

BETTER CARE, LOWER COSTS:

How Massachusetts Can Lead on Sensible Insurance Reform



November 2023

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Massachusetts hospitals and physician practices incur as much as \$1.75 billion in unnecessary administrative costs from billing- and insurance-related practices each year.

For many years, the commonwealth has studied and promoted ways to address healthcare costs through mechanisms such as the cost growth benchmark, reducing utilization of low-value services, and improving access to primary care and behavioral health. Many policy conversations have now rightfully shifted to the workforce, capacity, and financial pressures that providers across the state are experiencing.

Yet much less attention has been paid to the considerable costs of administrative complexity that result from billing- and insurance-related expenses.

Administrative complexity has been identified as not only a cost driver in Massachusetts and beyond, but also as a major contributor to caregiver burnout.

While a group of Massachusetts providers and insurers was formed to confront these issues, and has achieved some success, a broader, sustained effort is now required.¹ As policymakers and healthcare leaders grapple with long-term challenges borne out of the pandemic, reforming insurance practices presents the commonwealth with an immediate, highly effective way to reduce administrative complexity, remove extraneous healthcare costs, mitigate clinician and staff burnout, and make care more affordable for patients.

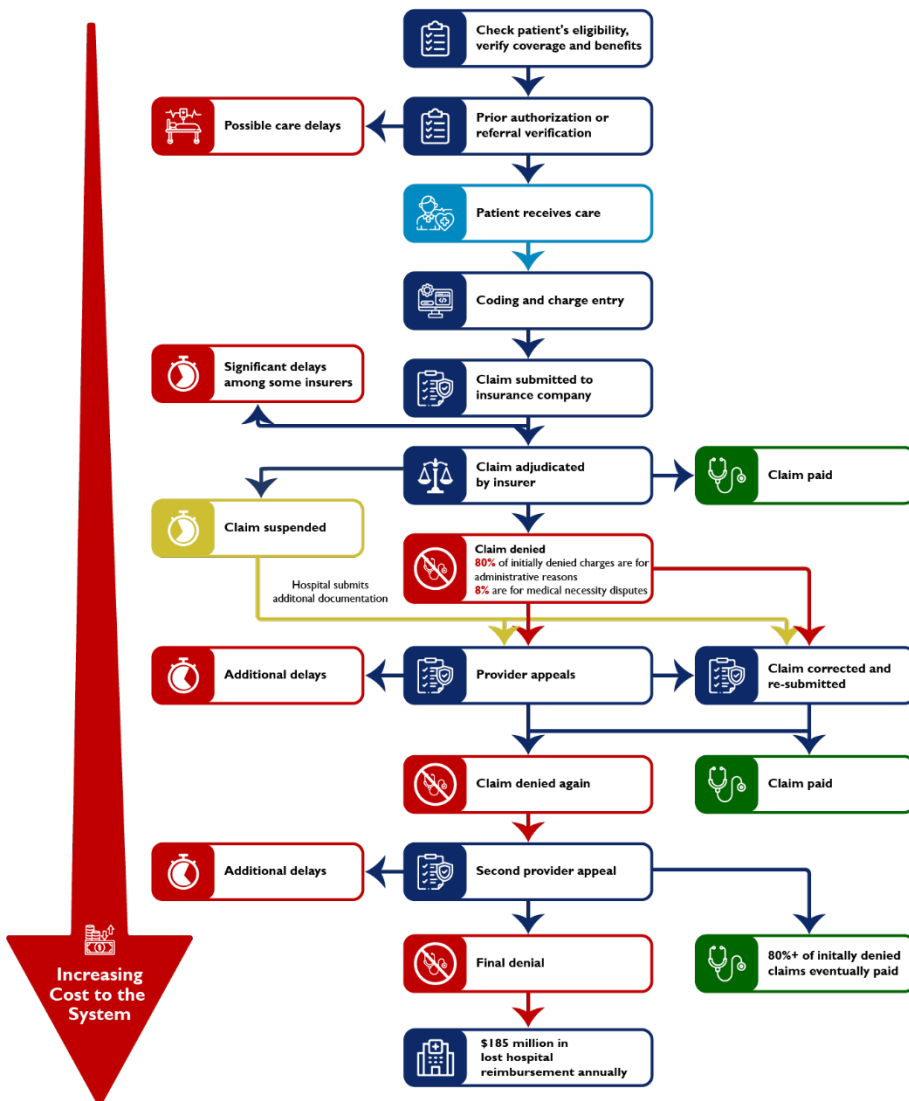
This report is intended to explain how certain insurance practices impose unnecessary stress on patients and providers, highlight new Massachusetts-specific data, and outline the simple solutions the commonwealth can pursue to remove wasteful administrative spending and reduce healthcare costs. Throughout this report are real-world examples of how administrative complexity adversely affects patient care.

