Alaska State Legislature

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Representative Justin Ruffridge
District 7 - Kenai/Soldotna

# HB 144 Version A
# Sponsor Statement

We have heard from Alaskans about the burden they face when seeking prior approval, or prior authorization for medical treatment, procedures, or medication.

Healthcare industry stakeholders convened numerous meetings over the interim to craft a bill that would address prior authorization and work for patients, providers, regulators, and insurers alike. These meetings culminated in House Bill 144.

HB 144 requires a process for prior authorization that is easily understood by both healthcare providers and their patients. It establishes time frames for approvals, as well as directions that must be followed if the insurer does not receive sufficient information to make a determination or if an adverse determination is made. It also outlines specific communication requirements between the insurer and provider regarding the process and when any changes to the process may be implemented.

The bill encourages the use of electronic data transmission through the insurers' website or a portal to safeguard patients' information, providing efficiencies for both healthcare providers and insurers.

HB 144 provides direction on the length of time a prior authorization may be granted for a chronic condition and how the prior authorization will be renewed when appropriate. It also provides direction on how the insurer is to implement step therapy protocols for patients with Stage 4 advanced metastatic cancer that allow the patient an expedient way to receive the treatment or prescription drugs that they need as quickly as possible.

HB 144 establishes that the Director of the Division of Insurance shall include in the division's annual report an update on the program's use, including statistics on approval time frames and other key metrics. Finally, the bill provides the Director with the authority to monitor compliance and enforcement.

34-LS0780\N
Wallace
4/1/25

**CS FOR HOUSE BILL NO. 144(HSS)**

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - FIRST SESSION

**BY THE HOUSE HEALTH AND SOCIAL SERVICES COMMITTEE**

**Offered:**
**Referred:**

**Sponsor(s): REPRESENTATIVE RUFFRIDGE**

**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.** <u>AS 21.07.005 - 21.07.090</u> [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.

**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;

(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.

# HOUSE BILL NO. 144

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH LEGISLATURE - FIRST SESSION

**BY REPRESENTATIVE RUFFRIDGE**

**Introduced: 3/21/25**
**Referred: Health and Social Services, Labor and Commerce**

## 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.** <u>**AS 21.07.005 - 21.07.090**</u> [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.

Alaska State Legislature

Session:
Alaska State Capitol
Juneau, AK 99801-1182
Office: (907) 465-2693

Interim:
145 Main St Loop
Kenai, AK 99611
Office: (907) 283-2690

Representative Justin Ruffridge
District 7 - Kenai/Soldotna

# HB 144-INSURANCE; PRIOR AUTHORIZATIONS
# Sectional Summary – Ver A

*This is a summary only. Please note that this summary should not be considered an authoritative interpretation of the bill; the bill itself is the definitive statement of its contents.*

**Section 1.** AS 21.07.080 is amended to make conforming changes, preserving the original intent by citing AS 21.07.005-21.07.090 (the original chapter contents).

**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. 21.07.120. 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.
(b) 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.
(c) 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.

**<u>Section 3.</u> Sec 21.07.250 is amended to**

Add 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.

# Fiscal Note

State of Alaska
2025 Legislative Session

Bill Version: HB 144
Fiscal Note Number:
() Publish Date:

Identifier: HB144-DCCED-DOI-03-28-25
Title: INSURANCE; PRIOR AUTHORIZATIONS
Sponsor: RUFFRIDGE
Requester: House Health and Social Services

Department: Department of Commerce, Community and Economic Development
Appropriation: Insurance Operations
Allocation: Insurance Operations
OMB Component Number: 354

**Expenditures/Revenues**

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

| | FY2026 Appropriation Requested | Included in Governor's FY2026 Request | Out-Year Cost Estimates | | | | |
|---|---|---|---|---|---|---|---|
| **OPERATING EXPENDITURES** | **FY 2026** | **FY 2026** | **FY 2027** | **FY 2028** | **FY 2029** | **FY 2030** | **FY 2031** |
| Personal Services | | | | | | | |
| Travel | | | | | | | |
| Services | | | | | | | |
| Commodities | | | | | | | |
| Capital Outlay | | | | | | | |
| Grants & Benefits | | | | | | | |
| Miscellaneous | | | | | | | |
| **Total Operating** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |

