

SENATE No.

The Commonwealth of Massachusetts

PRESENTED BY:

Joanne M. Comerford

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to improve the health insurance prior authorization process.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
<i>Joanne M. Comerford</i>	<i>Hampshire, Franklin and Worcester</i>	
<i>Anne M. Gobi</i>	<i>Worcester, Hampden, Hampshire and Middlesex</i>	<i>2/26/2021</i>
<i>Jack Patrick Lewis</i>	<i>7th Middlesex</i>	<i>2/26/2021</i>
<i>Michael O. Moore</i>	<i>Second Worcester</i>	<i>3/2/2021</i>
<i>Walter F. Timilty</i>	<i>Norfolk, Bristol and Plymouth</i>	<i>3/17/2021</i>
<i>Sal N. DiDomenico</i>	<i>Middlesex and Suffolk</i>	<i>4/4/2021</i>

SENATE No.

[Pin Slip]

The Commonwealth of Massachusetts

**In the One Hundred and Ninety-Second General Court
(2021-2022)**

An Act to improve the health insurance prior authorization process.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. Section 18 of chapter 15A of the General Laws is hereby amended by
2 adding the following two paragraphs:-

3 Any qualifying student health insurance plan authorized under this chapter shall adopt
4 utilization review criteria and conduct all utilization review activities under the criteria and in
5 compliance with this paragraph and the following paragraph. The criteria shall be, to the
6 maximum extent feasible, scientifically derived and evidence-based, and developed with the
7 input of participating physicians. Utilization review criteria, including detailed preauthorization
8 requirements and clinical review standards, shall be applied consistently and made easily
9 accessible and up-to-date on a website by the institutions of higher education or any entity that
10 provides or manages health insurance benefits and to the general public in a searchable electronic
11 format; provided, however, that the institutions of higher education or any entity that contracts to
12 provide or manage health insurance benefits shall not be required to disclose licensed,
13 proprietary criteria purchased by a carrier or utilization review organization on its website, but

14 shall disclose the licensed, proprietary criteria relevant to particular treatments and students and
15 their dependents and health care providers upon request. If the institution of higher education or
16 an entity with which the institution of higher education contracts to provide or manage health
17 insurance benefits intends either to implement a new preauthorization requirement or restriction
18 or amend an existing requirement or restriction, the new or amended requirement or restriction
19 shall not be implemented unless: (i) the appropriate website has been updated to reflect the new
20 or amended requirement or restriction; (ii) students of the institutions of higher education and
21 their dependents are notified of the changes by electronic means via email and the member
22 portal, or for those without access to electronic means of communication, by mail; and (iii) the
23 institutions of higher education or entity which that contracts to provide or manage health
24 insurance benefits has processes in place to ensure continuation of any previously approved
25 preauthorizations.

26 The institutions of higher education or any entity that contracts to provide or manage
27 health insurance benefits under this section shall not retrospectively deny authorization for an
28 admission, procedure, treatment or service when an authorization has already been obtained for
29 that service unless the approval was based upon inaccurate information material to the review or
30 the services were not provided consistent with the health care provider's submitted plan of care
31 and any restrictions included in the preauthorization approved by the student health plan program
32 or an entity with which the commission contracts to provide or manage health insurance benefits.

