

**JOINT COMMITTEE ON FINANCIAL SERVICES  
2025-2026 (194<sup>th</sup>) BILL SUMMARY**

**Bill No:** H1118

**Title:** AN ACT RELATIVE TO PRIOR AUTHORIZATION REQUESTS

**Sponsor:** Rep. Mark J. Cusack (*Braintree*)

**Hearing Date:** July 15, 2025

**Reporting Deadline:** September 13, 2025

**Prior History:** None

**Similar Matters:** H1255 - Markey, S796 - Montigny

**CURRENT LAW:**

*M.G.L. c. 6D Health Policy Commission §1 Definitions*

"Health insurance plan", the Medicare program or an individual or group contract or other plan providing coverage of health care services and which is issued by a health insurance company, a hospital service corporation, a medical service corporation or a health maintenance organization.

"Health care provider", a provider of medical or health services or any other person or organization that furnishes, bills or is paid for health care service delivery in the normal course of business.

*M.G.L. c. 176O Health Insurance Consumer Protections § 12 Utilization Review*

(b) A carrier or utilization review organization will make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information. For purposes of this section, "necessary information" will include the results of any face-to-face clinical evaluation or second opinion that may be required. In the case of a determination to approve an admission, procedure or service, the carrier or utilization review organization will notify the provider rendering the service by telephone within 24 hours and will provide written or electronic confirmation of the telephone notification to the insured and the provider within two working days thereafter. In the case of an adverse determination, the carrier or utilization review organization will notify the provider rendering the service by telephone within 24 hours and will provide written or electronic confirmation of the telephone notification to the insured and the provider within one working day thereafter.

*M.G.L. c. 176O Health Insurance Consumer Protections, §25 Use and acceptance of specifically designated prior authorization forms*

(b) If a payer or any entity acting for a payer under contract fails to use or accept the required prior authorization form or fails to respond within 2 business days after receiving a completed prior authorization request from a provider, the prior authorization request shall be deemed to have been granted.

**SUMMARY:**

This bill requires health insurance plans to be staffed during evening, weekend, and holiday hours so that they are able to act on prior authorization requests within 24 hours.

The bill defines “prior authorization request” as a submission by a health care provider, as defined by *Section 1 of Chapter 6D*, to a patient’s health insurance plan for approval of a service that the patient’s treating health care provider deems necessary.