ALASKA HOSPITAL & HEALTHCARE ASSOCIATION

Overview of Legislation – SB 133 Prior Authorization Reform

Prior authorization is a review process used by insurers that requires healthcare providers to obtain express authorization to provide a certain treatment or procedure for their patients. It is commonly required for surgeries, diagnostic imaging, outpatient procedures, rehabilitation services, durable medical equipment, and medications.

The 33rd Legislature considered legislation concerning prior authorization in 2024. SB 219 / HB 187 sought to implement a "gold card" program that would have exempted a healthcare provider from having to complete a prior authorization if the utilization review entity has approved or would have approved at least 80 percent of the prior authorization requests submitted by the healthcare provider for that healthcare service over the most recent 12-month period.

In May 2025, the 34th Legislature passed SB 133, which does not include a gold card program. Rather, the bill focuses on comprehensively reforming prior authorization with provisions that:

- Speed up turnaround times for decisions from 5 working days to 72 hours
- Provide long-term prior authorization for treatment of chronic conditions
- Prohibit restrictions on key therapies for Stage Four Advanced Metastatic Cancer
- Require exception process to step therapy requirements
- Increase transparency for policies, peer review, enforcement, and accountability
- Prioritize automation

SB 133 amends Alaska's insurance code in Title 21, so the prior authorization reforms will apply to individual, small group, and large group insurance plans. These plans cover about 118,205 lives or 15% of the insurance market.

After passing the Legislature, SB 133 became law on July 15, 2025. The bill had broad support from healthcare providers, insurers, and regulators. This was a direct result of the Alaska Hospital & Healthcare Association dedicating months to working with these interested parties to coalesce around shared priorities and concrete reforms to improve the prior authorization process.

Bullet Point Takeaways

Turnaround Times

- Speed Up - go from 5 working days to 72 hours to provide decision on standard submissions
    - Note, decision for submission by fax is 72 hours excluding weekends
    - Automatic approval if timelines are missed

Exemptions and Exceptions

- Chronic conditions – 12-month approval for chronic conditions w/ automatic renewals
- Exemption for Stage Four Advanced Metastatic Cancer Treatments – treatments are automatically approved if consistent with Category 1 or 2A of Evidence and Consensus in the FDA's National Comprehensive Cancer Network
- Exceptions to Step Therapy – clear process to request exception to step-therapy protocols, including carryover of approval for consumers from prior plans

Transparency

- Clear requirements for criteria used – plain language, on website, based on peer-reviewed / clinical review criteria, consistently applied
- Clinical Peer Reviewers – equivalent specialty to the requesting provider, attestation that relevant records personally reviewed, disclosure of reviewer's qualifications
- Adverse decisions and appeals – evidence and criteria used in the decision, detailed list of missing documents / info needed for appeal, direct contact information for appeal

Automation

- Interface - Insurers must build and maintain automated interfaces for prior authorization submission and decisions

Compliance

- Accountability - Director of Insurance has full jurisdiction, including random examinations at least biennially, power to fine, suspend, and revoke for non-compliance
- Reporting - Annual report documenting evidence of compliance, and detailed denial information for top 20 billed codes