

ALASKA STATE LEGISLATURE
HOUSE HEALTH AND SOCIAL SERVICES STANDING COMMITTEE

April 3, 2025

3:20 p.m.

MEMBERS PRESENT

Representative Genevieve Mina, Chair
Representative Andrew Gray
Representative Zack Fields
Representative Donna Mears
Representative Mike Prax
Representative Justin Ruffridge
Representative Rebecca Schwanke

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

HOUSE BILL NO. 52

"An Act relating to the rights of minors undergoing evaluation or inpatient treatment at psychiatric hospitals; relating to the use of seclusion or restraint of minors at psychiatric hospitals; relating to a report published by the Department of Health; relating to inspections by the Department of Health of certain psychiatric hospitals; and providing for an effective date."

- HEARD & HELD

HOUSE BILL NO. 144

"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."

- HEARD & HELD

PREVIOUS COMMITTEE ACTION

BILL: HB 52

SHORT TITLE: MINORS & PSYCHIATRIC HOSPITALS

SPONSOR(S): REPRESENTATIVE(S) DIBERT

01/22/25 (H) READ THE FIRST TIME - REFERRALS

01/22/25 (H) HSS, L&C
03/25/25 (H) HSS AT 3:15 PM DAVIS 106
03/25/25 (H) Heard & Held
03/25/25 (H) MINUTE (HSS)
04/03/25 (H) HSS AT 3:15 PM DAVIS 106

BILL: HB 144

SHORT TITLE: INSURANCE; PRIOR AUTHORIZATIONS

SPONSOR(S): REPRESENTATIVE(S) RUFFRIDGE

03/21/25 (H) READ THE FIRST TIME - REFERRALS
03/21/25 (H) HSS, L&C
04/03/25 (H) HSS AT 3:15 PM DAVIS 106

WITNESS REGISTER

REPRESENTATIVE MAXINE DIBERT

Alaska State Legislature

Juneau, Alaska

POSITION STATEMENT: As prime sponsor, presented HB 52.

MATTIE HULL, Staff

Representative Maxine Dibert

Juneau, Alaska

POSITION STATEMENT: On behalf of Representative Dibert, prime sponsor, answered questions regarding HB 52.

KIM SWISHER, Deputy Director

Office of Children's Services

Department of Family and Community Service

Anchorage, Alaska

POSITION STATEMENT: Answered questions regarding HB 52.

ROBERT NAVE, Division Operations Manager

Division of Health Care Services

Department of Health

Anchorage, Alaska

POSITION STATEMENT: Answered questions regarding HB 52.

SETH GREEN, MD

Behavioral Health Clinical Supervisor

Aleutian Pribilof Islands Association

Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 52.

REPRESENTATIVE JUSTIN RUFFRIDGE

Alaska State Legislature

Juneau, Alaska

POSITION STATEMENT: As prime sponsor, presented HB 144.

BUD SEXTON, Staff

Representative Justin Ruffridge

Juneau, Alaska

POSITION STATEMENT: On behalf of Representative Ruffridge, prime sponsor, answered questions regarding HB 144.

JARED KOSIN, President and CEO

Alaska Hospital and Healthcare Association

Anchorage, Alaska

POSITION STATEMENT: Answered questions regarding HB 144.

JARED KOSIN

President and CEO

Alaska Hospital and Healthcare Association

Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 144.

GARY STRANNIGAN, Vice President

Congressional and Legislative Affairs

Premera Blue Cross Blue Shield of Alaska

Everett, Washington

POSITION STATEMENT: Testified in support of HB 144.

PAM VENTGEN, Executive Director

Alaska State Medical Association

Anchorage, Alaska

POSITION STATEMENT: Testified in support of HB 144.

ACTION NARRATIVE

[3:20:21 PM](#)

CHAIR GENEVIEVE MINA called the House Health and Social Services Standing Committee meeting to order at 3:20 p.m. Representatives Prax, Gray, Mears, Ruffridge, Schwanke, and Mina were present at the call to order. Representative Fields arrived as the meeting was in progress.

