MAHP
MASSACHUSETTS ASSOCIATION of HEALTH PLANS

FOR THE RECORD

COMMITTEE:	**Joint Committee on Financial Services**
ISSUE:	**H1136, An Act improving the health insurance prior authorization process** **H1255, An Act relative to reducing unnecessary delays in patient care** **H1320, An Act relative to reducing the administrative burden for preauthorization** **S796, An Act relative to reducing unnecessary delays in patient care** **S706, An Act to prevent inappropriate denials by insurers for medically necessary services**
DATE:	**July 15, 2025**
POSITION:	**Oppose**

The Massachusetts Association of Health Plans, on behalf of our 13 member plans and one behavioral health organization which provide coverage to nearly 3 million Massachusetts residents, strongly opposes House Nos. 1136, 1255, 1320 and Senate Nos. 706, 796 and 770, which will significantly curtail the use of prior authorization and undermine one of the most effective tools available to ensure that patients receive safe, effective and affordable care. Continued erosion of health plan tools to constrain costs threatens our collective ability to meet the state's health care cost growth benchmark.

Prior authorization is a critical patient protection tool, not a barrier to care. When employers purchase health insurance coverage or when government partners with managed care plans to deliver Medicaid or Medicare benefits, they expect health plans to use utilization management tools like prior authorization to ensure members receive evidence-based care at the right time and in the right setting. These bills threaten that foundational function by eliminating or limiting key components of utilization management, including concurrent and retrospective review, administrative denials, and the ability to reassess authorization mid-treatment.

These efforts to restrict or eliminate health plans' ability to manage care are hinged on the false premise that prior authorization is a barrier to care erected by non-medical health plan staff. In reality, prior authorization is just one example of a range of evidence-based medical management tools adopted by health plans and the state and federal government (and at the direction of the state and federal government in the Medicaid and Medicare programs) to ensure that patients receive optimal care based on well-established evidence of efficacy and safety. Under state and federal law and regulations, health plans are required to conduct prior authorizations under the supervision of a physician and appropriately trained and qualified personnel, licensed in the

appropriate specialty, tasked with reviewing and evaluating the medical necessity of a requested service or treatment. The criteria used to determine medical necessity must be scientifically derived and evidence-based, must be developed with the input of physicians in the health plan's network, and must be applied consistently. Indeed, prior authorization is not an arbitrary barrier to care – it is a carefully developed, scientifically derived, set of patient protections designed to ensure that the premium dollars employers and consumers pay to health plans are spent on clinically appropriate, evidence-based care.

Too often our health care dollars are wasted on unnecessary, inappropriate, or even harmful care. The Betsy Lehman Center reports that, in a single year, medical errors accounted for $617 million in excess costs in Massachusetts. And a 2019 JAMA study found that 65% of physicians have said that at least 15-30% of medical care rendered is unnecessary, and every year, low-value care costs our health care system over $340 billion. Unnecessary care isn't just costly, it can be harmful to patients – exposure to unnecessary radiation, missed diagnoses, false positives, ineffective treatments and procedures can all have a profound impact on patients.

Part of the problem is that diffusion of medical knowledge is notoriously slow. It takes, on average, seventeen years for the results of clinical trials to become standard clinical practice and the amount of medical knowledge is said to double every 73 days, making it much more difficult for physicians to identify innovative findings and newer guidelines for helping patients. Conversely, health plans are statutorily required to update their medical necessity criteria on a bi-annual basis to reflect the most up-to-date clinical practice guidelines. Restricting or eliminating the very tools used to ensure that patients are receiving evidence-based, high-quality health care will remove the vital checks and balances in our health care system.

We've seen, firsthand, the impact of removing prior authorization on members' care and costs with the waiver of prior authorization for admissions to post-acute care facilities from acute care hospitals for the period from December 6, 2022 through March 6, 2023. During this 90-day period, MAHP member plans tracked the waiver's impact and found that waiving prior authorization created care coordination challenges, raised concerns about members being placed in inappropriate or ill-equipped post-acute care facilities, and increased out of network charges for members. Rather than facilitating placement in appropriate post-acute care sites – including home with services – eliminating prior authorization for this period resulted in increased admissions to post-acute care facilities by 14% exacerbating existing capacity challenges, increased use of non-participating providers by 50%, and resulted in a significant number of members admitted to inappropriate sites of care. For members with complex medical and behavioral health needs, inappropriate placement can prolong inpatient care and exacerbate existing conditions. In response to these findings, the Legislature chose to enact a two-year pilot program for expedited prior authorization for transitions to post-acute care, to preserve critical

care coordination and medical necessity review, while working to hasten the turnaround time for approvals. This balance recognized the value and role of prior authorization.

MAHP and our member plans recognize that while prior authorization is critical, the process can be burdensome to patients, providers, and to health plans when outdated, manual, or paper-based systems are utilized. That is why Massachusetts health plans have worked with providers to develop and implement standardized prior authorization forms for all behavioral health care, prescription drug, imaging and radiology, autism spectrum disorder services and treatment, post-acute care, and home health services prior authorizations.

And as technology has advanced, health plans are at the forefront, actively advancing electronic prior authorization through the New England Health Exchange Network (NEHEN), leveraging HL7 FHIR standards to streamline provider workflows, reduce administrative burden, and accelerate access to care. These efforts will address many of the burdens associated with today's manual processes and provide greater transparency into the efficacy and value of prior authorization programs, and importantly, align with the requirements for Medicare, Medicaid, and QHP plans in the recently released final federal rule on prior authorization.

In Massachusetts, where total health care expenditures continue to climb – exceeding $78 billion in 2023 alone – and health care cost growth outpaces inflation and income growth, prohibiting health plans from conducting utilization management eliminates one of the few checks our health care system has on unfettered health care price growth.

At a time when health care costs threaten our ability to access care, we must focus on common sense solutions to modernize our health care system, rather than chipping away at needed cost containment tools. For these reasons we **OPPOSE House Nos. 1136, 1255, 1320 and Senate Nos. 706, 796 and 770.**