What the Data Show

Massachusetts hospitals and health systems, seeking reimbursement for the care they provide to patients, each year file with commercial health insurance companies claims representing approximately \$27.5 billion in charges.²

Chart 1 illustrates the numerous steps in the end-to-end process that a provider or hospital must follow – both prior to and after seeing a patient – to be reimbursed for care.

CHART 1
Chasing a Claim: Complicated & Costly



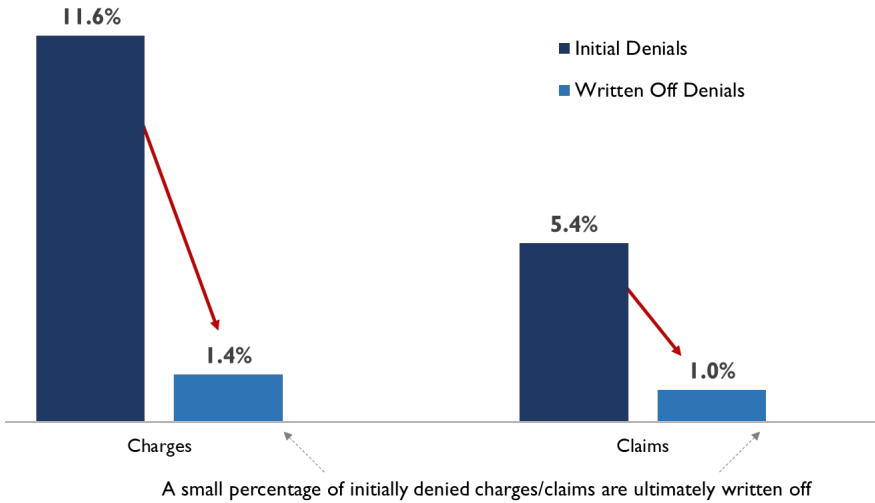
¹ The **Mass Collaborative** is a voluntary organization of more than 35 payers, providers, and trade associations dedicated to reducing complex and cumbersome healthcare administrative processes in Massachusetts. The Collaborative—formerly called the Mass Healthcare Administrative Simplification Collaborative—was developed in 2009.

² “Charges” represent the total amount that the healthcare organization bills for services provided to patients. The “allowed amount” is what the insurer actually pays for the services (minus any patient liability, such as co-pays or co-insurance) and is based on the contractual terms negotiated between insurers and providers. It is the allowed amount – along with any patient liability – that is ultimately reflected in a hospital’s revenue.

An estimated 11.6% of filed charges are initially denied in Massachusetts by commercial insurance companies, according to a recent Massachusetts Health & Hospital Association (MHA) analysis.³ **These initial denials represent an estimated \$1.5 billion in reimbursement for services that hospitals must expend time, effort, and resources to recover.** The commonwealth is not alone; the rising percentage of denials is also a concern nationally.

CHART 2
Percentage of Charges/Claims Initially Denied and Written Off

Hospitals spend significant time, effort, and resources to appeal initially denied charges/claims.



Just over 80% of denied claims in Massachusetts are eventually overturned (*Chart 2*), but the process of “chasing a claim” is expensive and time consuming. **Appealing each claim rejection – a process that often takes months, or even years – requires staff and resources that could be better devoted to patient care. Patients and employers ultimately bear these unnecessary administrative costs.**

Some literature suggests that filing an initial claim costs \$2, while working to overturn a claims denial costs **more than \$118 on average**. Each year, Massachusetts hospitals write off the remaining claims that are not overturned – amounting to \$185 million in lost hospital reimbursement.

As illustrated throughout this report, these complicated transactions and losses are adding tremendous costs to the state’s healthcare system and are impeding patients’ access to high-quality care.

A \$1.75 Billion Opportunity

For Massachusetts hospitals and physician practices, billing and insurance-related (BIR) expenses, including claims processing, total \$3.5 billion.⁴ **While some of those processes are necessary, studies suggest that up to half of that amount – \$1.75 billion – could be erased from the system through a series of red-tape-reducing initiatives that are detailed in this report.**⁵

³ Analysis is based on data obtained from a recent survey of a subset of MHA members, with extrapolation for non-respondents using publicly available data contained in the [Annual Report on the Performance of the Massachusetts Health Care System \(March 2023\)](#) from the Center for Health Information & Analysis.

