

**SENATE BILL NO. 133**

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Introduced: 3/17/25

Referred: Labor and Commerce, Finance

**A BILL**

**FOR AN ACT ENTITLED**

1   **"An Act relating to prior authorization requests for medical care covered by a health**  
2   **care insurer; relating to a prior authorization application programming interface;**  
3   **relating to step therapy; and providing for an effective date."**

4   **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

5       **\* Section 1.** AS 21.07.080 is amended to read:

6               **Sec. 21.07.080. Religious nonmedical providers. AS 21.07.005 - 21.07.090**

7               [THIS CHAPTER] may not be construed to

8                       (1) restrict or limit the right of a health care insurer to include services  
9               provided by a religious nonmedical provider as medical care services covered by the  
10           health care insurance policy;

11                   (2) require a health care insurer, when determining coverage for  
12           services provided by a religious nonmedical provider, to

13                               (A) apply medically based eligibility standards;

14                               (B) use health care providers to determine access by a covered

1 person;

2 (C) use health care providers in making a decision on an  
3 internal or external appeal; or

4 (D) require a covered person to be examined by a health care  
5 provider as a condition of coverage; or

6 (3) require a health care insurance policy to exclude coverage for  
7 services provided by a religious nonmedical provider because the religious  
8 nonmedical provider is not providing medical or other data required from a health care  
9 provider if the medical or other data is inconsistent with the religious nonmedical  
10 treatment or nursing care being provided.

11 \* **Sec. 2.** AS 21.07 is amended by adding new sections to read:

12 **Article 2. Prior Authorizations.**

13 **Sec. 21.07.100. Prior authorization requests.** (a) A health care insurer  
14 offering a health plan issued or renewed on or after January 1, 2027, shall designate a  
15 prior authorization process that complies with the standards for prior authorizations for  
16 medical care and prescription drugs in AS 21.07.100 - 21.07.180. The process must be  
17 reasonable and efficient and minimize administrative burdens on health care providers  
18 and facilities.

19 (b) If a health care provider submits a prior authorization request that contains  
20 the information necessary to make a determination, a health care insurer shall make a  
21 determination and notify the provider of the decision within

22 (1) 72 hours after receiving a standard request submitted by a method  
23 other than facsimile;

24 (2) 72 hours, excluding weekends, after receiving a standard request  
25 submitted by facsimile; or

26 (3) 24 hours after receiving an expedited request.

27 (c) If a health care provider submits a prior authorization request that does not  
28 contain the information necessary to make a determination, the health care insurer  
29 shall request specific additional information from the covered person's health care  
30 provider within

31 (1) one calendar day after receiving an expedited request; or

1 (2) three calendar days after receiving a standard request.

2 (d) If a health care insurer determines that the information provided by a  
3 health care provider is not sufficient to make a determination under (b) of this section,  
4 the health care insurer may request additional information. The health care insurer  
5 may establish a due date of not less than five nor more than 14 working days after  
6 receiving the prior authorization request by which the additional information must be  
7 submitted. The health care insurer must notify the health care provider and covered  
8 person of the due date along with the request for additional information and specify  
9 the additional information needed to complete the request.

10 (e) A health care insurer that receives a prior authorization request from a  
11 health care provider shall provide to the health care provider confirmation of receipt  
12 that shows the date and time the request was received by the health care insurer.

13 (f) A prior authorization request submitted under this section is considered  
14 approved if the health care insurer fails to provide a written denial, approval, or  
15 request for additional information within the time specified under this section.

16 **Sec. 21.07.110. Prior authorization standards.** (a) A health care insurer shall  
17 make its most current prior authorization standards available to a covered person and  
18 health care provider on the health care insurer's Internet website, including  
19 information or documentation to be submitted by the covered person or health care  
20 provider or facility. If the health care insurer provides a portal, the insurer shall also  
21 make the prior authorization standards available on the portal. A health care insurer  
22 shall describe the standards in detailed, easily understood language.

23 (b) A health care insurer's prior authorization standards must include prior  
24 authorization requirements used by the insurer and by the insurer's utilization review  
25 organizations. The prior authorization requirements must be based on peer-reviewed,  
26 evidence-based clinical review criteria and be consistently applied by all sources,  
27 including utilization review organizations, to avoid discrepancies or conflicts. The  
28 health care insurer shall evaluate and, if necessary, update the clinical review criteria  
29 at least annually.

