



MASSACHUSETTS
MEDICAL SOCIETY

Every physician matters, each patient counts.



MASSACHUSETTS
Health & Hospital
ASSOCIATION



January 17, 2024

Hon. John C. Velis, Chair
Joint Committee on MHSUR
State House, Room 513
Boston, MA 02133

Hon. Adrian C. Madaro, Chair
Joint Committee on MHSUR
State House, Room 33
Boston, MA 02133

Re: Testimony in support of SB 1249

The Massachusetts Medical Society (MMS), Massachusetts Health & Hospital Association (MHA), and Health Care For All (HCFA) have come together to create Putting Patients Over Paperwork: *The Coalition to Streamline Access to Care* (PA Coalition). We collectively represent Massachusetts' physicians and healthcare providers, hospital systems, and most importantly, patients. The PA Coalition was formed in recognition of the pressing need to reform the prior authorization (PA) process in Massachusetts as it delays necessary patient care and creates inordinate burdens for physicians and hospitals alike. The PA Coalition strongly supports Senate Bill 1249, *An Act relative to reducing administrative burden*, as an important step toward ensuring timely patient access to care and high-quality, efficient, care.

Prior authorization 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 common lifesaving devices like inhalers. Prior authorizations can negatively impact patient care. As noted in the Milliman report referenced below, the application and efficacy of PA programs vary from plan to plan due to varying clinical considerations, such as medical policy and clinical judgement, as well as the plan's resources and rigor applied to the PA process internally, meaning that even when *evidence-based policies* are used, they are not always evenly applied resulting in delays or denial of *evidence-based care* for patients.. Today, the burdens associated with the prior authorization process far exceed the stated benefits of cost and quality control, leading to avoidable patient harm, physician burnout and waste in the system.

Prior Authorization Harms Patients

Prior authorization often leads to the delay or outright denial of care for patients, negatively impacting outcomes. HCFA provides direct consumer assistance through a toll-free HelpLine that takes over 20,000 calls a year staffed by enrollment counselors in five different languages. Too often, the HelpLine counselors hear stories about how health coverage does not always translate to access to care. One of the most difficult issues they deal with is assisting callers with lags or unnecessary breaks in treatment due to prior authorizations, particularly for patients with complicated medical needs and/or chronic diseases for whom adherences to a medical treatment plan is critical. Helpline counselors often hear complaints about redundant authorizations, delays in processing, requirements to reestablish prior authorizations under a new plan, and confusion about plan communications and forms. Furthermore, over half of the calls to HCFA's HelpLine each year are conducted in Spanish and Portuguese. For people with limited English proficiency, language barriers further complicate the ability to understand and navigate the PA process, which can further exacerbate the negative impacts of delayed or denied care.

Physicians also see the impact on patients. A recent [survey](#) by the American Medical Association (AMA) demonstrates the harmful impact of PA on patients, with physicians overwhelmingly reporting that PAs delay care and can lead to treatment abandonment. Ninety four percent of physicians surveyed reported that PA delayed access to necessary care, and over one third of physicians reported that prior authorization requirements led to a serious adverse health event for their patients, including hospitalization or a life-threatening event. The process can suspend necessary access to life-saving treatments and care for diseases like cancer, as oncologists are forced to obtain prior authorization for treatments and procedures like transplants, which are already heavily regulated and required to meet rigorous, nationally mandated, evidence-based standards.

Take for example one HCFA HelpLine caller who called the HelpLine after going through a divorce and losing his spouse's coverage. The HelpLine counselor was able to get him enrolled in a new plan but his provider was not in his new plan's network. He had an active prior authorization for blood pressure medication from his previous insurer but couldn't get the medication through the new insurer until he saw his new doctor. He thought he would be okay waiting a week or two without his medication, but a couple of weeks later, he called back. He was hospitalized after a cardiac event and due to the hospitalization, he lost his job. If he had a grace period to continue accessing his medication while his new insurance processed a prior authorization, he wouldn't have ended up in the hospital and losing his livelihood.

