

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

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:

1 SECTION 1. Chapter 26 of the General Laws, as most recently amended by section 23 of
2 chapter 177 of the acts of 2022, is hereby amended by inserting after section 8M the following
3 section:-

4 8N. (a) All carriers licensed under chapters 175, 176A, 176B and 176G that provide
5 medical or prescription drug benefits subject to utilization review consistent with section 12 of
6 chapter 176O, shall make publicly available on their website a searchable list of all items,
7 services and medications that require prior authorization. Prior authorization may not be
8 requested for an item, service or medication that is not listed on the publicly available website.

9 (b) If a carrier contracts with another entity that manages or administers such benefits for
10 the carrier, including a utilization review organization as defined in section 1 of said chapter
11 176O, that entity shall provide the carrier the information required under subsection (a) and that
12 carrier shall post the required information publicly on the carrier's website consistent with the
13 requirements of subsection (a).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

148 SECTION 8. Chapter 176O, as so appearing, is hereby amended by inserting after section
149 12B the following sections:

150 12C. (a)(1) For items, services or drugs covered under the insured's medical benefit, a
151 carrier or utilization review organization shall implement and maintain a prior authorization
152 application programming interface for the automated processing of prior authorization requests
153 to enable a provider to: (i) determine whether prior authorization is required for a health care
154 item, service or drug; (ii) identify prior authorization information and documentation
155 requirements, including any standardized forms; and (iii) facilitate the exchange of prior
156 authorization requests and determinations from the provider's electronic health records or
157 practice management systems through secure electronic submission.

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

160 Secretary of the United States Department of Health and Human Services as specified in 42 CFR
161 422.119(c)(2) through (4), (d), and (e) and utilizing the Health Level 7 Fast Healthcare
162 Interoperability Resources standard in accordance with 45 CFR 170.215(a)(1), (b)(1)(i), and
163 (c)(1) and the most recent standards and guidance adopted by the United States Department of
164 Health and Human Services to implement said regulations; provided, however, that the prior
165 authorization application programming interface shall:

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

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

169 (A) whether the carrier or utilization review organization:

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

172 (2) denies the prior authorization request; or

173 (3) requests more information; and

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

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

181 12D. (a) For purposes of this subsection, “artificial intelligence” means an engineered or
182 machine-based system that varies in its level of autonomy and that can, for a given set of human-
183 defined explicit or implicit objectives, make predictions, recommendations or decisions
184 influencing real or virtual environments. Artificial intelligence systems use machine and human-
185 based inputs to: (i) perceive real and virtual environments; (ii) abstract such perceptions into
186 models through analysis in an automated manner; and (iii) use model inference to formulate
187 options for information or action.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

245 12E. The division shall enforce the requirements of sections 12 through 12D, inclusive,
246 and section 16 and shall impose a penalty or other remedy against a carrier or utilization review
247 organization that fails to comply with the requirements of these sections. If the commissioner
248 determines that a carrier or utilization review organization is failing to comply with the
249 requirements of section 12 through 12D, inclusive, or 16 of this chapter, the commissioner shall
250 notify the carrier of such violation and shall impose a corrective action plan. If the carrier does
251 not come into compliance by adhering to the corrective action plan within a period determined
252 by the commissioner, the carrier shall be fined up to \$5,000 for each day during which such
253 violation continues; provided, however, that the commissioner may impose additional penalties
254 for repeated or wanton violations.

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

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

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

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

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

267 15 members: the executive director of the health policy commission or a designee, who shall
268 serve as co-chair; the commissioner of insurance or a designee, who shall serve as co-chair; the
269 secretary of the executive office of health and human services or a designee; the assistant
270 secretary for MassHealth or a designee; the executive director of the group insurance
271 commission or a designee; the executive director of the center for health information and
272 analysis, or a designee; a representative of the Massachusetts Medical Society; a representative
273 of the Massachusetts Health and Hospital Association; a representative of Health Care For All; a
274 representative of the Massachusetts Association of Health Plans; a representative of Blue Cross
275 Blue Shield of Massachusetts; a representative of the Massachusetts Association for Mental
276 Health; a representative of the Association for Behavioral Health; a representative of the
277 Massachusetts League of Community Health Centers; and a representative of the Massachusetts
278 Health Data Consortium. The task force shall consult with other health care experts as
279 appropriate, including, but not limited to, non-hospital providers.

280 (b) The task force shall analyze: (i) data collected by the division of insurance under
281 section 8N of chapter 26 of the General Laws; (ii) total health care expenditures associated with
282 the submission and processing, including appeals, of prior authorization determinations; (iii) an
283 analysis of the impact of prior authorization requirements on patient access to and cost of care;
284 (iv) identification of items, services and medications subject to prior authorization that have low
285 variation in utilization across providers and carriers or no or low denial rates across carriers; (v)
286 identification of items, services and medications subject to prior authorization for certain chronic
287 disease services that negatively impact chronic disease management; (vi) the integration of
288 standardized electronic prior authorization attachments, standardized forms, requirements and
289 decision support into electronic health records and other practice management software to

290 promote transparency and efficiency; and (vii) recommendations regarding the simplification of
291 health insurance prior authorization standards and processes to improve health care access and
292 reduce the burden on health care providers.

293 (c) The task force shall develop recommendations regarding: (i) simplifying and
294 standardizing prior authorization for evidence-based treatments, services or courses of
295 medication across carriers; (ii) improving access to medically necessary care for patients; (iii)
296 reducing the response time from a carrier or utilization review organization for prior
297 authorization approvals and denials; (iv) reducing administration burden and costs related to
298 prior authorization for health care providers; (v) limiting the recoupment and denial of claims for
299 medical necessary covered services; (vi) increasing transparency for covered benefit and prior
300 authorization requirements; (vii) standardizing prior authorization processes, forms and
301 requirements across health insurance carriers; (viii) eliminating prior authorization requirements
302 for admissions, items, services and medications that have low variation in utilization across
303 providers or low denial rates across carriers; (ix) eliminating prior authorization for urgently
304 needed or emergency treatments, services or courses of medications; (x) ensuring any physician
305 or provider under the supervision of a physician that is reviewing a prior authorization request
306 for a carrier or utilization review organization has the clinical expertise to treat the medical
307 condition or disease that is the subject of the request; and (xi) removing prior authorization for
308 certain chronic disease management.

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

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

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

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

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

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

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

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