HOUSE DOCKET, NO. 3505 FILED ON: 1/17/2025

HOUSE . . . . . No.

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:
John J. Lawn, Jr.	*10th Middlesex*	*1/17/2025*

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HOUSE . . . . . No.

[Pin Slip]

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:

SECTION 1. (a) Notwithstanding any general or special rule to the contrary, the health policy commission, in collaboration with the center for health information and analysis and the division of insurance, shall conduct an analysis and report on the use of prior authorization for health care services and its impact on cost, quality and access.

(b) The report shall include, but not be limited to: (i) an assessment and inventory of admissions, items, services, treatments, procedures and medications that require prior authorization and that have a high rate of approval or denial for standard and expedited requests, including after appeal; (ii) the timeline for review and adjudication, including the time to adjudicate an appeal, for standard and expedited requests for admissions, items, services, treatments, procedures and medications that require prior authorization; (iii) total health care expenditures associated with the submission and processing, including appeals, of prior authorization determinations; (iv) an analysis of the impact of prior authorization requirements on patient access to and cost of care by patient demographics, geographic region and type of

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

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

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

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

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

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

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

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

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

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

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

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

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

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