SENATE DOCKET, NO. 2471 FILED ON: 1/17/2025

SENATE . . . . . No. 1403

The Commonwealth of Massachusetts

PRESENTED BY:

Cindy F. Friedman

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 to reducing administrative burden.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	
Cindy F. Friedman	*Fourth Middlesex*	
Joanne M. Comerford	*Hampshire, Franklin and Worcester*	*2/21/2025*
Mike Connolly	*26th Middlesex*	*3/5/2025*
Adam Gómez	*Hampden*	*3/5/2025*
Adam J. Scanlon	*14th Bristol*	*3/21/2025*
Michael D. Brady	*Second Plymouth and Norfolk*	*3/28/2025*
Rebecca L. Rausch	*Norfolk, Worcester and Middlesex*	*4/4/2025*
Michelle M. DuBois	*10th Plymouth*	*5/12/2025*
Jacob R. Oliveira	*Hampden, Hampshire and Worcester*	*6/6/2025*
Robyn K. Kennedy	*First Worcester*	*6/10/2025*
Patrick M. O'Connor	*First Plymouth and Norfolk*	*6/12/2025*
James B. Eldridge	*Middlesex and Worcester*	*9/9/2025*

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SENATE . . . . . No. 1403

By Ms. Friedman, a petition (accompanied by bill, Senate, No. 1403) of Cindy F. Friedman, Joanne M. Comerford, Mike Connolly, Adam Gómez and other members of the General Court for legislation relative to reducing administrative burden. Mental Health, Substance Use and Recovery.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE SENATE, NO. *1249* OF 2023-2024.]

The Commonwealth of Massachusetts

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

An Act relative to reducing administrative burden.

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. Chapter 26 of the General Laws, as most recently amended by section 23 of chapter 177 of the acts of 2022, is hereby amended by inserting after section 8M the following section:-

8N. (a) All carriers licensed under chapters 175, 176A, 176B and 176G that provide medical or prescription drug benefits subject to utilization review consistent with section 12 of chapter 176O, shall make publicly available on their website a searchable list of all items, services and medications that require prior authorization. Prior authorization may not be requested for an item, service or medication that is not listed on the publicly available website.

(b) If a carrier contracts with another entity that manages or administers such benefits for the carrier, including a utilization review organization as defined in section 1 of said chapter 176O, that entity shall provide the carrier the information required under subsection (a) and that carrier shall post the required information publicly on the carrier's website consistent with the requirements of subsection (a).

(c) Carriers and utilization management organizations shall report annually, not later than July 1, to the division of insurance data regarding approval and denials of prior authorization requests, including request for drug benefits, in a readily accessible, standardized, searchable format as determined by the division. Data shall be submitted for the following categories: medical, inpatient and outpatient surgical services, post-acute care admissions to skilled nursing facilities, inpatient rehab facilities and home care services, prescription drugs, behavioral health, diagnostic services including labs and imaging and all other categories of health care services or drug benefits for which a prior authorization request was required. Such data shall include:

(i) the number and percentage of standard prior authorization requests that were approved or denied;

(ii) the number and percentage of standard prior authorization requests that were initially denied and approved after appeal;

(iii) the number and percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved;

(iv) the number and percentage of expedited prior authorization requests that were approved or denied;

(v) the average and median time that elapsed between the submission of a request and a determination by the payer, plan or issuer, for standard and expedited prior authorizations;

(vi) the average and median time that elapsed to process an appeal submitted by a health care provider initially denied by the payer, plan or issuer, for standard and expedited prior authorizations; and

(vii) any other information as deemed relevant by the commissioner.

(d) The commissioner shall determine the information required in order to comply with this section and in accordance with applicable state and federal privacy laws.

(e) Annually, not later than December 1, the commissioner shall submit a summary of the reports, including all data submitted, that the commissioner receives from each carrier, or any other entity that manages or administers such benefits for the carrier, under subsection (a) to the clerks of the senate and house of representatives, the joint committee on health care financing, the center for health information and analysis and the health policy commission. The commissioner shall make publicly available, through its website or alternative means, the submitted data, including a listing of all items, services and medications subject to prior authorization by each individual carrier.