HB 52-MINORS & PSYCHIATRIC HOSPITALS

[3:21:01 PM](#)

CHAIR MINA announced that the first order of business would be HOUSE BILL NO. 52, "An Act relating to the rights of minors

undergoing evaluation or inpatient treatment at psychiatric hospitals; relating to the use of seclusion or restraint of minors at psychiatric hospitals; relating to a report published by the Department of Health; relating to inspections by the Department of Health of certain psychiatric hospitals; and providing for an effective date." [Before the committee, adopted as a working document on 3/25/25, was the proposed committee substitute (CS) for HB 52, Version 34-LS0399\N, Radford, 3/24/25 ("Version N").]

[3:21:25 PM](#)

REPRESENTATIVE MAXINE DIBERT, Alaska State Legislature, as prime sponsor, provided a brief recap of HB 52, Version N. She explained that Version N would include three straightforward reforms: expand rights of parents to communicate with their children receiving care; require unannounced thorough inspections by state public health officials twice annually; and ensure that facilities are transparent about their use of physical and chemical restraints and seclusion.

[3:25:00 PM](#)

MATTIE HULL, Staff, Representative Maxine Dibert, on behalf of Representative Dibert, prime sponsor, answered questions regarding HB 52, Version N, from the previous hearing on the bill. He said that Version N would not be duplicative, but expansive, of current patients' rights while in psychiatric treatment facilities. He said that 35 students would be interviewed from two different facilities twice a year. He added that inspections under HB 52, Version N, would be unannounced to ensure the authenticity of their results.

[3:28:41 PM](#)

REPRESENTATIVE GRAY asked about medications that are being used as both restraints and medications and how that would affect the need for substance use to be reported.

MR. HULL responded that chemical restraints are drugs used on a patient for discipline or convenience but not required to treat medical systems. He added that he would be willing to clarify this distinction through an amendment to Version N.

REPRESENTATIVE GRAY expressed a concern that Version N would allow facilities to do something and not report it, such as overprescribing a drug that a child already takes.

[3:32:23 PM](#)

KIM SWISHER, Deputy Director, Office of Children's Services (OCS), Department of Family and Community Service (DFCS), responded that she may not be the best to answer the question from Representative Gray.

[3:32:48 PM](#)

ROBERT NAVE, Division Operations Manager, Division of Health Care Services (DHCS), Department of Health (DOH), responded that there should be a record of all drug administration at the facility.

[3:33:28 PM](#)

REPRESENTATIVE RUFFRIDGE asked what current inspections of these facilities look like and if unannounced inspections, under HB 52, Version N, would replace current inspections.

MR. HULL responded that all hospital inspections are unannounced, according to Medicaid standards. However, hospitals are allowed to contract out private agencies to conduct these inspections. He does not know the frequency of current inspections.

MR. NAVE added that the unannounced inspections under the proposed legislation would be in addition to current inspections of the facilities.

REPRESENTATIVE RUFFRIDGE asked again if current inspections are unannounced.

MR. NAVE responded that that is correct.

REPRESENTATIVE RUFFRIDGE asked when the last time the psychiatric facilities underwent inspections.

MR. NAVE responded that he does not have the last date of the inspections.

REPRESENTATIVE RUFFRIDGE asked about the frequency of current inspections.

MR. HULL responded that the inspections occur at least annually.

REPRESENTATIVE RUFFRIDGE asked about the safety of interviewers if they are required to conduct interviews alone.

MR. HULL responded that he would work to clear up that concern.

[3:37:50 PM](#)

REPRESENTATIVE FIELDS said that the mistreatment of children in hospitals has cost the state much more money than it would cost to keep these vulnerable patients safe.

[3:38:55 PM](#)

REPRESENTATIVE SCHWANKE asked about who would approve communication between patients and their families.

MR. HULL responded that treatment plans are not always overseen by a physician but by other high-level staff, who could approve of this communication.

REPRESENTATIVE SCHWANKE asked for clearer language regarding who can approve communications.

CHAIR MINA explained that the original language of the bill seemed too restrictive.

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MR. NAVE said that less restrictive language would include mental health clinicians, psychiatrists, and other healthcare professionals.

REPRESENTATIVE SCHWANKE expressed concern regarding a broad range of individuals being allowed to approve or deny communications.

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CHAIR MINA asked if Version N would have more restrictive rights for minors, limiting length of video calls with families.

MR. HULL responded that the proposed legislation would not set a maximum number of communications per week but would set a minimum of one hour per week.

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REPRESENTATIVE GRAY asked what the facility is responsible for if a patient does not want to spend one hour in communication with their family.

