

ALASKA STATE LEGISLATURE
SENATE LABOR AND COMMERCE STANDING COMMITTEE

March 19, 2025

1:32 p.m.

MEMBERS PRESENT

Senator Jesse Bjorkman, Chair
Senator Kelly Merrick, Vice Chair
Senator Elvi Gray-Jackson
Senator Forrest Dunbar
Senator Robert Yundt

MEMBERS ABSENT

All members present

COMMITTEE CALENDAR

SENATE BILL NO. 132

"An Act relating to insurance; and providing for an effective date."

- HEARD & HELD

SENATE BILL NO. 133

"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: SB 132

SHORT TITLE: OMNIBUS INSURANCE BILL

SPONSOR(s): LABOR & COMMERCE

03/14/25	(S)	READ THE FIRST TIME - REFERRALS
03/14/25	(S)	L&C, FIN
03/19/25	(S)	L&C AT 1:30 PM BELTZ 105 (TSBldg)

BILL: SB 133

SHORT TITLE: INSURANCE; PRIOR AUTHORIZATIONS

SPONSOR(s): LABOR & COMMERCE

03/17/25 (S) READ THE FIRST TIME - REFERRALS
03/17/25 (S) L&C, FIN
03/19/25 (S) L&C AT 1:30 PM BELTZ 105 (TSBldg)

WITNESS REGISTER

KONRAD JACKSON, Staff
Senator Jesse Bjorkman
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Introduced SB 132 on behalf of Senate Labor and Commerce Committee.

LORI WING-HEIER, Director
Division of Insurance
Anchorage, Alaska

POSITION STATEMENT: Provided the sectional analysis for SB 132.

KONRAD JACKSON, Staff
Senator Jesse Bjorkman
Alaska State Legislature
Juneau, Alaska

POSITION STATEMENT: Introduced and provided the sectional analysis for SB 133 on behalf of Senate Labor and Commerce Committee.

ACTION NARRATIVE

[1:32:00 PM](#)

CHAIR BJORKMAN called the Senate Labor and Commerce Standing Committee meeting to order at 1:32 p.m. Present at the call to order were Senators Merrick, Gray-Jackson, Dunbar, Yundt and Chair Bjorkman.

SB 132-OMNIBUS INSURANCE BILL

[1:32:55 PM](#)

CHAIR BJORKMAN announced the consideration of SENATE BILL NO. 132 "An Act relating to insurance; and providing for an effective date."

[1:33:13 PM](#)

KONRAD JACKSON, Staff, Senator Jesse Bjorkman, Alaska State Legislature, Juneau, Alaska, introduced SB 132 on behalf of Senate Labor and Commerce Committee and stated that SB 132

updates Title 21 with technical corrections, aligns terms with National Association of Insurance Commissioners (NAIC) model laws, and refreshes federal statute references. The last major update was in 2016.

[1:34:36 PM](#)

LORI WING-HEIER, Director, Division of Insurance, Anchorage, Alaska, provided the sectional analysis for SB 132.

- Section 1 of SB 132 aims to better protect consumers, especially elderly victims, from fraud involving life insurance. She said because these products are renewed yearly and crimes like theft or forgery may not be discovered right away, SB 132 extends the time allowed for prosecution to 20 years.
- Section 2 restores the option for employers in Alaska to offer HMOs (Health Maintenance Organizations), a common and often cheaper health insurance choice in other states. By adding the provisions back into the statute, it gives employers more flexibility and options to reduce healthcare costs for their workers.

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CHAIR BJORKMAN asked what the provisions in Section 2 accomplish.

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MS. WING-HEIER answered that Alaska law allows HMOs but doesn't let providers guide patients on where to get care. SB 132 updates the law so that, under an HMO plan, patients can be directed to a primary care provider chosen by their employer and then referred to a specialist if needed. This helps ensure patients follow the right care path. She said SB 132 does not mandate HMOs, it simply gives employers and providers the option to offer them.

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SENATOR DUNBAR asked if employees maintain the choice of what healthcare they want.

[1:38:05 PM](#)

MS. WING-HEIER answered that the employer will make the healthcare choice. The employee would be part of the plan, first visiting primary care before seeing a specialist.

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MS. WING-HEIER continued with the sectional analysis.

