IT'S TIME TO FIX PRIOR AUTHORIZATION

SD.2471, An Act Relative to Reducing Administrative Burden

HD.4148, An Act Improving the Health Insurance Prior Authorization Process

Sponsors: Senator Cindy Friedman and Representative Marjorie Decker

WHAT IS PRIOR AUTHORIZATION AND WHY IS IT A PROBLEM?

- Health plans routinely require providers to obtain prior authorization (PA) to justify why a recommended treatment is medically necessary *before* a prescription medication or medical services can be delivered to the patient.
- When a prior authorization is denied, the health plan will not cover the service or medication, often resulting in treatment being delayed or abandoned by the patient or leaving the patient with significant out-of-pocket costs.
- There is a widespread lack of transparency with prior authorization utilization, which obscures whether it is an effective cost-cutting measure and how it impacts access to care.

PATIENT IMPACT

- Prior authorization significantly impacts patients by causing delays in access to medically necessary care, which can harm their health outcomes.
- In the 2024 AMA Annual Prior Authorization Survey, physicians reported on the impact of PA on their patients:
  - 93% said PA led to delays in accessing care.
  - 82% said PA often or sometimes results in their patients abandoning a recommended course of treatment.
  - 80% said PA led to patients paying out of their own pocket for a medication.
  - More than 1/4 of physicians (29%) found PA led to a serious adverse health event for their patients.

PROVIDER IMPACT

- Overutilized PA practices create inordinate stressors, unsustainable workloads, and considerable operational and financial burden for physician practices, hospitals, and health care professionals.
- The lack of uniformity and standardization across payor prior authorization requirements and the variation in applicable medical necessity criteria exacerbate these challenges and are exceptionally difficult for providers to navigate.
- Massachusetts' primary care system is in crisis in part, according to a new Health Policy Commission (HPC) report, because of **high administrative burden**, which leads to less time to care for patients, increased provider frustration and burnout, and providers leaving the field further exacerbating severe patient access challenges.
  - 55% of physician survey respondents reported experiencing symptoms of burnout, and PA was identified as one of the top five stressors.
- The Massachusetts Health & Hospital Association's (MHA) brief on billing and insurance-related expenses shows that sensible administrative reforms could remove as much as $1.75 billion in cost waste from the Commonwealth's health care system.

PATIENT STORY

I saw a young patient in the Emergency Department (ED) who required an inpatient hospitalization because a prior authorization denied her care. She had a history of severe gastric reflux that required surgical intervention but had been well-controlled through medication. Despite no changes in her insurance or medication, her insurer unnecessarily required and repeatedly denied a new prior authorization for her generic medication. As a result, she ended up in the ED throwing up blood from uncontrolled gastric reflux because she was denied access to her treatment.

— Boston-area Pediatric Resident

Massachusetts Medical Society

HCFA Health Care For All Massachusetts

MHA Massachusetts Health & Hospital Association

THE SOLUTION *(over)*

THE SOLUTION

When PA determinations override evidence-based decisions and recommendations of medical professionals, quality of care is reduced, costs go up, and waste is increased. To reduce administrative burden and promote timely access to quality care, this legislation will maintain PA but introduce meaningful reforms to accomplish the following:

Improve Timely Access to and Continuity of Care for Patients

- Requires PA to be valid for the duration of treatment, or at least one year
- Requires insurers to honor the patient's PA from another insurer or maintain coverage when a drug is removed from a plan's formulary for at least 90 days
- Establishes a 24-hour response time for urgently needed care

Promote Transparency and Fairness in the PA Process

- Requires public PA data from insurers documenting what services, items, or medications are subject to PA, as well as data on approvals, denials, appeals, wait times, and more
- Prohibits retrospective denials for preauthorized care
- Regulates the use of artificial intelligence (AI) in PA programs, including prohibiting the use of AI as the sole basis for denial of authorization for care

Improve Administrative Efficiency

- Establishes a task force to study the use of PA and make recommendations for simplification and standardization
- Directs the Division of Insurance (DOI) to develop rules and regulations to simplify prior authorization standards and processes
- Requires insurers to adopt software to facilitate automated, electronic processing of PA and DOI to implement standardized PA forms

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