(f) The division shall promulgate rules and regulations necessary to implement this section.

SECTION 2. Chapter 32A of the General Laws, as appearing in the 2022 Official Edition, is hereby amended by inserting after section 4B the following section:-

Section 4C. The commission or an entity with which the commission contracts to provide or manage health insurance benefits, shall adopt utilization review criteria and conduct all utilization review activities under the criteria and in compliance with this section. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians. Utilization review criteria, including detailed preauthorization requirements and clinical review criteria, shall be applied consistently and posted on a publicly-available website by the commission or any entity with which the commission contracts to provide or manage health insurance benefits in an up-to-date, readily accessible, standardized and searchable electronic format. If the commission or an entity with which the commission contracts to provide or manage health insurance benefits intends either to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the new or amended requirement or restriction shall not be implemented unless: (i) the appropriate website has been updated to reflect the new or amended requirement or restriction; (ii) active or retired employees of the commonwealth and their dependents who are affected are notified of the changes by electronic means via email and any applicable online member portal, or for those without access to electronic means of communication, by mail; and (iii) the commission or an entity with which the commission contracts to provide or manage health insurance benefits has processes in place to ensure continuation of any previously approved preauthorizations.

The commission or an entity with which the commission contracts to provide or manage health insurance benefits shall not retrospectively deny authorization for an admission, procedure, treatment, service or course of medication when an authorization has already been

approved for that service unless the approval was based upon fraudulent information material to the review.

SECTION 3. Section 24B of chapter 175, as so appearing, is hereby amended by adding the following paragraphs:-

A carrier, as defined in section 1 of chapter 176O, shall be required to pay for health care services ordered by the treating health care provider if: (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services follow the carrier's clinical review criteria; provided, however, that a claim for treatment of medically necessary services may not be denied if the treating health care provider follows the carrier's approved method for securing authorization for a covered service for the insured at the time the service was provided.

A carrier shall not deny payment for a claim for medically necessary covered services on the basis of an administrative or technical defect in the claim except in the case where the carrier has a reasonable basis, supported by specific information available for review, that the claim for health care services rendered was submitted fraudulently. A carrier shall have no more than 1 year after the original payment was received by the health care provider to recoup a full or partial payment for a claim for services rendered, or to adjust a subsequent payment to reflect a recoupment of a full or partial payment. Claims may not be recouped for utilization review purposes if the services were already deemed medically necessary or the manner in which the services were accessed or provided were previously approved by the carrier or its contractor.

SECTION 4. Subsection (a) of section 12 of chapter 176O, as so appearing, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

A carrier or utilization review organization shall adopt utilization review criteria and conduct all utilization review activities under the criteria and in compliance with this section. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians, consistent with the development of medical necessity criteria under section 16. Utilization review criteria, including detailed preauthorization requirements and clinical review criteria, shall be applied consistently by a carrier or a utilization review organization and posted on a carrier or utilization review organization's public-facing website in an up-to-date, readily accessible, standardized and searchable electronic format. If a carrier or utilization review organization intends either to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless: (i) the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction; (ii) insureds who are affected are notified of the changes by electronic means via email and any applicable online member portal, or for those without access to electronic means of communication, by mail; and (iii) the carrier or utilization review organization has processes in place to ensure continuation of any previously approved preauthorizations.

SECTION 5. Said subsection (a) of said section 12 of said chapter 176O, as so appearing, is hereby further amended by inserting after the third paragraph the following paragraphs:-

A carrier or utilization review organization shall not retrospectively deny authorization for an admission, procedure, treatment, service or course of medication when an authorization has already been approved for that service unless the approval was based upon fraudulent information material to the review.

