Prior Authorization and Utilization Management

What is Prior Authorization and Utilization Management?

Prior authorization and other utilization management practices are tools used by health plans to protect patients, reduce medical expenses, and prevent fraudulent care. When employers purchase health insurance coverage, they expect health plans to utilize these tools to ensure that their members can access safe, evidence-based, and cost-effective care at the right time and in the right setting. Health plans and government programs use prior authorization in limited circumstances to lower patient's out of pocket costs, prevent misuse, overuse, and unnecessary or potentially harmful care, and to ensure that care is consistent with evidence-based practices.

2023-2024 Legislative Session:

This legislative session, approximately 34 bills have been filed to eliminate or modify utilization management tools like prior authorization, including the following:

- Prohibition of prior authorization for all prescription drugs, including costly branded and specialty drugs (Senate Bill 677 Mark / House Bill 941 Balser)
- Elimination of prior authorization, concurrent review, and retrospective review (Senate Bill 1249 Friedman / House Bill 1143 Santiago)
- Shortening the response time for a prior authorization request to 24 hours, constricting health plans' ability to manage complex cases (House Bill 1091 Markey)
- Prohibition on prior authorization for certain services or treatments, including:
    - Experimental COVID-19 therapeutics (SB625 DiDomenico)
    - Food (SB604 Crighton)
    - Alternative pain management (SB659 Keenan/HB990 Balser)

Talking Points:

- We must ensure that the right care is delivered at the right time in the right setting – and covered at a cost that consumers and employers can afford.
- Prior authorization, retrospective review, and concurrent review are utilization management tools used to ensure access to safe, evidence-based, and affordable health care for consumers and employers, and to provide intervention in areas that are vulnerable to misuse, excessive spending, or fraud.
- Our healthcare system needs utilization management for three key reasons:
    - To protect against unnecessary care – doctors themselves estimate that nearly a quarter of care is unnecessary, which has been confirmed by numerous studies.
    - To protect against harmful care – inappropriate care can be more than merely wasteful, it can be harmful, such as exposure to unnecessary radiation, missed diagnoses and false positives, and ineffective procedures and treatments. 65% of physicians themselves have reported that at least 15-30% of medical care is unnecessary.
    - To increase health care affordability – needless medical tests waste billions of dollars every year; $200-$800 billion is wasted annually on excessive testing and treatment.
- Health plans are subject to rigorous statutory and regulatory standards for the development and application of utilization management programs.
    - On behalf of the employers and consumers they serve, health plans regularly review and update the scope of services subject to prior authorization, with input and guidance from provider experts.
    - Prior authorization requirements and medical necessity guidelines are filed with the Division of Insurance and are publicly posted on health plan websites.
    - Health plans are required to respond to a complete prior authorization request within 2 business days.
    - As technology advances opportunities to streamline the prior authorization process, health plans are at the forefront, working alongside the Network for Excellence in Health Innovation (NEHI) on their project to advance prior authorization automation in Massachusetts.