**Fund Source (Operating Only)**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| None | | | | | | | |
| **Total** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |

**Positions**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Full-time | | | | | | | |
| Part-time | | | | | | | |
| Temporary | | | | | | | |

**Change in Revenues**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| None | | | | | | | |
| **Total** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** | **0.0** |

**Estimated SUPPLEMENTAL (FY2025) cost:** 0.0 *(separate supplemental appropriation required)*

**Estimated CAPITAL (FY2026) cost:** 0.0 *(separate capital appropriation required)*

**Does the bill create or modify a new fund or account?** No

*(Supplemental/Capital/New Fund - discuss reasons and fund source(s) in analysis section)*

**ASSOCIATED REGULATIONS**

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? Yes
If yes, by what date are the regulations to be adopted, amended or repealed? 01/01/27

**Why this fiscal note differs from previous version/comments:**

Not applicable; initial version.


Prepared By: Lori Wing-Heier, Division Director — Phone: (907)269-7896
Division: Division of Insurance — Date: 03/28/2025
Approved By: Hannah Lager, Administrative Services Director — Date: 03/28/25
Agency: Department of Commerce, Community, and Economic Development

**FISCAL NOTE ANALYSIS**

**STATE OF ALASKA** **BILL NO.** HB144
**2025 LEGISLATIVE SESSION**

## Analysis

HB 144 establishes designation of prior authorization processes of health care insurers that complies with the standards for prior authorizations for medical care and prescription drugs in AS 21.07.100 - 21.07.180 to minimize administrative burdens on health care providers and facilities. This legislation will require health care insurers to provide a report to the Director of the Division of Insurance and will require the director to monitor compliance with the provisions of AS 21.07.100 - AS 21.07.180, as well as adopt regulations establishing penalties for noncompliance with AS 21.07.100 - 21.07.180.

The Division of Insurance anticipates minor fiscal impact ($7.5) in FY2027 for regulations review with the Department of Law. This cost will be absorbed by the division.

# HB 144
# Prior Authorization

Representative Justin Ruffridge

# Issue

- Need for Prior Authorization (PA) before obtaining services.
- Time
- Individuals with Chronic Conditions.
- Crafting a solution that takes into account the needs and protocols for all parties.

# Solution contained in HB 144

- Over the past year, numerous meetings between stakeholders.
- Easy to understand process.
- Establish timelines
- Enforcement

# HB 144 specifies times

- Easy to understand by patients and healthcare providers.
- Process must be reasonable and efficient.
- Determination with 72 hours for standard request.
- 24 hours for an expedited request.
- Prior Authorization request is approved if timeline is not met under.

# Process for incomplete information

- If more information is needed to make a determination, the insurer shall send a request within one calendar day for an expedited request and three calendar days for a standard request.
- Information due to the insurer between five to 14 days.

# Prior Authorization process improvements

- PA standards listed on the health care insurer's website or portal (both locations if available).
- PA criteria based on peer-reviewed, evidenced-based clinical review criteria.
- Consistently applied by all sources including Utilization Review Organizations.

# Favorable to patients

- Patients benefit…if the standards by the insurer and the utilization review organization are different.
- For each service, the insurer must list:
  - If a prior authorization process is necessary.
  - Date the requirement became effective

# Chronic Conditions

- PA is valid for not less than 12 months.
- Automatic renewal if condition remains unchanged.
- Stage 4 metastatic cancer/Step therapy.

# Accountability and Compliance

- Dept of Insurance Director shall monitor compliance.
- Examination of health care insurers at least every two years:
  - PA response times and adherence to timeframes.
  - Accuracy and completeness of PA requirements.
  - Consistency of PA practices by Utilization Review Organizations and Third-Party Administrators.

# Enforcement

- The director may impose penalties
  - May impose a penalty for each instance of noncompliance
  - Persistent or severe violations may warrant suspension or revocation of health insurer’s certificate of authority

# Questions?

Representative Justin Ruffridge

Rep.Justin.Ruffridge@akleg.gov

(907) 465-2693

ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

March 25, 2025

Representative Justin Ruffridge
State Capitol Room 424
Juneau AK, 99801
Representative.Justin.Ruffridge@akleg.gov

**RE: AHHA Supports House Bill 144 – Prior Authorization**

Dear Representative Ruffridge,

For over 70 years, the Alaska Hospital & Healthcare Association (AHHA) has served as a non-profit trade association representing Alaska's hospitals, nursing homes, and a growing number of healthcare partners across the continuum of care. AHHA members play an invaluable role, both as community providers and essential employers, in cities, towns, and villages across Alaska.