⁴ Calculated using publicly available data on hospital and physician spending in Massachusetts, applying findings from the National Academy of Medicine, [Best Care at Lower Cost: The Path to Continuously Learning Health Care in America](#) study’s conclusions on BIR spending percentages.

⁵ There is abundant research on excess administrative costs in the U.S. and the percentage of BIR that is wasteful. Among the many reports indicating that 50% of BIR is wasteful are:

- David Cutler, [Reducing Administrative Costs in U.S. Health Care](#) (The Hamilton Project, 2020)
- Health Affairs, [“The Role of Administrative Waste in Excess US Health Spending”](#) (October, 2022)

In addition to the excessive cost and wasted resources used in challenging claims denials – most of which are overturned – unnecessary administrative complexity leads to clinician burnout, as well as stress and delayed care for patients. According to a [2022 American Medical Association \(AMA\) survey](#), 94% of physicians reported care delays associated with prior authorizations, while 82% indicated that prior authorization hassles led to patient abandonment of treatment. A [2023 study from the Massachusetts Medical Society](#) detailed physicians’ thoughts on burnout; the top three work stressors were increased documentation requirements not always related to clinical care (80.9%), lack of support staff for non-medical tasks (64.2%), and prior authorization requirements (58.2%).

Growing Administrative Complexity & Its Underlying Drivers

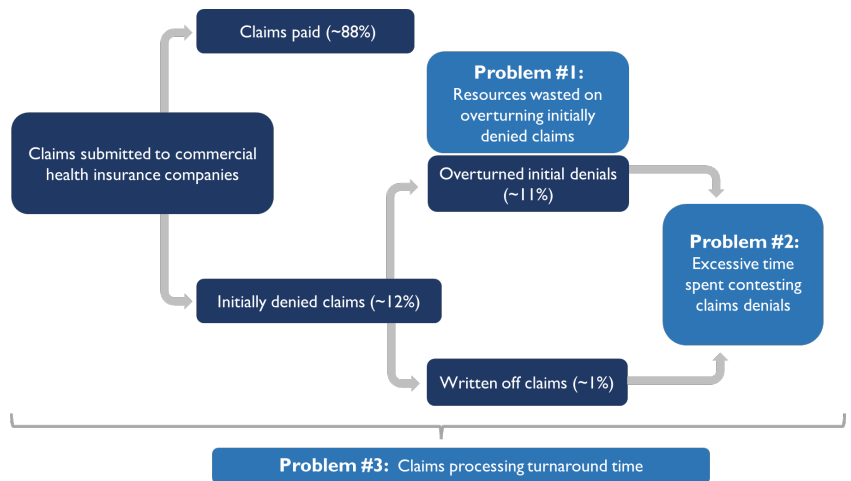
Administrative complexity, delays in obtaining prior authorizations, and insurer claims denials are a growing obstacle to timely patient care and the efficient use of healthcare dollars.

As the system’s red tape has grown in recent years, insurers’ administrative practices have been the subject of increasing scrutiny both locally and nationally. The Massachusetts Health Policy Commission (HPC) in its [2023 Cost Trends Report](#) identified “high administrative spending” as one reason for excess healthcare costs in Massachusetts and the U.S. Prior to the 2023 HPC cost trend hearings, [a majority of providers cited](#) administrative burdens as a significant problem and recommended that the state take steps to eliminate unnecessary processes.

Among the HPC’s recommendations for reducing healthcare spending in the commonwealth is greater standardization, including the creation of uniform medical necessity criteria among insurers and a uniform set of limited services appropriate for prior authorization.

In this report, we focus on three key problem areas, their drivers, and common-sense solutions to reducing administrative complexity.

