

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

March 26, 2024

3:04 p.m.

MEMBERS PRESENT

Representative Mike Prax, Chair
Representative Justin Ruffridge, Vice Chair
Representative CJ McCormick
Representative Dan Saddler
Representative Jesse Sumner
Representative Zack Fields
Representative Genevieve Mina

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

HOUSE BILL NO. 187

"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."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 187

SHORT TITLE: PRIOR AUTH EXEMPT FOR HEALTH PROVIDERS

SPONSOR(S): REPRESENTATIVE(S) SUMNER

05/03/23	(H)	READ THE FIRST TIME - REFERRALS
05/03/23	(H)	HSS, L&C
02/15/24	(H)	HSS AT 3:00 PM DAVIS 106
02/15/24	(H)	Heard & Held
02/15/24	(H)	MINUTE(HSS)
03/14/24	(H)	HSS AT 3:00 PM DAVIS 106
03/14/24	(H)	Heard & Held
03/14/24	(H)	MINUTE(HSS)
03/21/24	(H)	HSS AT 3:00 PM DAVIS 106
03/21/24	(H)	<Bill Hearing Canceled>
03/26/24	(H)	HSS AT 3:00 PM DAVIS 106

WITNESS REGISTER

GREG LOUDON, Principal
Parker, Smith & Feek Insurance, LLC
Anchorage, Alaska

POSITION STATEMENT: Gave invited testimony in opposition to HB 187.

GARY STRANNIGAN, Vice President
Congressional and Legislative Affairs
Premera Blue Cross
Everett, Washington

POSITION STATEMENT: Gave invited testimony on HB 187.

LORI WING-HEIER, Director
Division of Insurance
Department of Commerce, Community & Economic Development
Anchorage, Alaska

POSITION STATEMENT: Answered committee questions related to HB 187.

MARC REECE, Director
Public Policy
Aetna, Inc
Denver, Colorado

POSITION STATEMENT: Answered committee questions related to HB 187.

EZEQUIEL "ZEKE" SILVA III, MD, Chair
Specialty Society Relative Value Scale Update Committee
American Medical Association; Chair
Council on Legislation
Texas Medical Association
San Antonio, Texas

POSITION STATEMENT: Answered questions during the hearing on HB 187.

PAM VENTGEN, Executive Director
Alaska State Medical Association
Anchorage, Alaska

POSITION STATEMENT: Gave invited testimony on HB 187.

JEFF DAVIS, President
Radiation Business Solutions
Wenatchee, Washington

POSITION STATEMENT: Gave invited testimony on HB 187.

SHEELA TOLLMAN, Vice President
External Affairs
UnitedHealth Group, Inc.
Seattle, Washington

POSITION STATEMENT: Gave invited testimony on HB 187.

ACTION NARRATIVE

[3:04:45 PM](#)

CHAIR PRAX called the House Health and Social Services Standing Committee meeting to order at 3:04 p.m. Representatives Ruffridge, Saddler, Sumner, Fields, Mina, McCormick, and Prax were present at the call to order.

HB 187-PRIOR AUTH EXEMPT FOR HEALTH PROVIDERS

[3:05:47 PM](#)

CHAIR PRAX announced that the only order of business would be HOUSE BILL NO. 187, "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."

[3:08:09 PM](#)

GREG LOUDON, Principal, Parker, Smith & Feek Insurance, LLC, gave invited testimony in opposition to HB 187. He explained that Parker, Smith & Feek has concerns that HB 187 could possibly promote fraud and medically unnecessary treatments.

[3:10:24 PM](#)

REPRESENTATIVE FIELDS asked Mr. Loudon for clarification as to how Parker, Smith & Feek, LLC approaches prior authorization on treatments.

MR. LOUDON replied that the way Parker, Smith & Feek, LLC approaches prior authorization is precedent to all insurance companies.

[3:11:33 PM](#)

REPRESENTATIVE RUFFRIDGE asked Mr. Loudon to explain how prior authorization could prevent fraud, waste, and abuse.

MR. LOUDON explained that there are examples of medical waste in the insurance industry, but the goal is to avoid that through proper prior authorization.

REPRESENTATIVE RUFFRIDGE commented in agreement with Mr. Loudon that medical waste does exist and asked how the insurance company "knows best" when it comes to diagnosing a medical issue.

MR. LOUDON replied that none of the health plans offered by insurance companies are trying to practice medicine, rather they are trying to provide a different perspective on insurance authorization requests.

REPRESENTATIVE RUFFRIDGE asked if a prior authorization's denial is an exercise of influence over the top of an insurance provider.

