CS FOR HOUSE BILL NO. 187(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-THIRD LEGISLATURE - SECOND SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE

Offered: 4/24/24
Referred: Rules

Sponsor(s): REPRESENTATIVE SUMNER

A BILL

FOR AN ACT ENTITLED

"An Act relating to utilization review entities; relating to prior authorization requests; and providing for an effective date."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) An exemption under (a) of this section remains in effect until the 30th day after the date the utilization review entity notifies the health care provider of its

determination to revoke the exemption or, if the health care provider appeals the determination, the fifth day after the revocation is upheld on appeal.

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

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

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

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

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

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

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

(j) If a utilization review entity requires a prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization is valid for the length of the treatment and the utilization review entity may not require the covered person to obtain another prior authorization for the health care service.

(k) In this section,

(1) "health care service" means

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

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

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

(ii) by a doctor of medicine, by a doctor of osteopathy, or within the scope of practice of a health care professional who is licensed in this state;

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

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

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

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

(B) a health care insurer;

(C) a preferred provider organization;

(D) a health maintenance organization; or

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

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