CHART 3
Key Problems Within the Insurance Claims Process

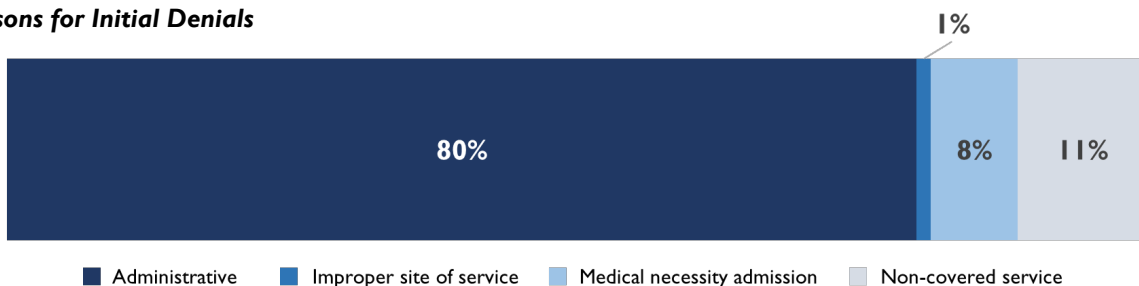


Problem #1: Resources Wasted on Overturning Initially Denied Claims

Eighty-eight percent of claims submitted to insurers are paid when received. But providers must expend time, effort, and resources in appealing the 12% of initially denied claims. This is a wasteful process, especially given that a vast majority of initial denials are ultimately overturned.

New MHA data shows that 80% of initial denials are due to administrative reasons, as shown in the chart below. This includes registration/eligibility issues, prior authorization, medical documentation requests, coding, missing information, and more.

CHART 4
Reasons for Initial Denials



Some denials are avoidable and providers recognize that they have a part to play in submitting correct claims. But the volume of both denials and delays has exceeded what hospitals alone can control. Some reasons for this are outlined below.

Because the means of **submitting claims are not standardized** across all insurers, and because hospitals contract with numerous payers with varying products, the possibility of administrative obstacles multiplies as providers must comply with different insurance company rules and requirements.

Excessive insurer requests for documentation from providers, and the lack of personnel at the insurer to resolve disputes or to answer questions in a timely manner, only leads to further delays, increased burnout, and added costs to the system.

Many times, **insurers hire third parties** to handle utilization management, meaning that a provider often must deal not only with the “carve-out” entity that handles one aspect of care (for example, behavioral health or radiology) but also with the insurance company itself – oftentimes with no clear determination of who holds the final decision-making authority.

Medical Necessity Disputes

Providers and insurers are often in conflict over the “medical necessity” of a patient’s course of care. Some of these disputes play out during the prior authorization process, when an insurer denies a clinician’s request for a service or procedure. Should certain imaging be conducted with contrast or without? Should the patient have been admitted to an inpatient bed or could he or she have been treated as an “observation” case? Was the insurer’s insistence on “step therapy” – that is, trying less expensive treatment options before trying the clinically recommended option – in the best interest of the patient? In other cases, denials occur after the service is provided and the claim is submitted; in some cases these denials occur even when there was a prior authorization issued.

MHA’s survey shows that just 8% of claims denials are due to disagreement over the medical necessity of a healthcare service. Yet the process for appealing a medical necessity denial requires extensive documentation from the provider and a review from the insurer that should involve – but often does not – a clinician who practices in the same/similar specialty as the treating clinician. This process often breaks down, resulting in patients being saddled with the burden of paying for a service they assumed was covered, or hospitals writing off the cost of the services the patient received.

Changing Insurers

A surprisingly common problem involves patients who are in the middle of receiving inpatient care when their insurance company changes because of a switch in jobs or because an employer offers a different plan for the coming year. In those cases, the healthcare provider continues to use existing prior authorizations from the previous insurer and submits claims to that company. The problem is exacerbated because employers do not always provide timely notification when an employee leaves – so even the previous insurer may initially be unaware of the change.

However, the original insurer’s system eventually catches up with the patient’s change of health plan and begins to reject claims. The provider then bills the patient’s new insurer, which also rejects the claims since it is not the plan that originally approved the required authorizations. Because there is no uniformity between plans about prior authorization requirements – even among common procedures – the provider is caught in the middle and must expend time and resources to get paid. This can take months or even more than a year.

Changes in insurance carriers are also problematic for patients, who may have a prior authorization for a course of treatment or medication from a current insurer. But when the patient changes health plans, they must obtain a new authorization, which the new insurer may or may not approve, resulting in treatment delays and unnecessary administrative burdens for the treating clinician and staff.

Problem #2: Excessive Time Spent Contesting Claims Denials

While it is understandable that the complex nature of healthcare billing and payment systems may lead to claims disputes, such disputes are often remarkably difficult to resolve even when mistakes are identified. The major causes of these delays are noted below.