MR. LOUDON answered that the fact is that some of the services requested by a provider or patient are not medically necessary.

[3:14:44 PM](#)

REPRESENTATIVE MINA asked what percentage of services under the Pacific Health Coalition's (PHC's) health plan require prior authorization and further questioned how many of those services' prior authorization requests get disapproved.

MR. LOUDON replied that he does not have an idea of statistics at the moment.

REPRESENTATIVE MINA asked if PHC works to reduce the wait time for prior authorization requests.

MR. LOUDON answered yes, PHC does work to reduce wait time for prior authorization requests, and he added that Aetna, Inc. processes all of the prior authorization requests for PHC.

REPRESENTATIVE MINA commented that she would like more specifics related to the encouragement of streamlining of prior authorization and asked for examples related to difficulties that insurance providers face when processing prior authorization requests.

MR. LOUDON answered that he would defer his answer to someone else because PHC does not handle prior authorization requests directly.

3:18:21 PM

GARY STRANNIGAN, Vice President, Congressional and Legislative Affairs, Premera Blue Cross, gave invited testimony on HB 187. He explained that the role of insurance companies as it relates to their oversight of prior authorization is to provide a different perspective on the grants and authorization while not obstructing proper medical care. He cited a piece of legislation in the State of Washinton and explained how it addresses the issue of prior authorization, and he detailed how Alaska could follow suit by mirroring those policies.

3:22:59 PM

REPRESENTATIVE RUFFRIDGE asked what the average time for a prior authorization requests' approval is for Alaska.

MR. STRANNIGAN answered under five days for standard turnaround times and under one day for urgent requests.

REPRESENTATIVE RUFFRIDGE asked if the goal that the State of Washington set with its prior authorization bill was met on behalf of Premera Blue Cross.

MR. STRANNIGAN said yes, Premera Blue Cross is granting requests in under three days as outlined by Washington's legislation.

REPRESENTATIVE RUFFRIDGE asked where Premera Blue Cross got its figure of \$120 million in fraud if HB 187 were to become law.

MR. STRANNIGAN explained that the fraud is actually specific to a set of out-of-state providers, who are providing a false residency scheme in Alaska.

3:27:25 PM

LORI WING-HEIER, Director, Division of Insurance, Department of Commerce, Community & Economic Development, answered committee questions related to HB 187. In response to a request from Representative Saddler, she clarified for the committee that the \$120 million figure is in incurred claims, not paid claims. She said that she has Department of Health (DOH) investigators knocking on doors to verify residency and existence and added that "body brokers" [insurance scammers] are disproportionately targeting Alaska Natives, American Indians, and people experiencing homelessness.

[3:30:21 PM](#)

CHAIR PRAX asked if prior authorization could help control body brokers.

MS. WING-HEIER answered that removing prior authorization would not help with residency scams.

[3:31:41 PM](#)

REPRESENTATIVE FIELDS asked how many people are getting sent to clinics in the Lower 48 and how many are sent to Alaska.

MS. WING-HEIER answered that DOH is not aware of anyone being sent to Alaska and said that most are sent to California.

REPRESENTATIVE RUFFRIDGE commented that he finds this testimony fascinating and shared his opinion that it is not compelling because Ms. Wing-Heier is claiming that prior authorizations are needed in a greater degree when, in fact, they are a process that is currently exacerbating this problem.

MR. STRANNIGAN explained that the point of prior authorization is to verify medical necessity and said it is a vital tool for insurance companies to avoid medical waste.

REPRESENTATIVE RUFFRIDGE asked if downward pressure on insurance scams is helping.

MR. STRANNIGAN replied that the current mode of operations is not working ideally and added that part of the solution is removing friction from the system of prior authorization.

[3:35:35 PM](#)

REPRESENTATIVE MINA asked what percentage of claims received are denied and what percent are approved.

MR. STRANNIGAN said that doesn't know the answer and said he would get back to the committee later.

[3:36:34 PM](#)

CHAIR PRAX asked if it is regulation that prior authorization requests are processed by facsimile ("fax") machine.

MS. WING-HEIER answered that it is not a regulatory requirement for insurance providers to process prior authorization by fax machine, but some providers use those machines because that is the only resource they have.

MR. STRANNIGAN added that Premera Blue Cross has been working to encourage providers to switch to electronic processing.

[3:38:06 PM](#)

REPRESENTATIVE SADDLER asked how electronic processing of prior authorization requests speeds up approvals.

MR. STRANNIGAN answered that he doesn't have any specific data.

