

**HOUSE . . . . . No. 1383**

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**The Commonwealth of Massachusetts**

PRESENTED BY:

***John J. Lawn, Jr.***

*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 relative the use and impact of prior authorization for health care services.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>John J. Lawn, Jr.</i>	<i>10th Middlesex</i>	<i>1/17/2025</i>
<i>Greg Schwartz</i>	<i>12th Middlesex</i>	<i>7/10/2025</i>
<i>Vanna Howard</i>	<i>17th Middlesex</i>	<i>7/17/2025</i>

**HOUSE . . . . . No. 1383**

By Representative Lawn of Watertown, a petition (accompanied by bill, House, No. 1383) of John J. Lawn, Jr., that the Health Policy Commission conduct an analysis on the use of prior authorization for health care services and its impact on cost, quality and access. Health Care Financing.

**The Commonwealth of Massachusetts**

**In the One Hundred and Ninety-Fourth General Court  
(2025-2026)**

An Act relative the use and impact of prior authorization for health care services.

*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. (a) Notwithstanding any general or special rule to the contrary, the health  
2 policy commission, in collaboration with the center for health information and analysis and the  
3 division of insurance, shall conduct an analysis and report on the use of prior authorization for  
4 health care services and its impact on cost, quality and access.

5           (b) The report shall include, but not be limited to: (i) an assessment and inventory of  
6 admissions, items, services, treatments, procedures and medications that require prior  
7 authorization and that have a high rate of approval or denial for standard and expedited requests,  
8 including after appeal; (ii) the timeline for review and adjudication, including the time to  
9 adjudicate an appeal, for standard and expedited requests for admissions, items, services,  
10 treatments, procedures and medications that require prior authorization; (iii) total health care  
11 expenditures associated with the submission and processing, including appeals, of prior  
12 authorization determinations; (iv) an analysis of the impact of prior authorization requirements

13 on patient access to and cost of care by patient demographics, geographic region and type of  
14 service; (v) identification of admissions, items, services, treatments, procedures and medications  
15 subject to prior authorization that have low variation in utilization across providers and carriers,  
16 or low denial rates across carriers; (vi) identification of admissions, items, services, treatments,  
17 procedures and medications subject to prior authorization for certain chronic disease services that  
18 negatively impact chronic disease management; (vii) review and analysis of the integration of  
19 standardized electronic prior authorization attachments, standardized forms, requirements and  
20 decision support into electronic health records and other practice management software to  
21 promote transparency and efficiency; (viii) review and analysis of a waiver of prior authorization  
22 based on a carrier's standards or policies, or "gold-carding status," so called, and whether such  
23 status is available to all providers in a carrier's network; and (ix) recommendations regarding the  
24 simplification of health insurance prior authorization standards and processes to improve health  
25 care access and reduce the burden on health care providers.

26 (c) The report shall be informed by data and information submitted by carriers to the  
27 division of health insurance and shall include, but not be limited to the following:

28 (1) a list of all admissions, items, services, treatments, procedures and medications that  
29 require prior authorization;

30 (2) the number and percentage of standard prior authorization requests that were  
31 approved, individualized for each admission, item, service, treatment, procedure and medication;

32 (3) the number and percentage of standard prior authorization requests that were denied,  
33 individualized for each admission, item, service, treatment, procedure and medication;

34 (4) the number and percentage of standard prior authorization requests that were initially  
35 denied and approved after appeal, individualized for each admission, item, service, treatment,  
36 procedure and medication;

37 (5) the number and percentage of prior authorization requests for which the timeframe for  
38 review was extended, and the request was approved, individualized for each admission, item,  
39 service, treatment, procedure and medication;

40 (6) the number and percentage of expedited prior authorization requests that were  
41 approved, individualized for each admission, item, service, treatment, procedure and medication;

42 (7) the number and percentage of expedited prior authorization requests that were denied,  
43 individualized for each admission, item, service, treatment, procedure and medication;

44 (8) the average mean and median time that elapsed between the submission of a request  
45 and a determination by the carrier for standard prior authorizations, individualized for each  
46 admission, item, service, treatment, procedure and medication;

47 (9) the average and median time that elapsed between the submission of a request and a  
48 decision by the carrier for expedited prior authorizations, individualized for each admission,  
49 item, service, treatment, procedure and medication;

50 (10) the average and median time that elapsed to process an appeal submitted by a health  
51 care provider initially denied by the carrier for standard prior authorizations, individualized for  
52 each admission, item, service, treatment, procedure and medication; and

53           (11) the average and median time that elapsed to process an appeal submitted by a health  
54 care provider initially denied by the carrier for expedited prior authorizations, individualized for  
55 each admission, item, service, treatment, procedure and medication.

56           (d) The report and any legislative recommendations shall be submitted to the chairs of the  
57 joint committee on health care financing, the house and senate committees on ways and means  
58 not later than 1 year from the effective date of this act.