Another HelpLine caller shared, "I have painful and disabling plaque psoriasis managed by medication. Three weeks ago, my doctor called in a refill for my medication, and provided the requested pre-authorization to my health plan but there has been no response." This is a treatment that the caller and their doctor has found effective for treating their condition that has not changed and repetitive prior authorizations led to a break in that treatment.

Here is a sampling of additional stories shared by MMS members:

I am a pediatric resident working at Boston Children's Hospital. Last night I saw a medically complex young adult in the Emergency Department who required an inpatient hospitalization because a prior authorization denied her care. She had a history of gastric reflux that was so severe that she required a surgical intervention in childhood. It had been well controlled for years using omeprazole...[s]he had not changed her insurance, medications, formulations, or pharmacy for years, but Aetna required a new prior authorization for her to continue her medically necessary, chronic, generic medication. Despite filling out all the necessary prior authorization paperwork, Aetna continued to decline refills of her omeprazole. This led to her presenting to the emergency department throwing up blood from uncontrolled gastric reflux. As a result, they had to pay for an expensive inpatient admission rather than continuing to refill a basic generic medication.

I was working in primary care pediatrics and an infant had developed a milk allergy. He needed a special formula which is paid for by insurance. The Pedi GI national guidelines advise using a certain hydrolyzed formula and specifically not soy as 30% of milk allergic patients are also allergic to soy. The PA for the formula was denied. I did a telephone call with a "peer" - an older nonpracticing OB-GYN. He knew nothing about infant feeding. He insisted I use soy first. I explained the guidelines and that soy was NOT advised. He forced the family and myself to trial soy before the recommended formula would be covered. The infant tried soy and had anaphalaxis. Then the formula, the safe one, was approved. This didn't need to happen.

These examples of Massachusetts residents who have been harmed by the current prior authorization process highlight the need for the patient-centered reforms contained in S.1249.

Prior Authorization is a Driver of Physician Burnout

Burnout amongst Massachusetts is widespread – this [phenomenon existed](#) long before COVID-19, but has been acutely exacerbated by the pandemic. A recent MMS report “[Supporting MMS Physicians’ Well-being Report: Recommendations to Address the Ongoing Crisis](#),” found an astounding 55% of respondents reported experiencing symptoms of burnout. Even more alarming, one in four physicians responded that they planned to leave medicine in the next two years and 27% of Massachusetts physicians have already reduced their clinical care hours.

The largest category of stressors identified by physicians as contributing to burnout was administrative burdens, with prior authorization (PA) singled out by 58% of physicians as a source of stress. Prior authorizations take up considerable physician and staff effort, leaving less time dedicated to patient care. A [2022 American Medical Association survey](#) found that practices complete on average 45 prior authorizations per week, requiring roughly two business days (14 hours) of work, and 35% of physicians hire staff to work exclusively on prior authorizations. According to Section 12 of MGL Chapter 176O, prior authorization requests are required to be processed within two working days of submission of all necessary paperwork, which does not occur regularly in practice. Moreover, when a prior authorization is denied by an insurer, as is frequently the case, the appeal process requires the physician to get on a phone call with the insurer to justify the medical necessity of the service. These peer-to-peer calls typically take more than an hour and are scheduled at the convenience of the payor, not the busy patient schedule of the physician. Moreover, said Section 12 also requires that these peer-to-peer calls “shall be made by a person licensed in the appropriate specialty related to such health service and, if applicable, by a provider in the same licensure category as the ordering provider.” Anecdotally, the members of the MMS report that this requirement is rarely met. In one notable example, a surgeon board-certified in orthopedic surgery and hand surgery was required to speak with a pulmonologist in Atlanta for a prior authorization regarding peripheral nerve surgery. Not only is the current prior authorization unduly cumbersome, but the current statutory guardrails are largely not being complied with by commercial insurers in the commonwealth.