REPRESENTATIVE SADDLER asked if Premera Blue Cross tracks the number of claims that require prior authorization.

MR. STRANNIGAN said that Premera Blue Cross does track that data and said he would get the data to the committee in short order.

[3:39:26 PM](#)

CHAIR PRAX asked if Premera Blue Cross is the largest insurance provider in Alaska.

MR. STRANNIGAN confirmed that is correct.

CHAIR PRAX asked whether HB 187 would cover only private insurance or all insurance policies.

MR. STRANNIGAN answered that HB 187 would cover the fully insured marketplace, that being individual plans and small/medium group plans.

CHAIR PRAX asked how the Affordable Care Act (ACA) would affect HB 187.

MS. WING-HEIER answered that the person picks a plan and carrier through ACA.

[3:42:10 PM](#)

MARC REECE, Director, Public Policy, Aetna, Inc, answered committee questions related to HB 187. He explained that the mechanism that most concerns Aetna is the concept of a one-size-fits-all regulation that outlines 80 percent as a threshold for

prior authorization. He said that over 80 percent of prior authorization cases are already granted and detailed the complexities of prior authorization where a proposed blanket regulation might negatively impact a company's ability to verify the necessity of a treatment and avoid medical waste.

[3:47:02 PM](#)

REPRESENTATIVE SUMNER asked whether there is any percent other than 80 that Aetna would be comfortable with.

MR. REECE said that Aetna would not be comfortable with a set percent in statute because each prior authorization request is so different from each other and said that having a blanket regulation would hinder insurance companies and remove nuance from the process of prior authorization approval.

[3:49:02 PM](#)

REPRESENTATIVE RUFFRIDGE asked Mr. Reece if he is a healthcare provider.

MR. REECE answered that he is not a healthcare provider; he is a subject matter expert.

REPRESENTATIVE RUFFRIDGE asked Mr. Reece to describe who decides at Aetna whether a prior authorization request is approved or not.

MR. REECE answered that it depends on the service being requested. He further detailed that the insurance company has someone with unique clinical knowledge related to the prior authorization request and a knowledge of the backdrop of policy. He gave examples of automated prior authorization requests and responses and emphasized that insurance companies are trying to switch to automated electronic prior authorization requests sooner rather than later.

REPRESENTATIVE RUFFRIDGE noted prior authorization serves as sort of a check-and-balance to an already clinically complex medical and policy decision and asked why the onus of a drug treatment falls to the patient rather than the insurance provider.

MR. REECE offered the committee to look into the details of the checklists referenced in prior authorization cases and gave an example of a diabetic patient with the onset of a new condition

that would require a separate prior authorization request and explained how the separate cases and insurance providers would work together to get that person the medical care they need.

REPRESENTATIVE RUFFRIDGE commented that pharmacists exist for the purpose described in Mr. Reece's example and thanked him for his testimony.

[3:58:46 PM](#)

REPRESENTATIVE MINA asked how a provider differentiation program would work.

MR. REECE answered that providers look at member outcome and history of service from that provider to that member. He said that some providers would draw parallels between a provider differentiation program and a blanket percentage for prior authorization approval and said that there is not a one-size-fits-all solution for HB 187.

REPRESENTATIVE MINA asked what percentage of insurance providers is part of the differentiated status and further questioned the specifics of the processes and opportunities of the differentiated status for providers.

MR. REECE replied that he does not have information specific to Alaska, but reassured the committee that there are over 1,000 insurance providers in the nation enrolled in the provider differentiation program and gave an example of how the program is executed in practice.

REPRESENTATIVE MINA asked what actions Aetna has taken to speed up the prior authorization process for patients.

MR. REECE explained that the process of prior authorization is improving day by day. He credited automation of prior authorization cases with the majority of its improvements and clarified again that he does not have any Alaska-specific numbers.

REPRESENTATIVE MINA asked what the percentage of services billed as prior authorization is denied and further asked about the turnaround time for approved cases of prior authorization.

MR. REECE answered that he doesn't have the number for the percentage of services that require prior authorization and added that the percentage of approval/denial for prior

authorization claims is 80 approval and 20 percent denial. He finalized his remarks by saying that the turnaround time for prior authorization cases is generally 5 days for non-urgent cases and less than 24 hours for urgent cases.

[4:07:27 PM](#)

CHAIR PRAX offered his understanding that relatively few procedures compared to the whole of procedures performed by a medical care provider actually required prior authorization.

MR. REECE responded that that is a fair statement.

CHAIR PRAX added to his previous statement that comparing part of prior authorization cases to the total number of prior authorization cases isn't a fair way to describe the issue.

