IT'S TIME TO FIX PRIOR AUTHORIZATION

S.1249, An Act relative to reducing administrative burden

H.1143, An Act to improve the health insurance prior authorization process

Sponsors: Senator Cindy Friedman and Representative Jon Santiago

WHAT IS PRIOR AUTHORIZATION?

Health plans routinely require providers to obtain pre-approval, also known as prior authorization (PA), to justify why a recommended treatment is necessary *before* a prescription medication or medical services can be delivered to the patient.

PA began as a tool to monitor and control spending on costly or novel treatments but has proliferated to apply broadly to many services and treatments, including generic medications. Today, the burdens associated with the PA process far exceed the purported benefits of cost and quality control, leading to avoidable patient harm and waste in the system.

PRIOR AUTHORIZATION HURTS PATIENTS

A recent survey by the American Medical Association (AMA) demonstrates the harmful impact of PA on patients, with physicians overwhelmingly reporting PAs delay care and can lead to treatment abandonment. Over 1/3 of physicians reported that PA requirements led to a serious adverse health event for their patients, including hospitalization or a life-threatening event.[1] The PA process can delay access to life-saving treatments and care for diseases like cancer, as oncologists are forced to obtain PA for treatments and procedures like transplants, which are already heavily regulated and required to meet rigorous, nationally mandated, evidence-based standards. Furthermore, communities of color have higher rates of chronic disease, which are often subject to PAs, placing disproportionate bureaucratic barriers to evidence-based clinical care.

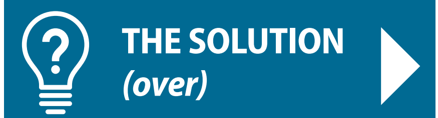
[1] 2022 *AMA Prior Authorization (PA) Physician Survey*. n.d. American Medical Association. www.ama-assn.org/system/files/prior-authorization-survey.pdf.

PRIOR AUTHORIZATION IS COSTLY AND ADMINISTRATIVELY BURDENSOME

Providers and staff spend 14 hours on average each week submitting paperwork, calling insurers, and appealing denials trying to secure medically necessary care for their patients. According to the AMA survey, more than four in five physicians (86%) reported that PA requirements led to higher overall utilization of health care resources, resulting in unnecessary waste rather than cost-savings. This excessive administrative burden contributes significantly to physician burnout, consistent with findings from an MMS member survey report assessing the state of physician well-being in Massachusetts. The report showed that 55% of physicians are experiencing symptoms of burnout and identified PA as a top five stressor. The American Hospital Association, in its November 2022 report on commercial insurance practices, came to similar conclusions regarding policies that delay patient care, burden clinicians, and potentially increase costs.[2]

[2] www.aha.org/press-releases/2022-11-01-aha-survey-some-commercial-health-insurers-apply-policies-delay-patient-care-burden-clinicians-and

Massachusetts Medical Society



THE SOLUTION

While there is a role for prior authorization, there is a critical need for reforms to streamline or eliminate low-value prior authorization requirements to minimize waste, delays, and disruptions in access to care for patients. To reduce administrative burden and promote access to quality, timely care, this legislative session **Senator Cindy Friedman** and **Representative Jon Santiago** introduced:

S.1249, An Act relative to reducing administrative burden

H.1143, An Act to improve the health insurance prior authorization process

This legislation **maintains prior authorization and proposes reforms that will:**

Improve Access to and Continuity of Care for Patients

- Prohibits PA for generic medications and medications and treatments that currently have low denial rates, low variation in utilization, or an evidence-base to treat chronic illness
- Requires PA to be valid for the duration of treatment or at least 1 year
- Requires insurers to honor the patient's PA from another insurer for at least 90 days

Promote Transparency and Fairness in the PA Process

- Requires public PA data from insurers relating to approvals, denials, appeals, wait times, and more
- Requires the Health Policy Commission to issue a report on the impact of PA on patient access to care, administrative burden, and system cost
- Prohibits retrospective denials if care is preauthorized
- Requires carriers to notify affected individuals about any new PA requirements

Improve Timely Access to Care and Administrative Efficiency

- Establishes a 24-hour response time to authorize urgent care
- Requires insurers to adopt software to facilitate automated, electronic processing of PA and the Division of Insurance (DOI) to implement standardized PA forms

Massachusetts Medical Society

Massachusetts Health & Hospital Association