30 (c) If the prior authorization standards published by the health care insurer  
31 differ from those published by the health care insurer's utilization review organization,

1 the health care insurer shall use the prior authorization standard most favorable to the  
2 covered person.

3 (d) A health care insurer shall indicate on its Internet website, for each service  
4 subject to prior authorization,

5 (1) whether a standardized electronic prior authorization request  
6 transaction process is available; and

7 (2) the date the prior authorization requirement

8 (A) became effective for a policy issued or delivered in this  
9 state; and

10 (B) was first listed on the health care insurer's Internet website.

11 (e) If the prior authorization requirement is terminated, a health care insurer  
12 shall indicate on its Internet website the date the prior authorization requirement was  
13 removed for a policy issued or delivered in this state.

14 **Sec. 21.07.120. Peer review of prior authorization request.** (a) A health care  
15 insurer shall establish a process for a health care provider to request a clinical peer  
16 review of a prior authorization request.

17 (b) A peer reviewer must have relevant clinical expertise in the specialty area  
18 or be of an equivalent specialty as the health care provider submitting the prior  
19 authorization request. A peer reviewer shall attest, in writing or electronically, that the  
20 reviewer has personally reviewed and considered all medical notes and relevant  
21 clinical information submitted as part of the prior authorization request.

22 (c) A health care insurer shall provide to a health care provider at the  
23 provider's request the qualifications of a peer reviewer issuing an adverse decision on  
24 a prior authorization request, including the specialty and relevant board certifications  
25 of the peer reviewer.

26 **Sec. 21.07.130. Period of validity of prior authorization.** (a) A prior  
27 authorization for a chronic condition is valid for a period of not less than 12 months  
28 while the covered person remains covered by the health care policy. If the treatment  
29 plan for a chronic condition is unchanged and the covered person's health care  
30 provider submits to the health care insurer certification of compliance with the current  
31 treatment plan, the health care insurer shall automatically renew the prior

1 authorization approval for the chronic condition for an additional 12-month period.

2 (b) Except for a prior authorization for a chronic condition subject to (a) of  
 3 this section, a prior authorization is valid for a period of 90 calendar days or a duration  
 4 that is clinically appropriate, whichever is longer. If a health care insurer intends to  
 5 implement a new prior authorization requirement or restriction, or amend an existing  
 6 requirement or restriction, the health care insurer shall provide a participating health  
 7 care provider written notice of the new or amended requirement or restriction not less  
 8 than 60 days before the requirement or restriction is implemented. The health care  
 9 insurer shall post notice on the health care insurer's public facing, accessible Internet  
 10 website not less than 60 days before implementation of the requirement or restriction.  
 11 If a health care provider agrees in advance to receive notices electronically, the written  
 12 notice may be provided in an electronic format. The health care insurer may not  
 13 implement a new or amended requirement until the Internet websites of both the health  
 14 care insurer and the utilization review organization have been updated to reflect the  
 15 new or amended requirement or restriction.

16 **Sec. 21.07.140. Adverse determinations.** If a health care insurer makes an  
 17 adverse prior authorization determination, the health care insurer shall notify the  
 18 covered person and the covered person's health care provider and provide each

19 (1) a clear explanation of the reasons for the adverse determination,  
 20 including the specific evidence-based reasons and criteria used to make the  
 21 determination and a description of any specific missing or insufficient information that  
 22 contributed to the adverse determination;

23 (2) a statement of the covered person's right to appeal the adverse  
 24 determination;

25 (3) instructions on how to file an appeal, including a clear explanation  
 26 of the appeals process, appeal timeline, and the direct telephone number and electronic  
 27 and physical mailing addresses for appeals.