**AHHA strongly supports HB 144, and we thank Representative Ruffridge for introducing this important piece of legislation.**

Prior authorization is a review process commonly used by insurers that essentially requires healthcare providers to obtain express authorization to provide a specific treatment or procedure for their patients. While prior authorization can be useful for reviewing the appropriateness of medical care, it can also cause significant delays in necessary, urgent patient treatment.

We hear story after story about time-consuming appeals, endless paperwork, lack of consistency and transparency, and needless interruptions to treatment when patients are at their most vulnerable. This has contributed to a contentious relationship between providers and insurers in Alaska and across the country.

AHHA spent the interim working to align insurers, providers, and regulators around shared priorities. To start, we partnered with our member hospitals to identify practical, workable solutions to the prior authorization challenges. We then engaged with the Division of Insurance to assess feasibility and impact from a regulatory perspective. From there, discussions with insurers revealed common ground, making it clear that we could agree to concrete reforms to improve the prior authorization process.

HB 144 is the result of this collaborative effort. The bill has the strong backing of Alaska's hospitals through AHHA, physicians via the Alaska State Medical Association, and the state's major health insurers. The bill prioritizes system automation and injects a new level of transparency for prior authorization, including policies, peer review and appeals, enforcement, and accountability.

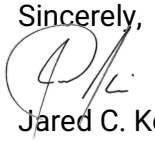
HB 144 also includes the following reforms that will have an immediate and positive impact on patients:

- Faster turnaround times for decisions – from five working days to 72 hours
- Long-term approval for treatments concerning chronic conditions
- Prohibit restrictions on key therapies for Stage Four Advanced Metastatic Cancer
- A clear process for requesting exceptions to step therapy requirements

Finally, AHHA is proud of the work that went into HB 144 and is grateful to Representative Ruffridge for bringing this legislation forward. This bill exemplifies effective, stakeholder-driven reform that will create lasting improvements in patient care. We strongly support HB 144 and urge the committee to swiftly consider and pass this bill.

Thank you for considering this request and for your commitment to advancing healthcare for Alaska.

Sincerely,



Jared C. Kosin, JD, MBA
President & CEO

central peninsula hospital

March 21, 2025

The Honorable Genevieve Mina
Chair, House Health & Social Services Committee
Alaska State Legislature
Capitol Building, Room 106
Juneau, Alaska 99801

**Subject: Support for House Bill 144 – Prior Authorization**

Dear Chair Mina:

I am writing to you on behalf of Central Peninsula Hospital to express our strong support for House Bill 144, which aims to improve the prior authorization process.

Central Peninsula Hospital is committed to providing high-quality, efficient care to our community. However, the current prior authorization process often creates unnecessary delays and administrative burdens for our patients. House Bill 144's provisions, such as the establishment of clear timelines for responses, the requirement for transparent and evidence-based standards, and implementation of a prior authorization application programming interface, will streamline the process and enhance patient access to timely care.

This legislation makes prior authorization standards that ensures transparency, establishes a process for health care providers to request a clinical peer review of a prior authorization request. In addition, it ensures that clinical expertise is considered in the decision-making process, mandates that prior authorizations for chronic conditions are valid for a minimum of 12 months and reduces the administrative burden associated with ongoing care. These are all positive improvements over todays prior authorization process!

We believe this legislation will have a positive impact on the delivery of care in Alaska, and we urge you hear and move this legislation as quickly as possible. Thank you for your leadership on this important issue.

Sincerely,

Shaun Keef
CEO
Central Peninsula Hospital

CC: Representative Justin Ruffridge

April 1, 2025

Representative Mina, Chair
House Health & Social Services Committee
State Capitol Room 106
Juneau, AK 99801
House.Health.And.Social.Services@akleg.gov

**RE: Heritage Place Supports House Bill 144 – Prior Authorization**

Dear Chair Mina and Committee Members,

**Heritage Place** is a 60-bed Long-Term Care Facility centrally located on the Kenai Peninsula, dedicated to serving our community's most vulnerable residents. Our mission is to provide the highest quality of care, and to this end, we strongly support **HB 144**.