- Section 3 adds protections for health insurance consumers by requiring insurers to clearly explain the process for benefit level exceptions, especially when it's different from standard prior authorization. She said this includes situations like getting care from an out-of-state provider within the same insurance network. The goal is to prevent surprise bills by making sure patients know in advance how to ensure their care is covered as in-network.
- Sections 4 and 5 give the insurance director more flexibility to grant delays or exemptions for financial reporting requirements. She stated that the director can only approve delays for audited financial reports, not other filings. These changes allow the director to approve more types of exemptions when appropriate, making regulation more efficient.
- Sections 6 and 62 aim to simplify how taxes are calculated for wet marine and transportation insurance policies. By removing certain unique deductions, the state expects to generate an additional \$110,000 in revenue. The current tax statute is confusing, often leading to errors and late fees. These changes will make the system clearer and easier for consumers, brokers, and insurance companies to follow.
- Section 7 updates state law to match a 2022 federal law requiring insurers to respond to the Department of Health within 60 days and not deny claims just because prior authorization wasn't received. This ensures better coordination with Medicaid and compliance with federal regulations.
- Section 8 makes a minor technical change to improve legal wording without changing the meaning of the law.
- Section 9 adds language that was accidentally left out of Senate Bill 87 to clarify which reinsurance transactions insurers will recognize. She said this change helps Alaska stay in compliance with national insurance standards set by the NAIC (National Association of Insurance Commissioners), which ensures that Alaska based insurers like Alaska National and Umialik are recognized and trusted in other states and vice versa.

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SENATOR DUNBAR noted that Section 8 is a conforming change, on page 5 line 30, the legislation changes "shall" to a "may". He asked whether this wording has an effect in this case and if so, why is the change being made.

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MS. WING-HEIER answered that Section 8 is talking about reciprocity agreements with 8 offshore jurisdictions. These agreements stem from federal insurance rules created under the Obama administration to align accreditation standards with foreign jurisdictions. Alaska adopted the required language but used the wrong word, which federal auditors flagged. Correcting this word is a change Alaska needs to make to help maintain accreditation, which is critical for Alaska's insurance industry.

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SENATOR DUNBAR asked if changing "shall" to "may" acknowledges that Alaska isn't changing what is already happening.

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MS. WING-HEIER answered yes. She explained Alaska had to pass the provision for accreditation and that part of the statute will likely never be used since Alaska is a small state.

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MS. WING-HEIER continued with the sectional analysis.

- Section 10 is amending, requires insurers using a principle-based valuation method to also have corporate governance procedures for reviewing waivers or modifications. She said this change aligns Alaska with national insurance model law 820 from the NAIC, which most other states have already adopted. Insurers support the update because it eliminates the need to keep separate financial records just for Alaska.
- Section 11 updates the definition of "policyholder behavior" to be more specific and align with current industry language and practices. This change brings Alaska's law in line with NAIC model law 820.
- Section 12 lets licensed firms appoint a compliance officer for each specific line of insurance, health, life, property, or casualty, instead of requiring one officer to cover all lines. This matches industry standards and recognizes that no single person is usually an expert in all four areas.
- Section 13 requires licensees who list Alaska as their home state to follow Alaska's existing continuing education requirements. The requirements themselves are not changing.
- Section 14 strengthens disclosure loops by requiring written documentation of criminal disclosures and any

administrative actions taken by other Alaska state agencies.

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MS. WING-HEIER continued with the sectional analysis.

- Section 15 updates the title "health authority" to "accident and health or sickness coverage" to better reflect the products offered and align with other states and NAIC guidance.
- Section 16 adds independent adjusters to Alaska's reciprocal licensing rules, allowing the division to license non-resident adjusters the same way the state licenses other out-of-state licensees.
- Section 17 removes exam and training requirements for non-resident independent adjusters getting reciprocal Alaska licenses, since these are already met in their home states.
- Section 18 expands the ability to designate Alaska as a home state to include independent adjusters.
- Section 19 requires applicants designating Alaska as their home state to meet Alaska's general licensing qualifications
- Section 20 updates Alaska law to allow official correspondence to be sent electronically, matching common industry practice.
- Section 21 updates language clarifying that third-party administrators are registrants, not licensees.
- Section 22 is a conforming change that removes outdated TPA requirements and closes disclosure gaps by requiring formal documentation of any criminal disclosures involving Alaska agencies.
- Section 23 updates the definition of compliance officer.
- Section 24 updates the definition of home state for adjusters and expands this to cover all industrial licenses. This is limited to non-resident independent portable electronic adjusters.
- Section 25 updates and broadens the definition of independent adjusters to include portable electronic adjusters.
- Section 26 removes the director's authority to create new limited lines insurance classes by regulation.
- Section 27 lets surplus lines brokers pay the wet marine and transportation tax on behalf of non-admitted insurers or the insured. This practice is already common in the industry, and SB 132 simply makes it official in state law.