REPRESENTATIVE DIBERT responded that she is not sure how that situation would look and she would have to investigate that question more deeply.

[3:47:07 PM](#)

MS. SWISHER responded that currently, if a youth does not want to speak with their family, then the facility does not force it.

[3:47:41 PM](#)

REPRESENTATIVE GRAY emphasized that he does not want a facility to be able to say communication did not happen because the child did not want to, whether the child truly said that or not.

[3:48:43 PM](#)

REPRESENTATIVE RUFFRIDGE emphasized that HB 52, Version N, would give the right, not the requirement, of a child to have communication with their guardian. He suggested also giving parents and guardians the right to communicate with their children in psychiatric facilities.

MR. HULL responded that the rights of parents are also very important and he would like to encourage parents to reach out to their children in psychiatric facilities.

[3:50:57 PM](#)

REPRESENTATIVE GRAY emphasized cases of nonverbal children, who may not be able to ask for the opportunity to communicate with their guardian.

[3:51:57 PM](#)

CHAIR MINA returned to her question regarding restrictions that HB 52 would place on the rights to communicate that currently exist under psychiatric rights law.

MR. HULL responded that the language Chair Mina referred to is present in both current statute on psychiatric rights and HB 52, Version N.

CHAIR MINA asked if providers currently have the ability to restrict the number of calls made by a psychiatric patient.

[3:53:49 PM](#)

MR. NAVE responded that facilities can put some limits on access to communication.

[3:54:21 PM](#)

REPRESENTATIVE FIELDS agreed that language regarding limits on communication should be amended.

[3:54:33 PM](#)

REPRESENTATIVE GRAY said that he disagrees and said that children in psychiatric hospitals should not have unlimited access to phone calls.

[3:55:17 PM](#)

CHAIR MINA said that if facilities can already restrict access to communication, the proposed legislation would not need to further restrict access.

[3:56:00 PM](#)

REPRESENTATIVE FIELDS said that existing language in Version N could be misconstrued and further limit access to communication.

[3:56:33 PM](#)

MR. HULL said that Version N of HB 52 would set a floor, not a maximum, of communication.

[3:57:18 PM](#)

SETH GREEN, MD, Behavioral Health Clinical Supervisor, Aleutian Pribilof Islands Association, advised that cutting off communication and connections to home increases loneliness for children in psychiatric facilities. He said that having access to communication increases the long-term benefits of psychiatric treatment. He added that he supports unannounced and unexpected inspections of psychiatric facilities. He emphasized that reducing the use of restraint is essential for positive outcomes of psychiatric treatment.

4:01:03 PM

REPRESENTATIVE PRAX asked if the Aleutian Pribilof Islands Association provides residential or out-patient care.

DR. GREEN responded that they only provide out-patient care.

4:02:05 PM

REPRESENTATIVE PRAX asked if psychiatric facilities are currently inspected annually with their license renewals.

MR. NAVE responded that that is correct.

REPRESENTATIVE PRAX asked if that inspection is announced or unannounced.

MR. NAVE said that it is an unannounced inspection.

REPRESENTATIVE PRAX asked if, under HB 52, Version N, there would be three unannounced inspections per year.

MR. NAVE responded that is correct.

REPRESENTATIVE PRAX asked if the accrediting agency also performs inspections and, if so, whether they are unannounced, as well.

MR. NAVE responded that those inspections are also unannounced.

REPRESENTATIVE PRAX asked if DOH reviews the results of the accrediting agency's inspections.

MR. NAVE responded that DOH does review the findings.

4:04:28 PM

REPRESENTATIVE GRAY described his experience with unannounced inspections at the hospital he worked at. He explained that although inspections were unannounced, they occurred within a predictable timeline, allowing the hospital to prepare in advance for the inspection. He asked whether the proposed legislation should include random unannounced inspections to prevent this ability to prepare.

MR. NAVE responded that the additional inspections under Version N would fall outside of the predictable timeline that currently exists.

[4:06:30 PM](#)

CHAIR MINA asked if there are any gaps in data collection currently being missed that would be included under the reports required under HB 52, Version N.

MR. HULL responded that the inspections would only inspect the in-state populations, even though the majority of Alaska children in psychiatric hospitals are sent to out-of-state facilities.