SECTION 6. Subsection (b) of said section 12 of said chapter 176O, as so appearing, is hereby amended by inserting after the word “information”, in line 38, the following words:-

; provided, however, that if additional delay would result in significant risk to the enrollee’s health or well-being, a carrier or a utilization review organization shall respond not more than 24 hours following the receipt of all necessary information. If a carrier or utilization review organization does not, within the time limits set forth in this section, respond to a completed prior authorization request or request missing information, the prior authorization request shall be deemed to have been granted; provided further that if a prior authorization is requested for an item, service, or medication that is not publicly listed on a carrier’s website as being subject to prior authorization, the request shall be deemed to have been granted.

SECTION 7. Said section 12 of said chapter 176O, as so appearing, is further amended by adding after subsection (f) the following subsections:-

(g) For an insured member who is stable on a treatment, service or course of medication as determined by a health care provider and approved for coverage by a previous carrier or health benefit plan, a carrier or utilization review organization shall not restrict coverage of such treatment, service or course of medication for at least 90 days upon the insured member’s enrollment.

(h) Preauthorization approval for a prescribed treatment, service or course of medication shall be valid for the duration of a prescribed or ordered course of treatment, or at least 1 year; provided further that a change in dosage for an approved medication shall not require a new preauthorization.

(i) For an insured member who is stable on a treatment, service or course of medication as determined by a health care provider and approved for coverage by the carrier or health benefit plan, and where that drug or medical service is then removed from a plan's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended, a carrier shall cover the approved drug or medical service without restrictions for the rest of the benefit year or 90 days, whichever is longer.

(j) If a carrier and a provider or provider organization are engaged in an alternative payment contract that includes downside risk, the carrier shall not unilaterally require prior authorization requirements for any particular health care service that is included in that alternative payment contract.

SECTION 8. Chapter 176O, as so appearing, is hereby amended by inserting after section 12B the following sections:

12C. (a)(1) For items, services or drugs covered under the insured's medical benefit, a carrier or utilization review organization shall implement and maintain a prior authorization application programming interface for the automated processing of prior authorization requests to enable a provider to: (i) determine whether prior authorization is required for a health care item, service or drug; (ii) identify prior authorization information and documentation requirements, including any standardized forms; and (iii) facilitate the exchange of prior authorization requests and determinations from the provider's electronic health records or practice management systems through secure electronic submission.

(2) A carrier or utilization review organization's application programming interface shall be conformant with the most recent standards and implementation specifications adopted by the

Secretary of the United States Department of Health and Human Services as specified in 42 CFR 422.119(c)(2) through (4), (d), and (e) and utilizing the Health Level 7 Fast Healthcare Interoperability Resources standard in accordance with 45 CFR 170.215(a)(1), (b)(1)(i), and (c)(1) and the most recent standards and guidance adopted by the United States Department of Health and Human Services to implement said regulations; provided, however, that the prior authorization application programming interface shall:

(i) support a Health Insurance Portability and Accountability Act-compliant prior authorization requests and responses, as described in 45 C.F.R. part 162; and

(ii) communicate the following information about prior authorization requests:

(A) whether the carrier or utilization review organization:

(1) approves the prior authorization request and the date or circumstance under which the authorization ends;

(2) denies the prior authorization request; or

(3) requests more information; and

(B) if the carrier or utilization review organization denies the prior authorization request, the carrier or utilization review organization must include a specific reason for the denial.

(b) For items and drugs covered under the insured's prescription drug benefit that require prior authorization, a carrier or utilization review organization shall implement and maintain a prior authorization application programming interface that complies with the most recent version of the National Council for Prescription Drug Programs SCRIPT standard or its successor standard, and 21 C.F.R. 1311.

12D. (a) For purposes of this subsection, “artificial intelligence” means an engineered or machine-based system that varies in its level of autonomy and that can, for a given set of human-defined explicit or implicit objectives, make predictions, recommendations or decisions influencing real or virtual environments. Artificial intelligence systems use machine and human-based inputs to: (i) perceive real and virtual environments; (ii) abstract such perceptions into models through analysis in an automated manner; and (iii) use model inference to formulate options for information or action.