33 SECTION 2. Chapter 32A of the General Laws is hereby amended by inserting after
34 section 4B the following section:-

35 Section 4C. The commission or an entity with which the commission contracts to provide
36 or manage health insurance benefits, shall adopt utilization review criteria and conduct all
37 utilization review activities under the criteria and in compliance with this section. The criteria
38 shall be, to the maximum extent feasible, scientifically derived and evidence-based, and
39 developed with the input of participating physicians. Utilization review criteria, including
40 detailed preauthorization requirements and clinical review criteria, shall be applied consistently
41 and made easily accessible and up-to-date on a website by the commission or any entity that
42 provides or manages health insurance benefits and to the general public in a searchable electronic
43 format; provided, however, that the commission or an entity with which the commission
44 contracts to provide or manage health insurance benefits shall not be required to disclose
45 licensed, proprietary criteria purchased by a carrier or utilization review organization on its
46 website, but shall disclose such licensed, proprietary criteria relevant to particular treatments and
47 services to active or retired employees of the commonwealth, their dependents and health care
48 providers upon request. If the commission or an entity with which the commission contracts to
49 provide or manage health insurance benefits intends either to implement a new preauthorization
50 requirement or restriction or amend an existing requirement or restriction the new or amended
51 requirement or restriction shall not be implemented unless: (i) the appropriate website has been
52 updated to reflect the new or amended requirement or restriction; (ii) active or retired employees
53 of the commonwealth and their dependents are notified of the changes by electronic means via
54 email and the member portal, or for those without access to electronic means of communication,
55 by mail; and (iii) the commission or an entity with which the commission contracts to provide or
56 manage health insurance benefits has processes in place to ensure continuation of any previously
57 approved preauthorizations.

58 The commission or an entity with which the commission contracts to provide or manage
59 health insurance benefits shall not retrospectively deny authorization for an admission,
60 procedure, treatment or service when an authorization has already been obtained for that service
61 unless the approval was based upon inaccurate information material to the review or the services
62 were not provided consistent with the health care provider's submitted plan of care and any
63 restrictions included in the preauthorization approved by the commission or an entity with which
64 the commission contracts to provide or manage health insurance benefits.

65 SECTION 3. Subsection (a) of section 12 of chapter 176O of the General Laws is hereby
66 amended by striking out the second paragraph and inserting in place thereof the following
67 paragraph:-

68 A carrier or utilization review organization shall adopt utilization review criteria and
69 conduct all utilization review activities under the criteria and in compliance with this section.
70 The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based,
71 and developed with the input of participating physicians, consistent with the development of
72 medical necessity criteria under section 16. Utilization review criteria, including detailed
73 preauthorization requirements and clinical review criteria, shall be applied consistently by a
74 carrier or a utilization review organization and made easily accessible and up-to-date on a carrier
75 or utilization review organization's website and to the general public in a searchable electronic
76 format; provided, however, that a carrier shall not be required to disclose licensed, proprietary
77 criteria purchased by a carrier or utilization review organization on its website, but shall disclose
78 such licensed, proprietary criteria relevant to particular treatments and services to insureds,
79 prospective insureds and health care providers upon request. If a carrier or utilization review
80 organization intends either to implement a new preauthorization requirement or restriction or

81 amend an existing requirement or restriction, the carrier or utilization review organization shall
82 ensure that the new or amended requirement or restriction shall not be implemented unless: (i)
83 the carrier's or utilization review organization's website has been updated to reflect the new or
84 amended requirement or restriction; (ii) insureds are notified of the changes by electronic means
85 via email and the member portal, or for those without access to electronic means of
86 communication, by mail; and (iii) the carrier or utilization review organization has processes in
87 place to ensure continuation of any previously approved preauthorizations.

88 SECTION 4. Said section 12 of said chapter 176O is further amended by adding after
89 subsection (f) the following subsection:-

90 (g) A carrier or utilization review organization shall not retrospectively deny
91 authorization for an admission, procedure, treatment or service when an authorization has
92 already been obtained for that service unless the approval was based upon inaccurate information
93 material to the review or the services were not provided consistent with the health care provider's
94 submitted plan of care and any restrictions included in the preauthorization approved by the
95 carrier or utilization review organization.

96 SECTION 5. (a) The division of insurance shall establish a committee to develop
97 recommendations regarding simplification of health insurance prior authorization standards and
98 processes to improve health care access and reduce the burden on providers.