[4:08:08 PM](#)

MS. SWISHER responded that current reporting captures youth at both in-state and out-of-state facilities. She said she is unaware of any gaps in current data reporting.

CHAIR MINA asked if the annual report, under Version N, would reference the children in out-of-state facilities.

MS. SWISHER responded that the annual report would encompass the reporting that already exists, regarding both children at in-state and out-of-state facilities.

CHAIR MINA asked if there is an existing report in DFCS related to children that are sent out of state.

MS. SWISHER responded that there is an existing quarterly report.

[4:10:18 PM](#)

REPRESENTATIVE GRAY asked what would prevent the state from doing unannounced visits to out-of-state facilities where Alaska children are residing.

MR. HULL responded that he is not entirely sure but could help to find that information.

MS. SWISHER responded that OCS occasionally does perform unannounced visits to out-of-state facilities, and she is not sure of any non-budgetary restrictions.

REPRESENTATIVE GRAY asked if Ms. Swisher goes to Utah.

MS. SWISHER responded that OCS does transfer children to out-of-state facilities when necessary.

[4:13:01 PM](#)

REPRESENTATIVE SCHWANKE asked what the benefit would be from posting annual reports of facilities online.

MR. HULL responded that HB 52 would ensure transparency as well as the anonymity of the patients.

REPRESENTATIVE SCHWANKE expressed concern regarding publishing the full report online.

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MR. HULL responded that psychiatric facilities have increasingly used medications improperly and that the state needs to protect children from this abuse. He said that full transparency is essential in this endeavor.

[4:17:09 PM](#)

REPRESENTATIVE RUFFRIDGE asked who is responsible for the deficiencies found in these facilities. He asked about accreditation agencies' responsibility.

MR. HULL responded that he would love to see more federal oversight of these facilities. He said that many states are increasing protections for the children in their psychiatric facilities.

MR. NAVE responded there are multiple layers of oversight and jurisdiction over these facilities. He said that each layer has different jurisdiction and different focuses.

[4:21:03 PM](#)

REPRESENTATIVE PRAX said that he is concerned about over-reporting.

MR. NAVE responded that the State of Alaska has a very broad definition of restraint, which he does not want to further restrict. He said that he would rather see more than less reporting.

REPRESENTATIVE PRAX asked if there are any Health Insurance Portability and Accountability Act (HIPAA) restrictions to be concerned about when reporting.

MR. NAVE responded that any reports published online would be de-identified.

REPRESENTATIVE PRAX asked if there is a problem with reporting to the state if a child is not in the custody of the state.

MR. NAVE answered that that would not be a HIPAA violation.

[4:24:47 PM](#)

REPRESENTATIVE GRAY named some of the main drugs used as restraints in psychiatric facilities and expressed his concerns regarding the more addictive substances. He said he wants to know if addictive substances are being used as restraints when there are other options for restraint.

REPRESENTATIVE SCHWANKE responded that she does not question the need for the report, especially to families and to the legislature. She said she wonders if publishing the report online would create more problems and questions for DOH.

[4:27:45 PM](#)

REPRESENTATIVE PRAX considered whether the House Health and Social Services Standing Committee should be required to read the report.

[HB 52, Version N, was held over.]

HB 144-INSURANCE; PRIOR AUTHORIZATIONS

[4:28:40 PM](#)

CHAIR MINA announced that the next order of business would be HOUSE BILL NO. 144, "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."

[4:28:50 PM](#)

REPRESENTATIVE MEARS moved to adopt the proposed committee substitute (CS) for HB 144, Version 34-LS0780\N, Wallace, 4/1/25, as the working document.

CHAIR MINA objected for the purpose of discussion.

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REPRESENTATIVE JUSTIN RUFFRIDGE, Alaska State Legislature, as prime sponsor, presented HB 144. He said this issue has been addressed in previous legislatures and addresses the issue of prior authorization.

[4:31:34 PM](#)

BUD SEXTON, Staff, Representative Justin Ruffridge, on behalf of Representative Ruffridge, prime sponsor, presented HB 144. He described the process of prior authorization, which must be reasonable and efficient. He said that under, HB 144, prior authorization would be required within 72 hours for a standard request and within 24 hours for an expedited request. He said that HB 144 would benefit patients, especially those with chronic conditions.