(b) A carrier or utilization review organization that uses an artificial intelligence, algorithm or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, or that contracts with or otherwise works through an entity that uses an artificial intelligence, algorithm or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, shall comply with this subsection and shall ensure all of the following:

(1) the artificial intelligence, algorithm or other software tool bases determinations on the following information, as applicable:

(i) an enrollee’s medical or other clinical history;

(ii) individual clinical circumstances as presented by the requesting provider;

(iii) other relevant clinical information contained in the enrollee’s medical or other clinical record;

(2) the artificial intelligence, algorithm or other software tool does not base determinations solely on a group dataset;

(3) the artificial intelligence, algorithm or other software tool's criteria and guidelines complies with this chapter, including, but not limited to, sections 12 through 16, inclusive, and applicable state and federal law;

(4) the artificial intelligence, algorithm or other software tool does not supplant health care provider decision-making;

(5) the use of the artificial intelligence, algorithm or other software tool does not discriminate, directly or indirectly, against enrollees in violation of state or federal law;

(6) the artificial intelligence, algorithm or other software tool is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the United States Department of Health and Human Services;

(7) the artificial intelligence, algorithm or other software tool shall be open to inspection for audit or compliance reviews by the division;

(8) carriers and utilization review organizations shall disclose to the division, each health care provider in the carrier's network, and each enrollee in a health benefits plan offered by the carrier, and on the carrier's public website if artificial intelligence-based algorithms are used or will be used by the carrier or utilization review organization's utilization review process; provided further that, if applicable, a carrier or utilization review organization shall disclose algorithm criteria, data sets used to train the algorithm, the algorithm itself and the outcomes of the software in which the algorithm is used;

(9) the artificial intelligence, algorithm or other software tool's performance, use and outcomes are periodically reviewed and revised to maximize accuracy and reliability;

(10) patient data is not used beyond said data's intended and stated purpose, consistent with the federal Health Insurance Portability and Accountability Act of 1996, as applicable; and

(11) the artificial intelligence, algorithm or other software tool does not directly or indirectly cause harm to the enrollee.

(c) Notwithstanding subsection (a), an artificial intelligence-based algorithm or other software tool shall not be the sole basis of a decision to deny, delay or modify health care services based, in whole or in part, on medical necessity. An adverse determination of medical necessity or denial of preauthorization shall be made only by a licensed physician or a licensed health care provider competent to evaluate the specific clinical issues involved in the health care services requested by the provider, as provided in subsection (a) of this section, by reviewing and considering the requesting provider's recommendation, the enrollee's medical or other clinical history, as applicable, and individual clinical circumstances.

(d) This section shall apply to utilization review or utilization management functions that prospectively, retrospectively or concurrently review requests for covered health care services.

(e) A carrier or utilization review organization subject to this section shall comply with applicable federal rules and guidance issued by the United States Department of Health and Human Services regarding the use of artificial intelligence, algorithm or other software tools. The division may issue guidance to implement this paragraph within 1 year of the adoption of federal rules or the issuance of guidance by the United States Department of Health and Human Services.

(f) The division shall issue regulations and guidance to ensure compliance with the requirements of this section.

12E. The division shall enforce the requirements of sections 12 through 12D, inclusive, and section 16 and shall impose a penalty or other remedy against a carrier or utilization review organization that fails to comply with the requirements of these sections. If the commissioner determines that a carrier or utilization review organization is failing to comply with the requirements of section 12 through 12D, inclusive, or 16 of this chapter, the commissioner shall notify the carrier of such violation and shall impose a corrective action plan. If the carrier does not come into compliance by adhering to the corrective action plan within a period determined by the commissioner, the carrier shall be fined up to $5,000 for each day during which such violation continues; provided, however, that the commissioner may impose additional penalties for repeated or wanton violations.

SECTION 9. Section 25 of said chapter 176O, as so appearing, is hereby amended by striking subsection (e) and inserting in place thereof the following subsection:-

(e) The division, in developing the forms, shall:

(1) ensure that the forms are consistent with existing prior authorization forms established by the Centers for Medicare and Medicaid Services; and

(2) consider other national standards pertaining to electronic prior authorization; provided, however, that the division shall adapt all forms developed pursuant to subsection (c) to conform with best practices for automated prior authorization practices.