MR. REECE responded that there is logic behind every prior authorization case and said that Aetna takes pride in its improvements in the prior authorization process.

CHAIR PRAX asked what percentage of denied prior authorization request win their appeal case.

MR. REECE replied that he did not have that information currently and would follow up with the committee later.

[4:10:04 PM](#)

REPRESENTATIVE RUFFRIDGE asked for an example of an "urgent" prior authorization request as previously mentioned.

MR. REECE explained that the general idea behind an urgent precertification is that the request is not a medical emergency; however, it could be something like a new drug regimen, an admission to a hospital, or certain medical or surgical procedures. He added that something like a knee replacement wouldn't be considered as "urgent".

REPRESENTATIVE RUFFRIDGE asked Mr. Reece to send to the committee a list of examples of specific cases that would be labeled as "urgent."

[4:12:58 PM](#)

EZEQUIEL "ZEKE" SILVA III, MD, Chair, Specialty Society Relative Value Scale Update Committee, American Medical Association;

Chair, Council on Legislation, Texas Medical Association, answered questions during the hearing on HB 187. He began by saying that Texas passed the first "gold card" bill in the United States and explained the adverse effects of prior authorization in healthcare, attributing declining health and loss of life to prior authorization.

REPRESENTATIVE RUFFRIDGE asked about the similarities between Texas' 2021 "gold card" legislation and Alaska's current proposed legislation.

DR. SILVA explained that Texas' threshold in its 2021 legislation was 90 percent and Alaska's proposed threshold is 80 percent. He shared the Texas Medical Association's (TMA's) belief that the threshold is not what led to the shortcomings of prior authorization in Texas, rather it is how the insurance companies make their determinations.

[4:17:17 PM](#)

REPRESENTATIVE MINA asked if the 2021 Texas "gold card" legislation only covered physicians.

DR. SILVA said yes.

REPRESENTATIVE MINA asked how the passage of the 2021 Texas "gold card" legislation impacted fraud and abuse of prior authorization in Texas.

DR. SILVA answered that the passage of the legislation in Texas gave the presumption of good will and good practice to physicians by giving them legal tools to make the judgement of the necessity of a prior authorization request.

REPRESENTATIVE MINA asked how the passage of the 2021 Texas "gold card" legislation impacted delay of treatment in prior authorization requests.

DR. SILVA answered by giving an example of how prior authorization requests could lead to an "avoidable service" and explained that the solution most often utilized to combat a delay of prior authorization services is to send the patient to the emergency department of a given hospital.

[4:22:32 PM](#)

CHAIR PRAX asked if physicians are specialized in the fields for which they are sending prior authorization requests.

DR. SILVA explained that the focus of prior authorization cases is on the outcome of the patients and emphasized that the point of a "gold card" is to ensure that one certain physician will always be approved once they are proven as a provider in their specific field of medicine.

[4:25:26 PM](#)

PAM VENTGEN, Executive Director, Alaska State Medical Association (ASMA), gave invited testimony in support of HB 187. She made clear to the committee that she was present primarily to answer committee questions. She emphasized that the "gold card" proposed under HB 187 is targeted towards physicians who consistently receive approval for prior authorization in the past, not physicians who've received approval once or twice in the past.

REPRESENTATIVE FIELDS asked what the balance is between legitimate mental health treatment and systematic abuse of prior authorization by a fraudulent person.

MS. VENTGEN answered that there have been egregious cases of fraud, but those cases were primarily happening before HB 187 was a prospect for Alaska's medical industry.

[4:29:22 PM](#)

CHAIR PRAX asked if certain prior authorizations requests are being consistently turned down compared to others.

MS. VENTGEN answered that an approval or denial of a prior authorization case depends on the type of practice and type of procedure being given. She used oncologists as an example of prior authorization requests being granted and explained that a person who is granting prior authorization requests might not be in the specific field of medicine that is being practiced by the specialist submitting the request.

[4:32:30 PM](#)

REPRESENTATIVE RUFFRIDGE asked Ms. Ventgen to explain how a given physician would prove that a patient is in need of the care that the physician is requesting that the insurance companies cover.

MS. VENTGEN answered by giving a list of daily living obstacles that a patient might be experiencing and how those obstacles might supplement a doctor's case for an insurance approval request.

[4:35:20 PM](#)

REPRESENTATIVE MINA asked how insurance companies are working to lower wait times for patients seeking prior authorization.