All of this results in a significant amount of physician time being redirected away from patient care to administrative tasks, leading to fewer hours spent on clinical care and longer patient wait times for appointments. The increased staffing needed to process PAs means increased expenses and overhead unrelated to patient care – essentially insurance companies are passing these costs onto practices. It is unsurprising to learn that according to the American Medical Association survey, more than four in five physicians (86%) reported that prior authorization requirements led to higher overall utilization of healthcare resources, resulting in unnecessary waste rather than cost savings. This, coupled with other administrivia, is unduly burdening the practice of medicine and resulting in physicians leaving clinical care altogether. We are facing unprecedented physician shortages in the commonwealth and we must address these unnecessary complexities in the practice of medicine to retain and draw back physicians to clinical practice – shoring up the pipeline alone will not alleviate physician shortages if we do not also address these structural issues.

Hospital capacity issues are also affected by PA requirements. Hospitals operate in a 24/7 environment where insurance companies do not, meaning that it's not unusual for a case

manager to wait days for a response from an insurer on a request to transfer a discharge-ready patient to a rehabilitation facility while the patient languishes in an acute care bed. In fact, MHA's Throughput Report clearly showed that insurance issues were the number one problem in timely discharges from acute care to post-acute settings. This bill would address this issue by instituting strict timelines for responding to requests.

Prior Authorization adds Unnecessary Waste into the System

Prior authorization was intended as a tool to control costs by reviewing high-cost and novel treatments, and insurers maintain that that prior authorization is necessary for containing healthcare spending. However, a 2021 McKinsey & Company [report](#) estimates that one-quarter of the \$4 trillion spent on healthcare annually in the United States - \$950 billion - is administrative. Recognizing some administrative spending is necessary, the report identifies simplification opportunities that could deliver \$265 billion in annual savings from roughly 30 interventions, including prior authorization reforms such as aligning jointly on PA criteria such as medical necessity or required documentation. MHA's recently released report on billing and insurance related expenses showed that as much as \$1.75 billion could potentially be saved in the state's healthcare system that in turn could improve affordability, care access, and delivery of services. Burdensome and varying requirements around prior authorization, differing interpretations and applications of medical necessity, and appeals of PA denials are among the major components of administrative costs outlined in this report that must be streamlined.

The Massachusetts Association of Health Plans (MAHP) recently funded a report illustrating its perspective on the importance of prior authorization in constraining healthcare costs. However, the report and its findings are misleading and do not support MAHP's premise that reforming prior authorization will frustrate the goal of containing healthcare costs. Firstly, the report is modeled off a complete elimination of prior authorization, which is misleading, **as neither S.1249, nor any bill before the legislature proposes the elimination of prior authorization.** In fact, the report underscores the need for prior authorization reform, noting that PA varies so much across plans that projecting a cost impact based on existing prior authorization programs was impossible. The report found that "overall effectiveness [of prior authorization] can vary from plan to plan, even when the scope of services is similar, due to varying clinical considerations such as medical policy and clinical judgement as well as the plan's resources and rigor applied to the PA process internally." It is also interesting to note that a very similar report by the Blue Cross Blue Shield Association, conducted by the same consulting firm, found that the impact of eliminating PA in the commercial market was significantly smaller than the conclusions reached in the MAHP report.

Finally, the study itself acknowledges that it does not take into consideration the savings that could be generated to insurers and providers by reforming prior authorization processes and reducing the number of services and medications that are subject to PA, and these savings are significant. [As previously noted, a recent MHA report](#) illustrated how excessive administrative burdens affect patient care, provider wellbeing, and overall healthcare costs and that wasteful costs could be significantly reduced through a series of sensible reforms like the ones contained in S.1249.

Some Massachusetts health plans have announced they are rolling back prior authorization requirements for some services. We applaud these individual steps, but relying on voluntary, non-uniform reductions does little to alleviate the burden prior authorization places on patients, providers, and hospitals. The lack of standardization in what procedures, medications and services require prior authorization is in and of itself, a driver of delays and burdens. If one plan

eliminates PA for a particular medication, but five other plans still require it, providers and hospitals will still be submitting prior authorizations for the medication. Statutory changes are necessary to achieve meaningful, standardized progress, as was achieved with the Mental Health ABC act, which eliminated prior authorization for acute mental health services, considerably improving access to care for patients and workflow for providers. As previously noted while the commonwealth does have some measures on the books regulating PA for fully funded commercial carriers, plans don't always comply with these requirements. Time and experience have shown we do not have the data and tools needed to meaningfully reign in this practice, making the transparency provisions in this legislation necessary.