Surplus lines insurers are those licensed differently from regular insurers but are still reputable companies.

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MS. WING-HEIER continued with the sectional analysis.

- Section 28 allows some disability insurance policies to be sold as surplus lines, helping high-risk individuals who can't find coverage from regular insurers.
- Section 29 updates the language about how non-admitted insurers can qualify to offer insurance in Alaska, reflecting industry and regulatory changes.
- Section 30 makes a technical change to align with the Non-Admitted and Reinsurance Reform Act of 2010.
- Section 31 reduces penalties for late surplus lines payments, slightly lowering state revenue as noted in the fiscal report.
- Section 32 updates the definition of "home state" to include multinational insurance placements.
- Section [33] aligns a definition to match with AS 21.12.090(b).
- Section 34 stops insurers from depreciating labor costs when settling property claims. Consumers have complained that being paid less for labor makes it hard to hire contractors upfront for repairs. The insurance department tried to address this on its own but faced legal challenges, so now they're asking the legislature to decide and fix the issue.

[1:53:27 PM](#)

CHAIR BJORKMAN asked Ms. Wing-Heier to explain how Section 34 would affect a homeowner who lost their garage in a fire.

[1:53:54 PM](#)

MS. WING-HEIER replied that the homeowner would have to upfront the cost then be reimbursed from the insurer which is typical for a cash value settlement. She said with labor consumers it's hard to find a contractor to do a job without a huge deposit upfront even though the insurer will pay in full once the job is complete.

[1:54:51 PM](#)

SENATOR DUNBAR asked if insurance companies are opposed to Section 34 of SB 132.

[1:55:10 PM](#)

MS. WING-HEIER responded that the Division of Insurance expects to hear opposition from some insurers, but Alaska based companies like Alaska National and Umialik are aware of the change. Other states have already adopted similar statute, either by law or bulletin. The division was surprised that Alaska was chosen as a test case for a lawsuit.

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MS. WING-HEIER continued with the sectional analysis.

- Section 35 requires health insurers to give at least 45 days' notice before canceling any major medical policy. Previously, this notice period applied to other health insurance types, but not major medical.
- Section 36 extends the notice period to 45 days for consumers when their premiums increase by more than ten percent, up from the current 20 days, giving them more time to explore options or adjust to the change.

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SENATOR DUNBAR asked if a consumer was told their policy premium is increasing by a certain amount, does the consumer always have the option to cancel the policy or do the rates have to stay fixed until the contract ends, or can the insurer raise rates in the middle of the contract.

[1:56:53 PM](#)

MS. WING-HEIER answered that insurers cannot raise rates in the middle of a policy term. The insurers can only increase premiums at renewal, and if the increase is ten percent or more, they must give advance notice. She said many consumers, such as those working remotely or on the slope, miss short notice periods. SB 132 proposes extending the notice from 20 days to 45 days to give people more time to respond.

[1:57:20 PM](#)

SENATOR GRAY-JACKSON asked whether it's legal for insurance companies to change coverage or increase the premium based on a claimless inquiry.

MS. WING-HEIER asked for clarification.

SENATOR GRAY-JACKSON provided an example.

[1:58:04 PM](#)

MS. WING-HEIER answered no, that should not happen as there are only about five or six instances in statute when insurance

companies can raise rates. She recalled that some Juneau residents without flood coverage experienced insurance cancellation after requesting two formal denial letters to meet Federal Emergency Management Agency (FEMA) aid requirements following repeated glacial dam flooding. She explained that although the residents lacked coverage, the act of requesting denial letters triggered policy cancellations. She stated that state officials are working to close this loophole. She added that the proposal aims to stop insurers from canceling coverage when individuals request denial letters solely to qualify for FEMA disaster assistance. She said this example is more than an inquiry.

[1:59:32 PM](#)

MS. WING-HEIER continued with the sectional analysis.