SECTION 10. (a) Notwithstanding any general or special law to the contrary, there shall be a task force to study and issue a report on the use of prior authorization, and its impact on overall costs in the health care system, including administrative costs on providers and health systems, and the delivery of and access to high quality health care. The task force shall consist of

15 members: the executive director of the health policy commission or a designee, who shall serve as co-chair; the commissioner of insurance or a designee, who shall serve as co-chair; the secretary of the executive office of health and human services or a designee; the assistant secretary for MassHealth or a designee; the executive director of the group insurance commission or a designee; the executive director of the center for health information and analysis, or a designee; a representative of the Massachusetts Medical Society; a representative of the Massachusetts Health and Hospital Association; a representative of Health Care For All; a representative of the Massachusetts Association of Health Plans; a representative of Blue Cross Blue Shield of Massachusetts; a representative of the Massachusetts Association for Mental Health; a representative of the Association for Behavioral Health; a representative of the Massachusetts League of Community Health Centers; and a representative of the Massachusetts Health Data Consortium. The task force shall consult with other health care experts as appropriate, including, but not limited to, non-hospital providers.

(b) The task force shall analyze: (i) data collected by the division of insurance under section 8N of chapter 26 of the General Laws; (ii) total health care expenditures associated with the submission and processing, including appeals, of prior authorization determinations; (iii) an analysis of the impact of prior authorization requirements on patient access to and cost of care; (iv) identification of items, services and medications subject to prior authorization that have low variation in utilization across providers and carriers or no or low denial rates across carriers; (v) identification of items, services and medications subject to prior authorization for certain chronic disease services that negatively impact chronic disease management; (vi) 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; and (vii) 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 task force shall develop recommendations regarding: (i) simplifying and standardizing prior authorization for evidence-based treatments, services or courses of medication across carriers; (ii) improving access to medically necessary care for patients; (iii) reducing the response time from a carrier or utilization review organization for prior authorization approvals and denials; (iv) reducing administration burden and costs related to prior authorization for health care providers; (v) limiting the recoupment and denial of claims for medical necessary covered services; (vi) increasing transparency for covered benefit and prior authorization requirements; (vii) standardizing prior authorization processes, forms and requirements across health insurance carriers; (viii) eliminating prior authorization requirements for admissions, items, services and medications that have low variation in utilization across providers or low denial rates across carriers; (ix) eliminating prior authorization for urgently needed or emergency treatments, services or courses of medications; (x) ensuring any physician or provider under the supervision of a physician that is reviewing a prior authorization request for a carrier or utilization review organization has the clinical expertise to treat the medical condition or disease that is the subject of the request; and (xi) removing prior authorization for certain chronic disease management.

(d) The task force shall develop a report of its findings and recommendations, including any legislative or regulatory changes necessary to implement its recommendations. The task force shall file its report with the clerks of the senate and the house of representatives, the senate

and house committees on ways and means and the joint committee on health care financing not later than July 31, 2026.

SECTION 11. Notwithstanding any general or special law to the contrary, the division of insurance shall consider the recommendations issued by the task force established in section 10 and the data submitted under section 8N of chapter 26 of the General Laws and, using these recommendations and data, shall develop and implement a uniform set of rules or regulations to simplify prior authorization standards and processes, including, but not limited to, prohibiting carriers from imposing prior authorization requirements on all admissions, items, services, and medications that have: (i) low variation in utilization across health care providers; (ii) low denial rates across carriers; and (iii) an established evidence-base for the treatment or management of certain chronic diseases.

SECTION 12. The rules and regulations required by subsection (f) of section 8N of chapter 26 of the General Laws shall be promulgated not later than 6 months after the effective date of this act.

SECTION 13. Sections 2 through 7, inclusive, shall take effect January 1, 2026.

SECTION 14. Section 8 shall take effect January 1, 2026; provided, however, that new section 12C of chapter 176O, as inserted by section 8, shall take effect on January 1, 2027.

SECTION 15. Sections 9 and 10 shall take effective immediately upon passage of this act.

SECTION 16. Section 11 shall take effect April 1, 2027.