Currently, the prior authorization process causes significant delays in providing timely care for our residents. These delays are particularly concerning given that our residents often have frail, compromised health, and lack the physical reserves to endure the wait for essential treatments. Each delay in care puts our vulnerable population at further risk, underscoring the urgent need for reform.

HB 144 is important because it brings much needed reforms to the prior authorization process that will help our residents. Speeding up turnaround time for prior authorization decisions, providing long-term prior authorization for treatment of chronic conditions, prohibiting restrictions on key therapies for advanced cancer, requiring an exception process to step therapy, increasing transparency and accountability, and prioritizing automation, are all positive steps for improving access to timely, quality care in our state. Please pass HB 144.

Thank you for your work in addressing healthcare challenges for Alaska.

Sincerely,

Cathy Reaktenwalt MSN, RN-BC, LNHA
Administrator, Director of Nursing

Heritage Place
232 W. Rockwell Ave.
Soldotna, AK 99669
907-714-5072

creaktenwalt@cpgh.org

# Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 215-3305 (fax)


March 31, 2025

Representative Genevieve Mina, Chair
House Health and Social Services
Juneau AK, 99801
House.Health.and.Social.Services@alaska.gov

RE: ASMA Support for House Bill 144 – Prior Authorization

Dear Representative Mina:

On behalf of the Alaska State Medical Association (ASMA), I am writing to express our strong support for House Bill 144, which addresses prior authorization processes for medical care covered by health care insurers.

This legislation represents a significant step toward improving access to timely and necessary medical care for Alaskans. By streamlining prior authorization requests and incorporating an application programming interface, HB 144 reduces administrative burdens on healthcare providers and ensures that patients receive the care they need without unnecessary delays.

The provisions related to step therapy offer a balanced approach to treatment protocols, prioritizing patient health and safety while maintaining cost-effective care.

Additionally, the peer-to-peer review criteria will greatly reduce physician frustration with having to explain current standard of care to a physician reviewer who is often not familiar with the best practices in the provider's medical specialty.

ASMA believes that HB 144 aligns with our mission to advocate for policies that enhance the quality and accessibility of healthcare in Alaska. We urge the legislature to pass this bill and stand ready to provide any assistance or testimony needed to support its enactment.

Thank you for your leadership and commitment to the health and well-being of Alaskans.

Sincerely,

Pam Ventgen

Pam Ventgen, Executive Director, Alaska State Medical Associatio

FOUNDATION
HEALTH PARTNERS

(907) 458-5300 Phone
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www.foundationhealth.org
1650 Cowles Street
Fairbanks, AK 99701

April 1, 2025

Representative Genevieve Mina, Chair
House Health & Social Services Committee
State Capitol
Juneau, AK 99801
House.Health.And.Social.Services@akleg.gov

Re: Support for HB 144 – Prior Authorizations

Dear Chairwoman Mina and Committee Members:

Foundation Health Partners (FHP) is a wholly owned subsidiary of The Greater Fairbanks Community Hospital Foundation operating Fairbanks Memorial Hospital, Denali Center, and Tanana Valley Clinic. As a healthcare system dedicated to providing a full continuum of health care services to Interior and Northern Alaska residents, FHP recognizes the urgent need to reform prior authorization processes to improve patient care and alleviate administrative burdens on providers.

Prior authorization, while intended to ensure the appropriateness of medical treatments, has become a significant barrier to timely patient care. Hospitals and healthcare providers across the state, including those under FHP, continually face delays caused by inefficient and inconsistent prior authorization requirements. These delays can lead to negative health outcomes, particularly for patients requiring urgent or ongoing treatment.

FHP's patients, families, and neighbors have countless stories about how the current prior authorization system has caused delays and failures in communication. HB 144 introduces much-needed reforms that will benefit both healthcare providers and the patients we serve by reducing delays in patient care, enhancing transparency and efficiency, protecting patients with chronic and advanced conditions, and establishing clear exceptions for step therapy.

These reforms will enable FHP and other healthcare providers to focus on what matters most—delivering high-quality, timely care to our patients. By addressing the inefficiencies and inconsistencies that have long plagued prior authorization, HB 144 ensures that Alaska's hospitals can operate more effectively and improve health outcomes statewide.