- Section 37 extends the notice period for non-renewing a homeowner or vehicle policy to 45 days.
- Section 38 clarifies that moving a policy within affiliated companies is not considered a non-renewal.
- Section 39 further limits cancellations or non-renewals when a denial is requested only to meet requirements for programs like FEMA.
- Section 40 updates the law to allow owner-controlled or contractor-controlled insurance policies. This proposal had broad support in a previous session but didn't reach a final vote, so it's now included in the omnibus bill.
- Section 41 says for the state to keep a better track of health discount plans, these plans must sign up with the state, follow renewal rules, and have direct contracts for the services or supplies they cover.
- Section 42 has been part of legislation before as House Bill 29, insurance discrimination.
- Section 43 updates insurance rules so companies must include restitution when they wrongly pay claims, giving the director more power to protect consumers.
- Section 44 changes workers' compensation rules by raising the premium threshold for assigned risk policies from \$3,000 to \$6,000 before a 25 percent surcharge applies, helping small employers and sole proprietors.
- Section 45 allows official notices by email.
- Section 46 lowers the colorectal cancer screening age from 50 to 45 years.
- Section 47 updates minimum interest rates for certain annuities to match national standards.

- Section 48 exempts certain group life insurance entities from filing requirements.
- Section 49 requires 45 days' notice before non-renewing a health policy.
- Section 50 is a technical change that changes the word agriculture to agricultural.
- Section 51 requires vehicle service contractors to file with the division like other insurers.

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SENATOR DUNBAR referred to Section 51 and asked what a motor vehicle service contract is in this context, whether it's intended for everyday consumers or businesses, and requested clarification on what it covers, and the changes being proposed.

[2:05:00 PM](#)

MS. WING-HEIER replied that when a person buys a new vehicle and gets an extended warranty or maintenance plan included in the loan, that's considered insurance called a vehicle service contract (VSC). She said the insurance division has received complaints that many of these contracts weren't filed with the division for approval. The division will now require these contracts to be filed and approved to ensure consumer protection and address any issues.

[2:05:54 PM](#)

MS. WING-HEIER continued with the sectional analysis.

- Section 52 closes disclosure gaps by requiring written documentation of criminal and administrative actions by other state agencies.
- Section 54 updates terminology from "unauthorized" to "not admitted" to match current insurance industry language.
- Section 55 amends federal code citations for the Alaska Life and Health Insurance Guarantee Association, clarifying it is not responsible for Medicaid or Medicare insolvencies since those aren't insurance products.

MS. WING-HEIER stated that Sections 56, 57, and 58 are amendments to restore effectiveness back into the HMO statutes in Section 2.

- Section 59 requires risk retention groups to file annual premium tax reports and pay taxes like other insurers.
- Section 60 asks for the division to be given authority to apply for waivers, like section 1332 federal reinsurance

program waiver, without needing legislative approval each time.

- Section 61 adds a consistent definition of motor vehicle from Title 28 to apply across all of Title 21.
- Section 62 gets into the repeals.
- Section 63 provides applicability for the owner-controlled piece of the legislation.
- Section 64 sets SB 132's effective date.

[2:08:14 PM](#)

SENATOR DUNBAR asked for an explanation of the practical change in Section 61.

[2:08:26 PM](#)

MS. WING-HEIER responded that there are concerns insurance companies are rating mobile equipment, like those used on the slope, as regular autos instead of construction equipment, even though these vehicles are never driven on roads.

[2:08:41 PM](#)

SENATOR DUNBAR asked whether the insurance companies have raised their premiums based on that categorization.

[2:08:49 PM](#)

MS. WING-HEIER answered yes, the division plans to use the existing statutory definition of motor vehicles and prevent it from being applied to equipment that is not legally classified as a motor vehicle under DMV rules.

[2:09:10 PM](#)

CHAIR BJORKMAN asked Ms. Wing-Heier to explain the repealers in Section 62.

[2:09:17 PM](#)

MS. WING-HEIER replied that Section 62 says:

- AS 21.09.210(d) aligns wet marine and transportation tax calculations with property and casualty tax rules, expected to raise about \$100,000 in revenue.
- AS 21.27. 020(g) repealing an inactive continuing education (CE) advisory committee, with the Division of Insurance seeking guidance instead from other state regulators and the NAIC.
- AS 21.27.330(a) protecting producers' home addresses from public disclosure, reflecting the shift to telework and removing the requirement for a physical business location.

