HOUSE DOCKET, NO. 3799 FILED ON: 2/19/2021

HOUSE . . . . . No. 1200

The Commonwealth of Massachusetts

PRESENTED BY:

Jon Santiago

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 to improve the health insurance prior authorization process.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
Jon Santiago	*9th Suffolk*	*2/19/2021*
James J. O'Day	*14th Worcester*	*2/25/2021*
Lindsay N. Sabadosa	*1st Hampshire*	*2/25/2021*
Jack Patrick Lewis	*7th Middlesex*	*2/26/2021*
Michelle L. Ciccolo	*15th Middlesex*	*2/26/2021*
Paul McMurtry	*11th Norfolk*	*2/26/2021*
Brian W. Murray	*10th Worcester*	*2/26/2021*
Walter F. Timilty	*Norfolk, Bristol and Plymouth*	*3/17/2021*
Vanna Howard	*17th Middlesex*	*3/19/2021*
David M. Rogers	*24th Middlesex*	*3/30/2021*
Joanne M. Comerford	*Hampshire, Franklin and Worcester*	*3/31/2021*

HOUSE DOCKET, NO. 3799 FILED ON: 2/19/2021

HOUSE . . . . . No. 1200

By Mr. Santiago of Boston, a petition (accompanied by bill, House, No. 1200) of Jon Santiago and others relative to the health insurance prior authorization process. Financial Services.

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Second General Court
(2021-2022)

An Act to improve the health insurance prior authorization process.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 18 of chapter 15A of the General Laws is hereby amended by adding the following two paragraphs:-

Any qualifying student health insurance plan authorized under this chapter shall adopt utilization review criteria and conduct all utilization review activities under the criteria and in compliance with this paragraph and the following paragraph. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians. Utilization review criteria, including detailed preauthorization requirements and clinical review standards, shall be applied consistently and made easily accessible and up-to-date on a website by the institutions of higher education or any entity that provides or manages health insurance benefits and to the general public in a searchable electronic format; provided, however, that the institutions of higher education or any entity that contracts to provide or manage health insurance benefits shall not be required to disclose licensed, proprietary criteria purchased by a carrier or utilization review organization on its website, but

shall disclose the licensed, proprietary criteria relevant to particular treatments and students and their dependents and health care providers upon request. If the institution of higher education or an entity with which the institution of higher education 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 shall not be implemented unless: (i) the appropriate website has been updated to reflect the new or amended requirement or restriction; (ii) students of the institutions of higher education and their dependents are notified of the changes by electronic means via email and the member portal, or for those without access to electronic means of communication, by mail; and (iii) the institutions of higher education or entity which that contracts to provide or manage health insurance benefits has processes in place to ensure continuation of any previously approved preauthorizations.

The institutions of higher education or any entity that contracts to provide or manage health insurance benefits under this section shall not retrospectively deny authorization for an admission, procedure, treatment or service when an authorization has already been obtained for that service unless the approval was based upon inaccurate information material to the review or the services were not provided consistent with the health care provider's submitted plan of care and any restrictions included in the preauthorization approved by the student health plan program or an entity with which the commission contracts to provide or manage health insurance benefits.

SECTION 2. Chapter 32A of the General Laws is hereby amended by inserting after section 4B the following section:-

Section 4C. The commission or an entity with which the commission contracts to provide or manage health insurance benefits, shall adopt utilization review criteria and conduct all utilization review activities under the criteria and in compliance with this section. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians. Utilization review criteria, including detailed preauthorization requirements and clinical review criteria, shall be applied consistently and made easily accessible and up-to-date on a website by the commission or any entity that provides or manages health insurance benefits and to the general public in a searchable electronic format; provided, however, that the commission or an entity with which the commission contracts to provide or manage health insurance benefits shall not be required to disclose licensed, proprietary criteria purchased by a carrier or utilization review organization on its website, but shall disclose such licensed, proprietary criteria relevant to particular treatments and services to active or retired employees of the commonwealth, their dependents and health care providers upon request. 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 shall 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 are notified of the changes by electronic means via email and the 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 shall not retrospectively deny authorization for an admission, procedure, treatment or service when an authorization has already been obtained for that service unless the approval was based upon inaccurate information material to the review or the services were not provided consistent with the health care provider's submitted plan of care and any restrictions included in the preauthorization approved by the commission or an entity with which the commission contracts to provide or manage health insurance benefits.

