  
21 (program) that exempts a subset of participating providers,  
22 including primary providers, from certain authorization  
23 requirements. Each carrier shall make available for each plan  
24 details about the plan's authorization exemption requirements  
25 on the carrier's internet site, including the carrier's  
26 criteria for a provider to qualify for the program, the health  
27 care services that are exempt from authorization requirements,  
28 the estimated number of providers who are eligible for  
29 the program, including the providers' specialties and the  
30 percentage of the providers that are primary care providers,  
31 and contact information for consumers and providers to contact  
32 the plan about the program or a provider's eligibility for the  
33 program. On or before January 15, 2027, each carrier required  
34 to implement a program under the bill shall submit a report  
35 to the commissioner containing the results of the program,

1 including an analysis of the costs and savings of the program,  
2 the plan's recommendations for continuing or expanding the  
3 program, feedback received by each plan, and an assessment of  
4 the administrative costs incurred by each of the carrier's  
5 plans to administer and implement authorization requirements  
6 under the program.