Foundation Health Partners is proud to support this collaborative, stakeholder-driven reform and urges the committee to advance HB 144 for the benefit of all Alaskans. Thank you for your commitment to improving healthcare access and efficiency in our state.

Sincerely,

Shelley D. Ebenal
Chief Executive Officer
Foundation Health Partners

ALASKA NATIVE HEALTH BOARD

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM
ALEUTIAN PRIBILOF ISLANDS ASSOCIATION
ARCTIC SLOPE NATIVE ASSOCIATION
BRISTOL BAY AREA HEALTH CORPORATION
CHICKALOON VILLAGE TRADITIONAL COUNCIL
CHUGACHMIUT
COPPER RIVER NATIVE ASSOCIATION
COUNCIL OF ATHABASCAN TRIBAL GOVERNMENTS
EASTERN ALEUTIAN TRIBES
KARLUK IRA TRIBAL COUNCIL
KENAITZE INDIAN TRIBE
KETCHIKAN INDIAN COMMUNITY
KODIAK AREA NATIVE ASSOCIATION
MANIILAQ ASSOCIATION
METLAKATLA INDIAN COMMUNITY
MT. SANFORD TRIBAL CONSORTIUM
NATIVE VILLAGE OF EKLUTNA
NATIVE VILLAGE OF EYAK
NATIVE VILLAGE OF TYONEK
NINILCHIK TRADITIONAL COUNCIL
NORTON SOUND HEALTH CORPORATION
SELDOVIA VILLAGE TRIBE
SOUTHCENTRAL FOUNDATION
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM
TANANA CHIEFS CONFERENCE
YAKUTAT TLINGIT TRIBE
YUKON-KUSKOKWIM HEALTH CORPORATION
VALDEZ NATIVE TRIBE

# Alaska Native Health Board

**THE VOICE OF ALASKA TRIBAL HEALTH SINCE 1968**

T 907.729.7510 F 907.729.7506 • 4000 Ambassador Drive (ANHB Office) • Anchorage, Alaska 99508 • **www.anhb.org**

April 1, 2025

*Transmitted via email*: House.Health.And.Social.Services@akleg.gov

Representative Genevieve Mina, Chair
House Health & Social Services Committee
State Capitol Room 106
Juneau, AK 99801

RE: Support for House Bill 144: Insurance - Prior Authorization

Dear Chair Mina and Committee Members,

The Alaska Native Health Board (ANHB)[1] writes to express our support for House Bill (HB) 144 Prior Authorization. Prior authorization is a review process commonly used by insurers that requires healthcare providers to obtain authorization to provide a specific treatment or procedure for their patients. While prior authorization can be useful for reviewing the appropriateness of medical care, it can also cause significant delays in necessary, urgent patient treatment.

Across the Alaska Tribal Health System, the current prior authorization process serves as an administrative challenge to our ability to provide healthcare services and medications in a timely and efficient manner. To preserve limited healthcare resources for direct patient care, it is critical that we work together to improve the existing prior approval process through a collaborative and coordinated effort. HB 144 is a product of this effort, representing a significant step in strengthening our care delivery system and the health of the patients we serve.

HB 144 is important because it brings much-needed reforms to the prior authorization process that will help patients. Speeding up turnaround time for prior authorization decisions, providing long-term prior authorization for treatment of chronic conditions, prohibiting restrictions on key therapies for advanced cancer, requiring an exception process to step therapy, increasing transparency and accountability, and prioritizing automation, are all positive steps for improving access to timely, quality care in our state.

[1] ANHB was established in 1968 to promote the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people. ANHB is the statewide voice on Alaska Native health issues and is the advocacy organization for the Alaska Tribal Health System (ATHS), which is comprised of Tribal health programs that serve all 229 Tribes and over 234,000 Alaska Native and American Indian people throughout the state. As the statewide Tribal health advocacy organization, ANHB supports Alaska's Tribes and Tribal programs to achieve effective consultation and communication with state and federal agencies on matters of concern.

We urge the Legislature to advance HB 144. Thank you for your leadership and commitment to the well-being of all of Alaskans. If you have any comments or questions regarding this letter, please contact ANHB at anhb@anhb.org or (907) 729-7510.

Sincerely,

Chief William F. Smith, Chairman
Alaska Native Health Board