SECTION 3. Subsection (a) of section 12 of chapter 176O of the General Laws is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

A carrier or utilization review organization shall adopt utilization review criteria and conduct all utilization review activities under the criteria and in compliance with this section. The criteria shall 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, including detailed preauthorization requirements and clinical review criteria, shall 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 to the general public in a searchable electronic format; provided, however, that a carrier shall not be required to disclose licensed, proprietary criteria purchased by a carrier or utilization review organization on its website, but shall 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 shall ensure that the new or amended requirement or restriction shall not be implemented unless: (i) the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction; (ii) insureds are notified of the changes by electronic means via email and the member portal, or for those without access to electronic means of communication, by mail; and (iii) the carrier or utilization review organization has processes in place to ensure continuation of any previously approved preauthorizations.

SECTION 4. Said section 12 of said chapter 176O is further amended by adding after subsection (f) the following subsection:-

(g) A carrier or utilization review organization shall not retrospectively deny authorization for an admission, procedure, treatment or service when an authorization has already been obtained for that service unless the approval was based upon inaccurate information material to the review or the services were not provided consistent with the health care provider's submitted plan of care and any restrictions included in the preauthorization approved by the carrier or utilization review organization.

SECTION 5. (a) The division of insurance shall establish a committee to develop recommendations regarding simplification of health insurance prior authorization standards and processes to improve health care access and reduce the burden on providers.

(b) The committee shall consist of the commissioner of insurance or a designee, who shall serve as chair and 17 members to be appointed by the commissioner, 1 of whom shall be a representative of the Massachusetts Health and Hospital Association, Inc., 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts, Inc., 1 of whom shall be the

executive director of the Office of Patient Protection or a designee, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of the Massachusetts Health Connector; 1 of whom shall be representative of the Massachusetts Medical Society, 1 of whom shall be a representative of the Group Insurance Commission, 1 of whom shall be currently practicing pediatric provider; 1 of whom shall be a currently practicing provider specialized in hospital medicine; 3 of whom shall have expertise in the treatment of individuals with a mental illness with at least 1 specializing on pediatric mental health and 1 with substance use disorder expertise, 1 of whom shall be a representative of the Massachusetts Association of Mental Health, Inc., 1 of whom shall be a representative of a Black, Indigenous, People of Color-led consumer organization, 1 of whom shall be a representative from a health consumer advocacy organization; 1 of whom shall be a representative of an organization representing people with a chronic disease, and 1 of whom shall be a representative of a legal services organization.

(c) The committee shall identify: (i) services which have no or low prior authorization denial rates across carriers, based on the report from the health policy commission in section 6 of this act; (ii) the administrative constraints to continuing active prior authorizations for their approved duration in instances where an insured transitions to a new plan with the same carrier or to a new carrier.

(d) The committee shall develop recommendations regarding: (i) establishing standardized prior authorization processes, forms, and requirements for use across health insurance carriers and plans; (ii) eliminating prior authorization requirements for services, treatments, procedures and prescription drugs that have low variation in utilization across providers or low denial rates, based on the services identified under subsection (c); (ii) removing

prior authorization requirements for certain chronic disease services to improve chronic disease management; (iii) implementing consistent time frames for how long prior authorizations are in effect across carriers that minimize the need for repeated authorization requests.

(e) The committee may prioritize certain services, treatments, procedures or prescription drugs in developing recommendations pursuant to subsections (c) and (d).

(f) In developing its recommendations, the committee shall consider the role of prior authorizations in alternative payment arrangements and whether to differentiate its recommendations based on payment arrangements.

(g) The committee shall establish recommended timelines for carriers to complete each of the committee's recommendations.

(h) The committee shall file its recommendations, including any proposed regulations, with the clerks of the senate and the house of representatives and the joint committee on health care financing no later than April 1, 2022.

(i) The division of insurance shall be authorized to implement the committee's recommendations by regulation or sub-regulatory guidance.

SECTION 6. (a) The health policy commission shall conduct an analysis, in consultation with the Massachusetts Collaborative, the center for health information and analysis, and the division of insurance, of the progress of adoption of statewide forms since the implementation of requirements under section 207A of chapter 224 of the acts of 2012, subsection (c) of section 25 of chapter 176O of the General Laws, and federal standards pursuant to section 1104 of the Patient Protection and Affordable Care Act, Public Law 111-148 as implemented by the National

Standards Group within the Center for Medicare and Medicaid Services. The analysis shall include a review of 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. The analysis shall include services which have no or low prior authorization denial rates across carriers to determine the necessity of prior authorizations for services with low denial rates.

(b) The commission shall request from insurance carriers all necessary and relevant data pursuant to section (a) within 90 days of the effective date of this act. All insurance carriers shall provide the requested data to the commission.

(c) The commission shall prepare a report of its findings that shall include, but not be limited to, administrative barriers encountered by health insurance carriers and providers to implementing the statewide standards for electronic prior authorization processes listed under subsection (a) and recommendations with proposed timelines for complete implementation of the standards. The health policy commission shall file its findings with the committee established under section 5 of this act by January 1, 2022.