- AS 21.34.030(d) updating surplus line requirements to maintain access to insurance products.
- AS 21.39.020(b)(4) starting to review aircraft insurance rates and forms due to rising costs
- AS 21.59.290(2) replacing the motor vehicle definition.
- AS 21.86.078 Section 51 addresses out of network access for the health maintenance organizations from Section 2.
- AS 21.34.030(d) refers to the minimums in AS 21.34.040 and should apply if the nonadmitted insurer is a form other than a foreign non-alien stock insurer. The intent is to clarify the language, which has already been addressed earlier in the bill. The current language is being repealed.

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CHAIR BJORKMAN held SB 132 in committee.

[2:12:44 PM](#)

At ease.

SB 133-INSURANCE; PRIOR AUTHORIZATIONS

[2:14:44 PM](#)

CHAIR BJORKMAN reconvened the meeting and announced the consideration of SENATE BILL NO. 133 "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."

[2:15:14 PM](#)

KONRAD JACKSON, Staff, Senator Jesse Bjorkman, Alaska State Legislature, Juneau, Alaska, introduced SB 133 on behalf of the Senate Labor and Commerce Committee and provided the sectional. He stated SB 133, which addresses insurance and prior authorizations, is the result of extensive collaboration among healthcare industry stakeholders through numerous meetings over the summer. He said providers, insurers, and other key players have reached full agreement on the legislation, which is a rare but appreciated occurrence in the legislative process.

MR. JACKSON stated the initial draft of the sectional summary was incorrect and the following is the correct version for SB 133:

[Original punctuation provided.]

Sectional Summary - ver. \N

This is a summary only. Note that this summary should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Section 1. AS 21.07.080 is amended making conforming changes to preserve the original intent by citing AS 21.07.005 - 21.07.090 (the original chapter contents).

[2:17:37 PM](#)

MR. JACKSON continued with the sectional summary:

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.

[2:20:02 PM](#)

MR. JACKSON continued with the sectional summary:

[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.

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MR. JACKSON continued with the sectional summary:

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.

[2:23:00 PM](#)

MR. JACKSON continued with the sectional summary:

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.

[2:24:23 PM](#)

MR. JACKSON continued with the sectional summary:

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.

[2:26:52 PM](#)

MR. JACKSON continued with the sectional summary:

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.

[2:29:54 PM](#)

SENATOR DUNBAR stated his belief that AS 27.07.100 is the heart of SB 133 and sought confirmation the enforcement provision falls to the Division of Insurance. He said on page 8 [AS 21.07.180(c)] it states, "If a health care insurer does not comply with AS 21.07.100-21.07.180, the director may impose penalties including a penalty in each instance of noncompliance," and asked whether SB 133 is modeled after the actions of other states.

[2:30:38 PM](#)

MS. WING-HEIER replied that SB 133 is based on models from other states. SB 133 represents a compromise of a bill from last year that payers and providers worked on during the interim. She stated that both parties support bringing it to the legislature.

[2:31:02 PM](#)

SENATOR DUNBAR asked what constitutes an appropriate penalty, how often the division expects to issue it and whether the division has the capacity to follow up once it is issued.

[2:31:35 PM](#)

MS. WING-HEIER responded that SB 133 allows the division to adopt fines, penalties, and caps in line with current regulation. She provided an example of penalties ranging from \$250-1000 and a cap of up to \$25,000. She stated that AS 21.06 was specifically included in SB 133 so that the insurance company incurs the expense of an examination.

[2:32:32 PM](#)

SENATOR DUNBAR stated he might have misunderstood how enforcement works and asked if enforcement would be ongoing and complaint driven, not just periodic reviews, and whether insurers would also cover those costs.

2:33:00 PM

MS. WING-HEIER replied that the division typically handles one off complaints internally, but a surge in similar complaints triggers a market conduct review to investigate broader issues within the insurer.

2:34:06 PM

At ease.

2:34:51 PM

CHAIR BJORKMAN reconvened the meeting.

[CHAIR BJORKMAN held SB 133 in committee.]

2:35:30 PM

There being no further business to come before the committee, Chair Bjorkman adjourned the Senate Labor and Commerce Standing Committee meeting at 2:35 p.m.