34-LS0780\A
Wallace
3/18/25

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVE RUFFRIDGE

Introduced:
Referred:

A BILL

FOR AN ACT ENTITLED

"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."

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

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

Sec. 21.07.080. Religious nonmedical providers. **AS 21.07.005 - 21.07.090** [THIS CHAPTER] may not be construed to

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

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

(A) apply medically based eligibility standards;

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

person;

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

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

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

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

Article 2. Prior Authorizations.

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

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

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

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

(3) 24 hours after receiving an expedited request.

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

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

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

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

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

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

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

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

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

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

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

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

(2) the date the prior authorization requirement

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 21.07.150. Prior authorization application programming interface. A health care insurer shall maintain a prior authorization application programming interface that automates the process for health care 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. The application programming interface must support the exchange of prior authorization requests and determinations for medical care and prescription drugs, including information on covered alternative prescription drugs. The application programming interface must indicate that a prior authorization denial, an authorization of medical care less intensive than the medical care included in the original request, or an authorization of a prescription drug other than the one included in the original prior authorization request is an adverse benefit determination and is subject to the health care insurer's grievance and appeal process under AS 21.07.005.

Sec. 21.07.160. Step therapy restrictions and exceptions. (a) A health care insurer that provides coverage under a health care insurance policy for the treatment of Stage 4 advanced metastatic cancer may not limit or exclude coverage under the health benefit plan for a drug that is approved by the United States Food and Drug Administration 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 if the use of the approved drug is an approved indication by the United States Food and Drug Administration or on the National Comprehensive Cancer Network Drugs and Biologics Compendium as an indication for the treatment of Stage 4 advanced metastatic cancer consistent with Category 1 or Category 2A of evidence and consensus or peer-reviewed medical literature.

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

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

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

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

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

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

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

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

(1) documentation of compliance with prior authorization response

times and other prior authorization requirements;

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

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

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

(5) any other information required by the director.

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

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

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

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

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

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

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

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

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

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

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

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