Prior Authorization and Utilization Management

MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

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.**

2025-2026 Legislative Session

This legislative session, approximately **37 bills** have been filed to eliminate or modify utilization management tools like prior authorization, including the following:

- Prohibition of prior authorization for any prescription drugs prescribed for chronic diseases, including costly branded and specialty drugs (*HB1222 Kerans*)
- Elimination of prior authorization, concurrent review, and retrospective review (*SB1403 Friedman*)
- Shortening the response time for a prior authorization request to 24 hours, constricting health plans' ability to manage complex cases (*Senate Bill 796 Montigny / House Bill 1255 Markey*)
- Prohibition on prior authorization for certain services or treatments, including:
  - HIV prevention drugs (*SB717 Cyr*)
  - Any prescription drug for serious mental illness (*HB1128 Decker*)
  - Any health care service for the prevention, diagnosis, or treatment of a contagious or infectious disease *(HB1137 Domb)*

Talking Points

Review and Regulations

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.

Talking Points

Ensuring Affordable, Quality Care

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.

Health plans alone cannot solve the health care affordability crisis in Massachusetts. Restricting or eliminating the few tools health plans have to ensure that patients are receiving evidence-based, high-quality health care will remove the vital checks and balances in our health care system. Health plan utilization management tools like prior authorization, retrospective review, and concurrent review are 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.

- A late 2023 Milliman report found that removing health plans' ability to conduct prior authorization will result in commercial premium increases ranging from 9.1% to 23.3% annually, or between $2.2 billion and $5.6 billion in additional premium costs for Massachusetts consumers.

Reasons for Utilization Management

Our health care system needs utilization management for three key reasons:

- To protect against unnecessary care – Physicians themselves report that more than 20% of medical care is not needed, including about a quarter of tests, more than a fifth of prescriptions, and more than a tenth of procedures.
- 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. A 2019 survey of physicians in the U.S. found that 398 out of 400, or 99.5%, of the physicians surveyed have seen cascades of care following incidental findings that did not lead to clinically meaningful outcomes, yet caused harm to patients.
- To increase health care affordability – needless medical tests waste billions of dollars every year; The HPC found that more than 20% of patients received at least one instance of low-value care. In total, there were nearly 800,000 low-value services identified over the study time period, accounting for nearly $80 million in health care spending.

Review and Regulations

Health plans in Massachusetts and nationally are working to implement electronic prior authorization pursuant to CMS requirements. Prior to the release of the CMS final rule, health plans in Massachusetts voluntarily worked alongside the Network for Excellence in Health Innovation (NEHI) on their project to advance prior authorization automation in Massachusetts.

- As technology advances opportunities to streamline the prior authorization process, health plans are at the forefront, now working alongside the New England Healthcare Exchange Network (NEHEN) and the Massachusetts Health Data Consortium (MHDC) to explore a cost-effective and collaborative pathway to the future of prior authorization automation.
- Since the major underlying cause of frustration with prior authorization is not with the fundamental tenets of prior authorization itself but with the manual process, integration and automation will not only streamline the administrative process but also improve the patient experience.