The Solution: Reforming Prior Authorization in Massachusetts

While there is a role for prior authorization, there is also a critical need for state reforms to streamline or eliminate low-value prior authorization requirements to minimize waste, delays, and disruptions in access to care for patients. **S.1249 would not eliminate prior authorization**; instead, S.1249 is a multifaceted, data-driven approach that would increase access to and continuity of care for patients, promote transparency and fairness in the prior authorization process, and improve timely access to care and administrative efficiencies. Building off the work the legislature enacted with step therapy reforms last session, this bill would institute many similar patient-centered reforms, especially for those with chronic illness.

Increasing Access to and Continuity of Care for Patients

Although Massachusetts leads the country in its insurance coverage rate, access to insurance is not the only barrier to receipt of care. Too often, prior authorizations lead to delays in accessing care or unnecessary breaks in treatment, particularly for patients with complicated medical needs and/or chronic diseases for whom adherence to a medical treatment plan is critical. Furthermore, communities of color have higher rates of chronic disease, which are often subject to prior authorization, placing disproportionate bureaucratic barriers to evidence-based clinical care.

This legislation addresses access to and continuity of care concerns by:

- Prohibiting prior authorization for generic medications and medications and treatments that currently have low denial rates, low variation in utilization across plans, or an evidence-base to treat chronic illnesses.
- Requiring prior authorization to be valid for the duration of a specific treatment or for at least one year.
- Requiring insurance carriers to honor a patient's prior authorization from another insurance carrier for at least 90 days during coverage transitions.

Promoting Transparency and Fairness in the Existing Prior Authorization Process

A key to advancing prior authorization reforms in Massachusetts is promoting transparency in the process so that patients and providers can be more fully informed while making care decisions, as well as cataloging PA data across insurers to work toward reduced variation and to create more consistency across plans.

This legislation promotes transparency and fairness by:

- Requiring public prior authorization data from insurers relating to approvals, denials, appeals, wait times, and more.
- Requiring the Health Policy Commission to issue a report on the impact of prior authorizations on patient access to care, administrative burden, and health system costs.
- Prohibiting retrospective denials if care is preauthorized.
- Requiring insurers to notify affected individuals about any new prior authorization requirements.

Importantly, the data that would be required to be submitted to the Division of Insurance (DOI) under the legislation mirrors similar reporting requirements proposed by the Centers for Medicare & Medicaid Services that will, once finalized, go into effect in 2026. Hence, payors in Massachusetts will largely need to report this data to CMS starting in 2026.

Improving Timely Access to Care and Administrative Efficiency

S.1249 improves timely access to care and administrative efficiency by establishing a 24-hour response time to authorize urgent care, similar to the compromise reached in the aforementioned step therapy law passed in 2022. The bill would further require insurers to adopt software to facilitate automated, electronic processing of prior authorizations and for DOI to implement standardized PA forms. This administrative streamlining and simplification, leveraging technology, would, in conjunction with the other reforms provided for in H.1143, greatly improve the efficiency of the prior authorization process. We are aware and engaged in the ongoing work outside of legislative proposals to support automation efforts. However, it cannot be overstated that while automation is key to streamlining the PA process, it alone is not a panacea for reducing the unnecessary burden associated with the PA – especially its overutilization.

States across the country and even the federal government are looking at ways to reform prior authorization so that it can serve its purpose, without unnecessarily burdening providers and standing in the way of patients accessing evidence-based critical care. S.1249 accomplishes this goal for Massachusetts. We respectfully request that the committee issue S.1249 a favorable report so that it may continue through the legislative process. Thank you for your time and attention to this pressing issue.