MS. VENTGEN explained that there are several factors affecting the current delay in services, most of them being analogue processing services that are hindering electronic processing services. She added that there are many cases where physicians were plainly unaware that a patient might need medication in the first place.

REPRESENTATIVE MINA asked Ms. Ventgen to give examples of how outside companies are pressuring patients and physicians to take certain treatments and further questioned how the ASMA is making efforts to promote more affordable patient-focused care in Alaska.

MS. VENTGEN replied that there is a heavy influence from commercial pharmaceutical companies on both patients and physicians to take a certain drug or participate in a certain treatment and said that the biggest issue in pressuring pharmaceuticals is mass advertising.

[4:39:43 PM](#)

JEFF DAVIS, President, Radiation Business Solutions, gave invited testimony on HB 187. He began his testimony by giving a history of his career in Alaska and gave his support for HB 187. He emphasized the effect that prior authorization and its issues have on patients rather than insurance providers or physicians. He said that prior authorization was noble in its conception but has deteriorated in its honest intention over time. Delays in treatment as a result of prior authorization have caused more harm than good for patients and physicians across Alaska. He concluded his opening remarks by saying that the goal of HB 187 is to set a clear standard of prior authorization approval for insurance providers and physicians.

[4:45:30 PM](#)

REPRESENTATIVE MINA asked Mr. Davis if he could respond to concerns that HB 187 would not allow for insurance companies to check or substantiate a new type of treatment.

MR. DAVIS explained that a physician would be "gold carded" for a specific medical service, not a new procedure or medication.

[4:48:06 PM](#)

CHAIR PRAX asked if most of the prior authorization requests that were initially denied were approved on appeal.

MR. DAVIS explained that a denial of a prior authorization goes through an appeals process and gave his understanding that the success of an appeal is driven by the patient being physically present to the attending physician, who may then explain to the reviewing physician their justification for the appeal. He added that in unusual circumstances, certain companies might take a month or up to two months to grant final approval to a prior authorization request.

CHAIR PRAX asked how common the one- to two-month approval times were.

MR. DAVIS shared his belief that Premera Blue Cross and Aetna are good companies that do the best for patients and further explained that there are quite a few companies below those two that cause issues for the rest.

[4:55:38 PM](#)

SHEELA TOLLMAN, Vice President, External Affairs, UnitedHealth Group, Inc. (UHG) gave invited testimony on HB 187. She began by giving explanation to a federal rule that is meant to simplify the process of prior authorization for insurance providers that she believed hadn't yet been taken into consideration for HB 187 and said that there must be steps taken by all parties to get to a real-time prior authorization approval process.

REPRESENTATIVE RUFFRIDGE asked Ms. Tollman whether UHG is in support of HB 187.

MS. TOLLMAN answered that UHG is supportive of trying to simplify the burden on patients and physicians but still recognizes the importance of prior authorization.

REPRESENTATIVE RUFFRIDGE commented that he would like to see written comment from UHG to the committee on how it would amend HB 187 and added his belief through experience that federal rules often don't streamline processes, rather they make them more complex.

[5:01:58 PM](#)

REPRESENTATIVE MINA asked what percentage of UHG's services require prior authorization and further questioned the turnaround time for prior authorization requests.

MS. TOLLMAN said UHG would follow up with the committee later.

[5:03:16 PM](#)

CHAIR PRAX asked Ms. Tollman when the new federal rule that impacts prior authorization will be implemented.

MS. TOLLMAN said that the respective rules would go into effect in 2026 and 2027.

[5:04:43 PM](#)

REPRESENTATIVE RUFFRIDGE asked whether the new federal rule would govern all types of insurance plans.

MS. TOLLMAN responded that the new federal rule would be applicable to all insurance plans in Alaska.

CHAIR PRAX asked whether the proposed "gold card" idea may be negotiated in or out of network health care plans.

[5:06:27 PM](#)

MS. WING-HEIER answered that the DOH sees no reason why the proposed "gold card" idea may not be negotiated into agreement with insurance providers around the State.

CHAIR PRAX asked whether the federal rule would be required by the Centers for Medicare and Medicaid services to be adopted by all other providers in the nation.

MS. WING-HEIER explained that it would take DOH time and money to analyze how federal bills would affect Alaska.

[5:08:28 PM](#)

REPRESENTATIVE MINA asked whether Ms. Wing-Heier had a breakdown of Alaskans that are covered by insurance companies that would be affected by the new federal rule.

MS. WING-HEIER answered that she would send that information to the committee after the meeting.

CHAIR PRAX announced that HB 187 was held over.

[5:10:14 PM](#)

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:10 p.m.