

**SENATE BILL NO. 219**

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-THIRD LEGISLATURE - SECOND SESSION

BY SENATOR WILSON

Introduced: 2/7/24

Referred: Labor and Commerce, Health and Social Services

**A BILL**

**FOR AN ACT ENTITLED**

1 **"An Act relating to utilization review entities; exempting certain health care providers**  
2 **from making preauthorization requests for certain services; and providing for an**  
3 **effective date."**

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

5 \* **Section 1.** AS 21.07.005(a) is amended to read:

6 (a) The director shall adopt regulations to provide standards and criteria for

7 (1) the structure and operation of utilization review and benefit  
8 determination processes, **including processes for utilization review entities under**  
9 **AS 21.07.100;**

10 (2) the establishment and maintenance of procedures by health care  
11 insurers to ensure that a covered individual has the opportunity for appropriate  
12 resolution of grievances; and

13 (3) an independent review of an adverse determination or final adverse  
14 determination.

1 \* **Sec. 2.** AS 21.07 is amended by adding a new section to read:

2           **Sec. 21.07.100. Utilization review entities.** (a) A utilization review entity may  
3 not require a health care provider to complete a prior authorization for a health care  
4 service for a covered person to receive coverage for the health care service if, during  
5 the most recent 12-month period, the utilization review entity has approved or would  
6 have approved at least 80 percent of the prior authorization requests submitted by the  
7 health care provider for that health care service.

8           (b) A utilization review entity may evaluate whether a health care provider  
9 continues to qualify for an exemption under (a) of this section not more than once  
10 every 12 months. A utilization review entity is not required to evaluate an existing  
11 exemption, and nothing prevents a utilization review entity from establishing a longer  
12 exemption period.

13           (c) A health care provider is not required to request an exemption to qualify  
14 for an exemption.

15           (d) If a health care provider does not receive an exemption under (a) of this  
16 section, the health care provider may, once every 12 months of providing health care  
17 services, request the utilization review entity to provide evidence to support its  
18 determination. A health care provider may appeal a determination to deny a prior  
19 authorization exemption under (a) of this section. The utilization review entity shall  
20 provide to the health care provider an explanation of how to appeal the determination.

21           (e) A utilization review entity may revoke an exemption under (a) of this  
22 section after 12 months if the utilization review entity

23                   (1) makes a determination that the health care provider would not have  
24 met the 80 percent approval criteria based on a retrospective review of the claims for  
25 the health care service for which the exemption applies for the previous three months  
26 or the period needed to reach a minimum of 10 claims for review;

27                   (2) provides the health care provider with the information used by the  
28 utilization review entity to make the determination to revoke the exemption; and

29                   (3) provides an explanation to the health care provider on how to  
30 appeal the determination.

31           (f) An exemption under (a) of this section remains in effect until the 30th day

1 after the date the utilization review entity notifies the health care provider of its  
 2 determination to revoke the exemption or, if the health care provider appeals the  
 3 determination, the fifth day after the revocation is upheld on appeal.

4 (g) A determination to revoke or deny an exemption by a utilization review  
 5 entity must be made by a health care provider licensed in the state with the same or a  
 6 similar specialty as the health care provider being considered for an exemption and  
 7 must have experience in providing the health care service for which the requested  
 8 exemption applies.

9 (h) A utilization review entity must provide a health care provider who  
 10 receives an exemption under (a) of this section with a notice that includes a

11 (1) statement that the health care provider qualifies for an exemption  
 12 from a prior authorization requirement and the duration of the exemption; and

13 (2) list of health care services for which the exemption applies.

14 (i) A utilization review entity may not deny or reduce payment for a health  
 15 care service exempted from a prior authorization requirement under (a) of this section,  
 16 including a health care service performed or supervised by another health care  
 17 provider when the health care provider who ordered the service received a prior  
 18 authorization exemption, unless the health care provider providing the health care  
 19 service

20 (1) knowingly and materially misrepresented the health care service in  
 21 a request for payment submitted to the utilization review entity with the specific intent  
 22 to deceive and obtain an unlawful payment from a utilization review entity; or

23 (2) failed to substantially perform the health care service.

24 (j) In this section,

25 (1) "health care service" means

26 (A) the provision of pharmaceutical products, services, or  
 27 durable medical equipment; or

28 (B) a health care procedure, treatment, or service provided

29 (i) in a health care facility licensed in this state; or

30 (ii) by a doctor of medicine, by a doctor of osteopathy,

31 or within the scope of practice of a health care professional who is

1 licensed in this state;

2 (2) "health maintenance organization" has the meaning given in  
3 AS 21.86.900;

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

9 (4) "utilization review entity" means an individual or entity that  
10 performs prior authorization for

11 (A) an employer in this state with employees covered under a  
12 health benefit plan or health insurance policy;

13 (B) a health care insurer;

14 (C) a preferred provider organization;

15 (D) a health maintenance organization; or

16 (E) an individual or entity that provides, offers to provide, or  
17 administers hospital, outpatient, medical, prescription drug, or other health care  
18 benefits to a person treated by a health care provider licensed in this state  
19 under a health care policy, plan, or contract.

20 \* **Sec. 3.** This Act takes effect immediately under AS 01.10.070(c).