

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

**Bill No:** H1255

**Title:** AN ACT RELATIVE TO REDUCING UNNECESSARY DELAYS IN PATIENT CARE

**Sponsor:** Rep. Christopher M. Markey (*Dartmouth*)

**Hearing Date:** July 15, 2025

**Reporting Deadline:** August 13, 2025

**Prior History:**

2023-24 (H1091): Ordered to a House Study

**Similar Matters:** S796 (Montigny - Identical); H1118 (Cusack)

**CURRENT LAW:**

*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:**

A payer, on an entity acting on such payer's behalf, will have 24 hours to respond to a completed required prior authorization form.

Payers and entities acting for payers under contract will not use appeals processes or other administrative means to delay responding a to completed prior authorization request from a provider. The division of insurance will conduct audits to ensure compliance with this provision.