Prior Authorizations

Health insurance companies require prior authorizations for many services before clinicians can deliver patient care – even care that uses standard, evidence-based practices. Additionally, insurers have varying requirements for prior authorization. Healthcare organizations must devote staff and resources to determine what is required for each service and each insurer, and to “check the same box” time after time to receive a prior authorization. This is an administrative burden that leads to significant care delays, additional healthcare spending, and is a documented cause of caregiver burnout.



Administrative complexity that does not add value permeates the Massachusetts healthcare system, from the wide array of plan options that are not easily comparable by consumers and employers, to non-standard contract terms and differing rules for provider credentialing, claims submission, and utilization management which consume significant provider time and resources. Prior authorization, often a multi-step, manual process, is particularly burdensome for providers and can result in patient challenges and delayed care, particularly for those with fewer resources. Standardizing among plans and streamlining processing can ease the administrative burden for providers, payers, and patients, and allow for the reallocation of healthcare resources to higher value tasks and improve equity.

*Massachusetts Health Policy Commission’s Market Oversight and Transparency Committee
October 4, 2023*

As part of this prior authorization process, insurers may require patients to endure ineffective treatment before permitting access to the most appropriate therapy or level of care. Use of such “step therapies” or “fail-first policies” often result in increased provider administrative burden, adding downstream costs due to patient delays and complications.

Providers appreciate the necessity of sensible prior authorization and undeniably have a responsibility to file claims accurately and on a timely basis. But hospitals and health systems cite a growing volume of prior authorization requirements and instances when they are unable to resolve claims disputes with an insurance company because they either cannot easily reach an insurer representative, or because the insurer is inflexible in correcting common errors.

Lack of Insurer Availability & Expertise

Much of the friction between payers and providers is a result of insurers not operating 24/7/365 as hospitals do. Consequently, hospital case managers and admissions staff may be unable to reach an insurance company to obtain prior authorization to admit or transfer a patient. What’s more, reviews are sometimes conducted by clinicians with no clinical expertise in the services under review, and peer-to-peer reviews often do not happen in a timely manner.

Use of Third Parties

As noted above, most insurers carve out certain services to outside vendors that provide utilization management services. Insufficient insurance company oversight of these vendors and differing rules and contracts can add to the administrative complexity providers experience when seeking prior authorization.



MRI Denied

A patient’s primary care physician orders an MRI for recurring headaches and receives a prior authorization for the procedure from the patient’s insurance company. When the patient arrives at the hospital outpatient department for the MRI, the radiologist determines that the MRI should be done with contrast dye. However, because contrast was not on the initial prior authorization, the claim is rejected and the hospital is not paid *anything* for the MRI. Hospital staff must file an appeal, provide additional documentation, and wait while the carrier decides if the dye was medically necessary and the service should be reimbursed. This is a common area for denials and results in unnecessary work for both the provider and the insurance carrier. These denials could be prevented if health insurers would adopt standardized “families of codes” allowing for radiology services with similar CPT codes to be paid even when the prior authorization is not an exact match with the service performed.

Problem #3: Claims Processing Turnaround Times

State law requires that “clean claims” from providers – that is, those without typographical errors or missing documentation – be adjudicated within 45 days by commercial insurers. Timely reimbursement is important to ensure that hospitals can remain viable and have the resources they need to continue comprehensive patient care.

As a result of the delays and denials described above, 42% of filed claims in Massachusetts remain in accounts receivable⁶ for 90 days or more, according to new data from MHA. Nationally, about one third (32%) of inpatient and outpatient claims that providers submit to commercial payers were unpaid after 90 days. For Medicare, the percentage is about 11%.⁷

CHART 4

Aging of Accounts Receivable: Massachusetts

In Massachusetts, 42% of claims submitted to commercial health insurance companies on average remain unpaid for 90 days or longer. Massachusetts insurance law mandates clean claims be adjudicated within 45 days.



The Case of an Underweight Baby

An 800-gram baby – that’s just 1.7 pounds – is being treated in a neonatal intensive care unit (NICU) operated within a world-class downtown Boston hospital. After nearly 60 days, the baby is transported to Boston Children’s Hospital for a procedure that only Children’s performs. After two days at Children’s and following a successful procedure there, the baby is transferred back to the hospital’s NICU where it spends about another 90 days.

The hospital with the NICU filed the first claim for the first stay, notified the insurer about the transfer – not discharge – and then filed a second claim for the next 90 days. In discussions with the insurer by phone – calls that were recorded, as is often standard procedure – the insurer effectively said, “We’ll link the two claims. No problem.”

