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SB 133-INSURANCE; PRIOR AUTHORIZATIONS

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

Sectional Summary – ver. \N

This is a summary only. Note that this summary should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. AS 21.07.080 is amended to read:
Sec. 21.07.080. Religious nonmedical providers
Amends the protections provided in AS 21.07, *Patient Protections Under Health Care Insurance Policies*, which will include the prior authorization statutes will extend to the Religious nonmedical providers.

Section 2. AS 21.07 is amended by adding a new section:

Article 2. Prior Authorization.

Sec 21.07.100. Prior authorization requests.

(a) Requires that each health care insurer offering a health plan, after January 1, 2027, shall designate a prior authorization process that is reasonable, efficient, and minimizes the administrative burden on health care providers and facilities and that complies with the standards for medical care and prescription drugs.

(b) Requires that if a health care provider submits a prior authorization request, the health care insurer shall make a determination and notify the provider within:
   a. 72-hours after receiving a standard request submitted by a method other than facsimile;
   b. 72-hours, excluding weekends, after receiving a standard request submitted by facsimile; or
   c. 24-hours after receiving an expedited request.

(c) Provides, that when a prior authorization request is submitted that does not contain the information necessary to make a determination, the health care insurer shall request specific additional information within:
   a. One calendar day after receiving an expedited request;
   b. Three calendar days after receiving a standard request.

(d) Allows an insurer, in making a determination, that if the submitted information is not sufficient to make a determination the insurer may request additional information with a due date of not less than five (5) working days nor more than fourteen (14) working days.
(e) Mandates that after the submission of the prior authorization request, the provider shall receive confirmation that the request has been received with a date and time of the receipt.
(f) Provides a prior authorization request is considered approved if the health care insurer fails to provide a written denial, approval or request for additional information within the time specified above.

Sec. 21.07.110.

(a) Provides that a health care insurer shall make its most current prior authorization standards available, on the health care insurer's website including information or document needed to make a determination. If the health care insurer provides a portal, the prior authorization standards shall be available on the portal.
(b) Provides that a health care insurer's prior authorization standards must include prior authorization requirements used by the insurer and by the insurer's utilization review organization. The requirements must be based on peer-reviewed, evidence-based clinical review criteria and be consistently applied by all sources.
(c) Provides that if the prior authorization standards published by the health care insurer differ from those published by their utilization review organization, the standard most favorable to the covered person shall be used.
(d) Provides that a health care insurer shall indicate on its website, for each service subject to prior authorization,
    (1) Whether a standardized electronic prior authorization request transaction is available; and
    (2) The date the prior authorization requirement became effective and was published on their website.
(e) Provides that if the prior authorization requirement is terminated, the health care insurer shall indicate on its website the date the requirement was removed.

Sec. 21.007.120. Peer review of prior authorization requests.

(a) Provides that an insurer shall establish a process for the health care provider to request a clinical peer review of a prior authorization request. The peer reviewer must have relevant clinical expertise in the specialty area or be an equivalent specialty of the provider submitting the prior authorization request.
(b) Provides that a heath care insurer shall provide to the health care provider upon request, the qualifications of a peer reviewer issuing an adverse decision.

Sec. 21.07.130. Period of validity of prior authorization.

(a) Requires that a prior authorization request, for a chronic condition, must be valid for not less than twelve (12) months while the covered person is covered by the insurer's policy. Also addresses how the prior authorization may be renewed.
(b) Provides that, except for (a) above, a prior authorization request shall be valid for ninety (90) calendar days or a duration that is clinically appropriate, whichever is longer.

Sec. 21.07.140. Adverse determinations.

Provides that if a health care insurer makes an adverse determination, the insurer shall notify the covered person and their health care provider and provide each
    (1) A clear explanation of the adverse determination,

(2) A statement of the covered person's right of appeal; and
(3) Instructions on how to file the appeal.

Sec. 21.07.150. Prior authorization application programming interface.

States that each insurer shall maintain a prior authorization application programming interface that automates the prior authorization process for providers to determine whether a prior authorization is required for medical care, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and determinations from its electronic health records or practice management system. The application programming interface must be consistent with the technical standards and implementation dates established in the Centers for Medicare and Medicaid Services rules on interoperability and patient access.

Sec 21.07.160. Step therapy restrictions and exception.

(a) Requires that an insurer that provides coverage under a policy for the treatment of Stage 4 advanced metastatic cancer shall not limit or exclude coverage for a drug that is approved by the Federal Drug Administration (FDA) and that is on the insurer's prescription drug formulary by mandating that a covered person with Stage 4 advanced metastatic cancer undergo step therapy.
(b) Provides that if coverage of a prescription drug for treatment of any medical condition is restricted by the insurer, or their utilization review organization because of a step therapy protocol, the health care insurer or utilization review organization must provide a covered person, and his/her provider, with access to a clear, convenient, and readily accessible process to request a step therapy exception determination.
(c) A step therapy exception determination shall be granted if the covered person has tried the step therapy required prescription drugs while under a current or previous health insurance policy.
(d) The insurer, or utilization review organization, may request relevant documentation from the covered person or provider to support the exception request.
(e) States that this section shall not be construed to prevent:
    (1) An insurer, or utilization review organization, from requiring a covered person to try a generic equivalent or other brand name drug prior to providing coverage for the requested prescription drug; or
    (2) A provider from prescribing a prescription drug he or she determines is medically appropriate.

Sec 21.07.170. Annual report.

Health care insurers shall submit annual reports, on a form prescribed by the director, detailing their adherence to AS 21.07.100 through AS 21.07.180.

Sec 21.07.180. Compliance and enforcement

(a) Requires that the director shall monitor compliance with the provision of AS 21.07.100 – AS 21.07.180.
(b) States that the examination of an insurer's prior authorization practices shall be consistent with AS 21.06.120 through AS 21.06.230. Examinations shall be performed at least every two years
(c) Provides that if an insurer is found to be non-compliant with the provisions of AS 21.07.100 through AS 21.07.180, the director may impose penalties including fines for each instance of non-compliance, orders to rectify deficiencies within a specified time frame or for suspension or revocation of the insurer's certificate of authority for persistent or severe violations.

(d) Provides that the director shall adopt regulations establishing penalties for noncompliance.

Sec 21.07.190.

Adds definitions for:

(15) Chronic Condition
(16) Covered person
(17) Expedited request
(18) Prior Authorization
(19) Standard request
(20) Step-therapy protocol
(21) Utilization review organization

Section 4. The uncodified laws of the State of Alaksa are amended by adding a new section to read: Transition Regulations providing that the director may adopt regulations necessary to implement this Act.

Section 5. Provides that Section 4 takes effect immediately.

Section 6. Provides that except as provided in Sec 5, this act takes effects on January 1, 2027.