99 (b) The committee shall consist of the commissioner of insurance or a designee, who
100 shall serve as chair and 17 members to be appointed by the commissioner, 1 of whom shall be a
101 representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a
102 representative of Blue Cross Blue Shield of Massachusetts, Inc., 1 of whom shall be the

103 executive director of the Office of Patient Protection or a designee, 1 of whom shall be a
104 representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a
105 representative of the Massachusetts Health Connector; 1 of whom shall be representative of the
106 Massachusetts Medical Society, 1 of whom shall be a representative of the Group Insurance
107 Commission, 1 of whom shall be currently practicing pediatric provider; 1 of whom shall be a
108 currently practicing provider specialized in hospital medicine; 3 of whom shall have expertise in
109 the treatment of individuals with a mental illness with at least 1 specializing on pediatric mental
110 health and 1 with substance use disorder expertise, 1 of whom shall be a representative of the
111 Massachusetts Association of Mental Health, Inc., 1 of whom shall be a representative of a
112 Black, Indigenous, People of Color-led consumer organization, 1 of whom shall be a
113 representative from a health consumer advocacy organization; 1 of whom shall be a
114 representative of an organization representing people with a chronic disease, and 1 of whom
115 shall be a representative of a legal services organization.

116 (c) The committee shall identify: (i) services which have no or low prior authorization
117 denial rates across carriers, based on the report from the health policy commission in section 6 of
118 this act; (ii) the administrative constraints to continuing active prior authorizations for their
119 approved duration in instances where an insured transitions to a new plan with the same carrier
120 or to a new carrier.

121 (d) The committee shall develop recommendations regarding: (i) establishing
122 standardized prior authorization processes, forms, and requirements for use across health
123 insurance carriers and plans; (ii) eliminating prior authorization requirements for services,
124 treatments, procedures and prescription drugs that have low variation in utilization across
125 providers or low denial rates, based on the services identified under subsection (c); (ii) removing

126 prior authorization requirements for certain chronic disease services to improve chronic disease
127 management; (iii) implementing consistent time frames for how long prior authorizations are in
128 effect across carriers that minimize the need for repeated authorization requests.

129 (e) The committee may prioritize certain services, treatments, procedures or prescription
130 drugs in developing recommendations pursuant to subsections (c) and (d).

131 (f) In developing its recommendations, the committee shall consider the role of prior
132 authorizations in alternative payment arrangements and whether to differentiate its
133 recommendations based on payment arrangements.

134 (g) The committee shall establish recommended timelines for carriers to complete each of
135 the committee's recommendations.

136 (h) The committee shall file its recommendations, including any proposed regulations,
137 with the clerks of the senate and the house of representatives and the joint committee on health
138 care financing no later than April 1, 2022.

139 (i) The division of insurance shall be authorized to implement the committee's
140 recommendations by regulation or sub-regulatory guidance.

141 SECTION 6. (a) The health policy commission shall conduct an analysis, in consultation
142 with the Massachusetts Collaborative, the center for health information and analysis, and the
143 division of insurance, of the progress of adoption of statewide forms since the implementation of
144 requirements under section 207A of chapter 224 of the acts of 2012, subsection (c) of section 25
145 of chapter 176O of the General Laws, and federal standards pursuant to section 1104 of the
146 Patient Protection and Affordable Care Act, Public Law 111-148 as implemented by the National

147 Standards Group within the Center for Medicare and Medicaid Services. The analysis shall
148 include a review of the integration of standardized electronic prior authorization attachments,
149 standardized forms, requirements and decision support into electronic health records and other
150 practice management software to promote transparency and efficiency. The analysis shall include
151 services which have no or low prior authorization denial rates across carriers to determine the
152 necessity of prior authorizations for services with low denial rates.

153 (b) The commission shall request from insurance carriers all necessary and relevant data
154 pursuant to section (a) within 90 days of the effective date of this act. All insurance carriers shall
155 provide the requested data to the commission.

156 (c) The commission shall prepare a report of its findings that shall include, but not be
157 limited to, administrative barriers encountered by health insurance carriers and providers to
158 implementing the statewide standards for electronic prior authorization processes listed under
159 subsection (a) and recommendations with proposed timelines for complete implementation of the
160 standards. The health policy commission shall file its findings with the committee established
161 under section 5 of this act by January 1, 2022.