[4:36:09 PM](#)

REPRESENTATIVE FIELDS asked about HB 144 automatically renewing coverage for those with chronic illnesses for an additional year, rather than "additional periods," which would be more subject to the medical condition at hand.

[4:37:13 PM](#)

JARED KOSIN, President and CEO, Alaska Hospital and Healthcare Association, responded that the Division of Insurance interprets the language of HB 144 as allowing renewals into perpetuity.

[4:38:11 PM](#)

REPRESENTATIVE FIELDS responded that he would like to hear confirmation on this matter from Legislative Legal Services.

[4:38:25 PM](#)

MR. SEXTON continued the presentation of HB 144. On behalf of Representative Ruffridge, prime sponsor, he read the sectional analysis of HB 144 [hard copy included in the committee file].

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 health 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.

Section 3. 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 Alaska 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.

[4:43:24 PM](#)

REPRESENTATIVE FIELDS, [referring to page 5, line 16, in Section 2 of HB 144], pointed to the language "Adverse determinations" and asked if it would be necessary to add "answered by a human" to add clarity.

[4:44:12 PM](#)

REPRESENTATIVE RUFFRIDGE responded that some other sections of HB 144 detail how to avoid an adverse determination. He said that there are options before a telephone conversation with a human would be necessary.

[4:45:48 PM](#)

REPRESENTATIVE FIELDS asked why stage 4 metastatic breast cancer, as opposed to other types or stages of cancer, is distinguished in HB 144.

REPRESENTATIVE RUFFRIDGE responded with an explanation of step therapy. He said that stage 4 metastatic breast cancer is not exclusive under HB 144.

[4:48:18 PM](#)

CHAIR MINA removed her objection to the motion to adopt the proposed CS for HB 144, Version 34-LS0780\N, Wallace, 4/1/25, as the working document. There being no further objection, Version N was before the committee.

[4:48:43 PM](#)

CHAIR MINA announced invited testimony.

[4:48:51 PM](#)

MR. KOSIN begin his invited testimony on HB 144, Version N, by explaining that at stage 4 of any cancer, one typically starts exploring trials and alternative treatments. He said that the Alaska Hospital and Healthcare Association strongly supports HB 144 and the effort to reform prior authorization. He said that HB 144, Version N, would address the delays in urgent care needed by patients and would have an immediate, positive impact on patients. He emphasized the importance of transparency that would be added to prior authorization under the proposed legislation.

[4:53:25 PM](#)

GARY STRANNIGAN, Vice President, Congressional and Legislative Affairs, Premera Blue Cross Blue Shield of Alaska, began his invited testimony in support of HB 144, Version N. He said that prior authorization is an important component to making healthcare affordable. He said he thinks the proposed legislation would improve prior authorization and increase its efficiency by increasing automation of the process.

[4:56:21 PM](#)

PAM VENTGEN, Executive Director, Alaska State Medical Association, began her invited testimony in support of HB 144, Version N. She said that the Alaska State Medical Association strongly supports the proposed legislation. She said that the process of prior authorization has become cumbersome and harmful to patients, but HB 144, Version N, would address those issues very well.

[4:58:31 PM](#)

REPRESENTATIVE GRAY raised concern that HB 144, Version N, would not actually reduce costs.

REPRESENTATIVE RUFFRIDGE responded that in states that have passed similar legislation, there have been direct correlations to reduce costs. He added that HB 144, Version N, would simplify the process of prior authorization and the number of employees required to complete the process.

REPRESENTATIVE GRAY explained that often, due to drug advertising, patients will ask a physician to prescribe specific, name-brand drugs, rather than the generic drug of the same kind. He said that doing so requires prior authorization, even in situations where physicians may not have the time to process a prior authorization. He asked for feedback on these cases.

REPRESENTATIVE RUFFRIDGE responded that prior authorization does help with cost containment and that HB 144, Version N, would improve the ability to provide step therapy, as well as help uphold patient safety.

REPRESENTATIVE GRAY suggested that one way to expand access to care and lower costs would be to allow pharmacists to prescribe medications.

REPRESENTATIVE RUFFRIDGE responded that pharmacists are awesome, and he supports Representative Gray's support of their work.

[HB 144, Version N, was held over.]

[5:09:48 PM](#)

ADJOURNMENT

There being no further business before the committee, the House Health and Social Services Standing Committee meeting was adjourned at 5:09 p.m.