28 **Sec. 21.07.150. Prior authorization application programming interface.** A  
 29 health care insurer shall maintain a prior authorization application programming  
 30 interface that automates the process for health care providers to determine whether a  
 31 prior authorization is required for medical care, identify prior authorization

1 information and documentation requirements, and facilitate the exchange of prior  
 2 authorization requests and determinations from its electronic health records or practice  
 3 management system. The application programming interface must be consistent with  
 4 the technical standards and implementation dates established in the Centers for  
 5 Medicare and Medicaid Services rules on interoperability and patient access. The  
 6 application programming interface must support the exchange of prior authorization  
 7 requests and determinations for medical care and prescription drugs, including  
 8 information on covered alternative prescription drugs. The application programming  
 9 interface must indicate that a prior authorization denial, an authorization of medical  
 10 care less intensive than the medical care included in the original request, or an  
 11 authorization of a prescription drug other than the one included in the original prior  
 12 authorization request is an adverse benefit determination and is subject to the health  
 13 care insurer's grievance and appeal process under AS 21.07.005.

14 **Sec. 21.07.160. Step therapy restrictions and exceptions.** (a) A health care  
 15 insurer that provides coverage under a health care insurance policy for the treatment of  
 16 Stage 4 advanced metastatic cancer may not limit or exclude coverage under the health  
 17 benefit plan for a drug that is approved by the United States Food and Drug  
 18 Administration and that is on the insurer's prescription drug formulary by mandating  
 19 that a covered person with Stage 4 advanced metastatic cancer undergo step therapy if  
 20 the use of the approved drug is an approved indication by the United States Food and  
 21 Drug Administration or on the National Comprehensive Cancer Network Drugs and  
 22 Biologics Compendium as an indication for the treatment of Stage 4 advanced  
 23 metastatic cancer consistent with Category 1 or Category 2A of evidence and  
 24 consensus or peer-reviewed medical literature.

25 (b) If coverage of a prescription drug for the treatment of any medical  
 26 condition is restricted by a health care insurer or utilization review organization  
 27 because of a step therapy protocol, the health care insurer or utilization review  
 28 organization must provide a covered person and the covered person's health care  
 29 provider with access to a clear, convenient, and readily accessible process for  
 30 requesting an exception to application of the step therapy protocol. A health care  
 31 insurer or utilization review organization may use its existing medical exceptions

1 process to satisfy this requirement. The health care insurer or utilization review  
 2 organization shall disclose the process to the covered person and the covered person's  
 3 health care provider, along with the information needed to process the request, and  
 4 make the process available on the health care insurer's Internet website for the plan.

5 (c) A health care insurer or utilization review organization shall grant a step  
 6 therapy exception under this section if the covered person has tried the prescription  
 7 drugs required under the step therapy protocol while under a current or previous health  
 8 care insurance policy or health benefit plan, including a health care insurance policy or  
 9 health benefit plan offered by a different insurer or payor, and the prescription drugs  
 10 were discontinued because of lack of efficacy or effectiveness, diminished effect, or  
 11 an adverse event or if the covered person's health care provider attests that coverage of  
 12 the prescribed prescription drug is necessary to save the life of the covered person.  
 13 Use of drug samples from a pharmacy may not be considered trial and failure of a  
 14 preferred prescription drug required under a step therapy protocol.

15 (d) The health care insurer or utilization review organization may request  
 16 relevant information from the covered person or the covered person's health care  
 17 provider to support a step therapy exception request made under this section. Upon  
 18 granting a step therapy exception request, the health care insurer or utilization review  
 19 organization shall authorize dispensation of and coverage for the prescription drug  
 20 prescribed by the covered person's health care provider if the drug is a covered drug  
 21 under the health care insurance policy.

22 (e) This section may not be construed to prevent a

23 (1) health care insurer or utilization review organization from requiring  
 24 a covered person to try a generic equivalent or other brand name drug before  
 25 providing coverage for the requested prescription drug; or

26 (2) health care provider from prescribing a prescription drug that the  
 27 provider determines is medically appropriate.

