JOINT COMMITTEE ON FINANCIAL SERVICES
2025-2026 (194th) BILL SUMMARY

Bill No: H1136

Title: AN ACT IMPROVING THE HEALTH INSURANCE PRIOR AUTHORIZATION PROCESS

Sponsor: Rep. Marjorie C. Decker (*Cambridge)*

Hearing Date: July 15, 2025

Reporting Deadline: August 13, 2025

Prior History:
2023-24 (H1143): Reported favorably; Referred to Health Care Financing; Reported favorably; Referred to SWM

Similar Matters: S1403 Committee on Mental Health, Substance Use and Recovery, Discharged to the Committee on Healthcare Financing (Friedman – Identical text), S706 (Cronin)

CURRENT LAW:
M.G.L. c. 26 Department of Banking and Insurance

M.G.L. c. 32A Contributory Group General or Blanket Insurance for Persons in the Service of the Commonwealth (Group Insurance Commission)

M.G.L. c. 175 Insurance

M.G.L. c. 176A Non-Profit Hospital Service Corporations (Blue Cross of Massachusetts)

M.G.L. c. 176B Medical Service Corporations (Blue Shield of Massachusetts)

M.G.L. c. 176G Health Maintenance Organizations (HMOs)

M.G.L. c. 176O Health Insurance Consumer Protections § 1 Definitions

M.G.L. c. 176O Health Insurance Consumer Protections § 12 Utilization Review (a)
A carrier or utilization review organization will adopt utilization review criteria and conduct all utilization review activities under said criteria. The criteria will 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 will be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website and upon request to the general public; provided, however, that a carrier will not be required to disclose licensed, proprietary criteria purchased by a carrier or utilization

review organization on its website, but will disclose such licensed, proprietary criteria relevant to particular treatments and services to insureds, prospective insureds and health care providers upon request. 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 will ensure that the new or amended requirement or restriction will not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

(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
(e) The division, in developing the forms, will:
(1) seek input from interested stakeholders and shall seek to use forms that have been mutually agreed upon by payers and providers;
(2) ensure that the forms are consistent with existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services; and
(3) consider other national standards pertaining to electronic prior authorization.

Chapter 41 of the Acts of 2019, An Act making appropriations for the fiscal year 2020 for the maintenance of the departments, boards, commissions, institutions and certain activities of the commonwealth, for interest, sinking fund and serial bond requirements and for certain permanent improvements §§ 26, 50, 55, 56, 57, 58
The Group Insurance Commission, MassHealth and commercial insurance carriers may not retroactively deny certain previously paid claims beginning 12 months after the claim was submitted by the behavioral health provider. A retroactive claims denial may be allowed after 12 months if the claim was determined to have been submitted fraudulently or is the subject of legal action. Other exemptions include if the claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim or if the health care services in the claim were not delivered by the provider.

Chapter 177 of the Acts of 2022, An Act addressing barriers to care for mental health § 23

42 CFR 422.119 Access to and exchange of health data and plan information (c)Technical Requirements (2) through (4), (d) Documentation requirements for APIs, and (e) Denial or discontinuation of access to the API

45 CFR 170.215 Application Programming Interface Standards (a) API base standard (1) Standard, (b)(1) United States Core Data Implementation Guides (i), and (c) Application access and launch (1) Implementation specification

45 C.F.R. part 162 Administrative Requirements

21 C.F.R. 1311 Requirements for Electronic Orders and Prescriptions

SUMMARY:
SECTION 1.
Amends *M.G.L. c. 26*. All commercial health insurance carriers and their third-party administrators will make publicly available on their website a searchable list of all items, services and medications that require prior authorization. Any item, service or medication that is not listed on the publicly available website will not be subject to prior authorization.

Carriers and utilization management organizations will report annually by 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.

Annually, by December 1, the commissioner will submit a summary of the reports, 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 will make publicly available, through its website or alternative means, the submitted data. The division will promulgate rules and regulations necessary to implement these requirements.

SECTION 2.
Amends *M.G.L. c. 32A*. Utilization review criteria will be scientifically derived and evidence-based and developed with the input of participating physicians. Utilization review criteria, including detailed preauthorization requirements and clinical review criteria, will 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 will 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 will 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.
Amends *M.G.L. c. 175*. A carrier, as defined in *section 1 of chapter 176O*, will 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 will not deny payment for a claim for medically necessary covered services based on 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 will 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 way the services were accessed or provided were previously approved by the carrier or its contractor.

SECTION 4.
Amends *M.G.L. c. 176O § 12 (a).* Requires that utilization review criteria, including detailed preauthorization requirements and clinical review criteria, will 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. In cases where 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 will in addition to posting such update on their website, ensure that the new or amended requirement or restriction will not be implemented unless: 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 the carrier or utilization review organization has processes in place to ensure continuation of any previously approved preauthorizations.

SECTION 5.
Amends *M.G.L. c. 176O § 12 (a).* A carrier or utilization review organization will 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.
Amends *M.G.L. c. 176O § 12 (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; 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 will 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 will 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 will be deemed to have been granted.

SECTION 7.
Amends *M.G.L. c. 176O § 12.* Updates the utilization review law. Adds the following:
(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 will be valid for the duration of a prescribed or ordered course of treatment, or at least 1 year. A change in dosage for an approved medication will 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 will 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 (potential for financial loss), the carrier will not unilaterally require prior authorization requirements for any particular health care service that is included in that alternative payment contract.

SECTION 8.
Adds the following sections, amending *M.G.L. c. 176O:*
12C. (a)(1) For items, services or drugs covered under the insured's medical benefit, a carrier or utilization review organization will 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 will conform 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 will:

(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, will comply with this subsection and will 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 will 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 will 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 will 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 will 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 will issue regulations and guidance to ensure compliance with the requirements of this section.

12E. The division will enforce the requirements of *sections 12 through 12D, and section 16* and will 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, or 16 of this chapter*, the commissioner will notify the carrier of the violation and will 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 will be fined up to $5,000 for each day during which such violation continues. The commissioner may impose additional penalties for repeated or wanton violations.

SECTION 9.

Amends *M.G.L. c. 176O § 25* replacing the existing subsection (e).

The division will as before, ensure that prior authorization forms are consistent with existing prior authorization forms established by the Centers for Medicare and Medicaid Services. However, the division will no longer be required to seek input from interested stakeholders and

to seek to use forms that have been mutually agreed upon by payers and providers. Additionally, the division will consider other national standards pertaining to electronic prior authorization and will adapt all forms to conform with best practices for automated prior authorization practices.

SECTION 10.
Establishes a task force, consisting of 15 members, 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 will 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.

The task force will develop a report of its findings and recommendations, including any legislative or regulatory changes necessary to implement its recommendations. The task force will 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 by July 31, 2026.

SECTION 11.
The division of insurance will 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, will 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* will be promulgated within 6 months of this act's effective date.

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

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

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

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