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Sectional Analysis
Senate Bill 219 v. A
"An Act relating to utilization review entities; exempting certain health care providers from making preauthorization requests for certain services; and providing for an effective date."

Section 1: Amends AS 21 (Insurance) .07 (Patient Protections Under Health Care Insurance Policies) .005 (Regulations relating to health care insurance policies).
Page 1, line 5, through line 14: Adds processes for the Director of Insurance to adopt regulations for utilization review entities, who are individuals that perform prior authorization, as established under section 2 of this bill.

Section 2: Adds a new section .100 (Utilization review entities) to AS 21 (Insurance) .07 (Patient Protections Under Health Care Insurance Policies)
Page 2, line 1 through line 7: Adds section (a) which explains a healthcare provider is not required to complete prior authorization for a covered person if at least 80 percent of prior authorization requests submitted by the provider for that health care service have been approved in the past 12 months.

Page 2, line 8 through line 12: Adds section (b) which explains a health care provider may be evaluated if they continue to qualify for an exemption not more than once every 12 months, and an existing exemption is not required to be evaluated and a longer exemption period may be established.

Page 2, line 13 through 14: Adds section (c) which explains health care providers do not have to request an exemption to qualify for an exemption.

Page 2, line 15 through 20: Adds section (d) which explains if a health care provider is denied an exemption, they may request evidence once every 12 months on why they were denied an exemption and an explanation of how to appeal the denial, and the health care provider may appeal the denial.

Page 2, line 21 through line 30: Adds section (e) which explains utilization review entities may revoke an exemption after 12 months if: (1) they determine the health care provider does not meet the 80 percent approval criteria based on a review of the claims for the health care service for which the exemption applies, (2) they provide the health care provider with the information used to determine revoking the exemption, (3) they explain to the health care provider how to appeal the determination.

Page 2, line 31 through page 3, line 3: Adds section (f) which explains the exemption remains in effect until 30 days after the health care provider is notified of the decision to revoke the exemption or, if the health care provider appeals the determination, five days after the revocation is kept after appeal.

Page 3, line 4 through line 8: Adds section (g) which specifies a decision to revoke or deny an exemption by a utilization review entity must be made by a health care provider licensed in Alaska with the same or similar specialty as the health care provider being considered and must have experience providing the health care service for which the requested exemption applies.

Page 3, line 9 through 13: Adds section (h) which specifies a utilization review entity must provide a health care provider who receives an exemption of this section with a notice that includes: (1) a statement that the health care provider qualifies for an exemption from a prior authorization requirement and the duration of the exemption, (2) a list of health care services for which the exemption applies.

Page 3, line 14 through line 23: Adds section (i) which specifies utilization review entities may not deny or reduce payment for a health care service exempted from prior authorization, including a health care service ordered by an exempted health care provider that is performed or supervised by another health care provider, unless the health care provider providing the health care service: (1) knowingly misrepresented the health care service in a request for payment with the specific intent to deceive and obtain an unlawful payment from a utilization review entity or, (2) failed to substantially perform the health care service.

Page 3, line 24 through page 4, line 19: Adds section (j) which defines in this section:

(1) "health care service" means: (A) the provision of pharmaceutical products, services, or durable medical equipment or, (B) a health care procedure, treatment, or service provided: (i) in a health care facility licensed in this state or, (ii) by a doctor of medicine, by a doctor of osteopathy, or within the scope of practice of a health care professional who is licensed in this state.

(2) "health maintenance organization" has the meaning given in AS 21.86.900 (means a person that undertakes to provide or arrange for basic health care services to enrollees on a prepaid basis).

(3) "prior authorization" means the process used by a utilization review entity to determine the medical necessity or medical appropriateness of a covered health care service before the health care service is provided or a requirement that a covered person or health care provider notify a health care insurer or utilization review entity before providing a health care service.

(4) "utilization review entity" means an individual or entity that performs prior authorization for: (A) an employer in Alaska with employees covered under a health benefit plan or health insurance policy, (B) a health care insurer, (C) a preferred provider organization, (D) a health maintenance organization or, (E) an individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health care benefits to a person treated by a health care provider licensed in Alaska under a health care policy, plan, or contract.

Section 3: Effective date. Provides an immediate effective date.