28 **Sec. 21.07.170. Annual report.** A health care insurer shall submit an annual  
 29 report to the director, on a form prescribed by the director, detailing compliance with  
 30 the requirements of AS 21.07.100 - 21.07.180. The report must include

31 (1) documentation of compliance with prior authorization response

1 times and other prior authorization requirements;

2 (2) evidence of transparency and accessibility of prior authorization  
3 requirements and clinical review criteria;

4 (3) information on the implementation and functioning of any prior  
5 authorization application programming interfaces;

6 (4) records of any prior authorization denials and the associated  
7 appeals process, including the number of prior authorization approvals and denials,  
8 reasons for denials, number of appeals, appeal outcomes, and, for the insurer's 20 most  
9 frequently billed codes, average approval times by diagnosis code and demographic  
10 information of the covered persons;

11 (5) any other information required by the director.

12 **Sec. 21.07.180. Compliance and enforcement.** (a) The director shall monitor  
13 compliance with the provisions of AS 21.07.100 - 21.07.180.

14 (b) The director shall conduct examinations of health care insurers in  
15 accordance with AS 21.06.120 - 21.06.230 to ensure compliance with AS 21.07.100 -  
16 21.07.180. At least once every two years, the director shall conduct the examinations,  
17 which may include reviewing

18 (1) prior authorization response times and adherence to specified time  
19 frames;

20 (2) accuracy and completeness of prior authorization requirements and  
21 restrictions published on the Internet website of the health care insurer; and

22 (3) consistency of prior authorization practices by all vendors,  
23 utilization review organizations, and third-party contractors.

24 (c) If a health care insurer does not comply with AS 21.07.100 - 21.07.180,  
25 the director may impose penalties, including a penalty for each instance of  
26 noncompliance, an order to rectify deficiencies within a specified time frame, or, for  
27 persistent or severe violations, suspension or revocation of the health care insurer's  
28 certificate of authority. The director shall impose penalties based on the nature and  
29 severity of the noncompliance, with consideration given to the health care insurer's  
30 history of adherence to the requirements of AS 21.07.100 - 21.07.180 and efforts to  
31 remedy violations.

(d) The director shall adopt regulations establishing penalties for noncompliance with AS 21.07.100 - 21.07.180. The civil penalty for a single instance of noncompliance may not exceed \$25,000.

\* **Sec. 3.** AS 21.07.250 is amended by adding new paragraphs to read:

(15) "chronic condition" means a medical condition or disease expected to last at least 12 months or expected to persist over the lifetime of an individual, requiring ongoing medical care to manage symptoms or prevent progression;

(16) "covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health care insurance policy;

(17) "expedited request" means a request by a health care provider for approval of medical care or a prescription drug when the covered person is undergoing a current course of treatment using a nonformulary drug or for which the passage of time

(A) could jeopardize the life or health of the covered person;

(B) could jeopardize the ability of a covered person to regain maximum function; or

(C) would, as determined by a health care provider with knowledge of the covered person's medical condition, subject the covered person to severe pain that cannot be adequately managed without the medical care or prescription drug that is the subject of the request;

(18) "prior authorization" means the process used by a health care insurer to determine the medical necessity or medical appropriateness of covered medical care before the medical care is provided or a requirement that a covered person or health care provider notify a health care insurer before receiving or providing medical care;

(19) "standard request" means a request by a health care provider for approval of medical care or a prescription drug for which the request is made in advance of the covered person's obtaining medical care or a prescription drug that is not required to be expedited;

(20) "step-therapy protocol" means a protocol, policy, or program used

1 by a health care insurer or utilization review organization that establishes which  
2 prescription drugs are medically appropriate for a particular covered person and the  
3 specific sequence in which the prescription drugs should be administered for a  
4 specified medical condition, whether by self-administration or administration by a  
5 health care provider, under a pharmacy or medical benefit of a health care insurance  
6 plan;

7 (21) "utilization review organization" means an entity, other than a  
8 health care insurer performing utilization review for the health care insurer's own  
9 health insurance policy, that conducts any part of utilization review.

10 \* **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to  
11 read:

12 TRANSITION: REGULATIONS. The director of the division of insurance may adopt  
13 regulations necessary to implement this Act. The regulations take effect under AS 44.62  
14 (Administrative Procedure Act), but not before the effective date of the law implemented by  
15 the regulation.

16 \* **Sec. 5.** Section 4 of this Act takes effect immediately under AS 01.10.070(c).

17 \* **Sec. 6.** Except as provided in sec. 5 of this Act, this Act takes effect January 1, 2027.