Weeks later, upon an internal insurer audit, the second claim was rejected. The reasoning? The insurer believes that while the first claim for NICU care was valid, it said the baby should have had a medical/surgical admission for the second claim – not an NICU admission.

“We don’t have that level of care,” says the hospital claims professional. “There’s no such thing as med/surg care for an extremely low-weight baby who needs to be in a neonatal intensive care unit.”

Because the hospital is a large facility, it has regular monthly calls with insurance representatives to go over such special cases. (Smaller community hospitals may not be afforded such personalized attention.) But the calls, the submission of clinical data, and more have not resolved the issue since the case began in June 2022.

“We’re now going through another round of the appeals process in an attempt to prove that our second claim for NICU care – as opposed to the insurer’s opinion for a less-expensive level of care that doesn’t really exist – was the right call for this baby.”

⁶ Accounts receivable are the balance of payments due for goods or services delivered that have not yet been paid.

⁷ Crowe RCA Benchmarking Analysis, “[Time for a commercial break](#)”; May 2023.

THE INSURANCE GO-ROUND: Kevin's Story



A 58-year-old patient, we'll call him Kevin Smith, is suffering chest pains and is brought to a hospital emergency department (ED) by his family.

Nurses and doctors give him an EKG, run blood tests, assess his condition over the course of a few hours, and Kevin's condition appears to be improving. He hasn't been admitted as an inpatient; he's on a gurney in a hallway outside of the ED – but his care team is keeping a close eye on him. They decide to watch him overnight.

During this time, hospital case managers send his information to the insurance company by fax. The insurer gets Kevin's H & P – History and Physical Examination report – that gives a comprehensive overview of the care he is receiving from the physicians and hospital. In most cases, the insurer will respond in 24 hours and, in cases like this, the hospital and insurer may agree that this is an “observation” case. As such, the hospital will eventually be paid a lower amount than it would be if the patient had been admitted to the hospital.

But overnight, Kevin is still not looking well. His chest pain returns. His family reveals that he once had a minor stroke several years before. Another EKG is ordered and the doctors begin the search for any ischemic changes, which affect the flow of blood through the body. Kevin is put on a “nitro drip” – intravenous nitroglycerin. The attending doctor says, “We have to get him upstairs,” meaning the hospital has now decided Kevin has to be admitted as an inpatient.

The updated information is again sent to the insurers as quickly as possible. But this time, after a day or more of review, the insurer decision comes back denying the inpatient claim. Kevin should have remained an observation patient, the insurance company rules.

“They just see it in black and white,” the hospital case manager says, seeing the denial. “They made an initial decision and they’re using their judgment over the judgment of the doctor treating the patient.”

Now someone from the care team must devote time to resolve the issue and to explain to the insurer why Kevin needs inpatient level of care. This involves getting the hospital's attending physician on the phone with the insurance company to do what is called a “peer-to-peer review.” The physician at the insurance company is often not a physician in the same discipline as the attending. The case manager gives the insurance company the hospital physician's cell phone number and an insurance representative calls the doctor and says, “You can consult with our physician sometime between 2 and 5 p.m. tomorrow. We'll give you a call.”

(The doctor thinks to herself, “What is this, a cable TV repair appointment? Tell me when you're going to call.”)

The call is eventually made, but the physician can't take it at that particular moment because she is with a patient. Phone tag occurs, and the denied claim gets mixed in with the hundreds of other claims that have been routinely denied. **Over the course of the next 60 days, the hospital claims personnel deal with different insurance company representatives, often providing the same information about Kevin's case until the claim is settled, and the hospital is paid for an inpatient stay.**

“Sometimes we get paid, but 90 days later when the insurer does an internal audit, it begins all over again,” the hospital revenue person says. “And then we're back to square one with them as they try to claw the money back and we have to resubmit the claims, resubmit the clinical papers, detail the conversations, and more. It's ticky-tack stuff that doesn't benefit anyone.”

At the end of it all, the hospital staff in charge of overseeing Kevin's care are exhausted by the ordeal. The hospital has expended significant resources that would be better devoted to direct patient care. And, most importantly, Kevin may not receive coverage for the care he needs in the timeliest manner.



Among the many parts of Chapter 177 of the Acts of 2022 (*The Mental Health ABC Act*) that Massachusetts providers welcomed, its elimination of prior authorization for mental health acute treatment and stabilization was especially noteworthy. The goal under the law was that people arriving in EDs in need of behavioral healthcare could be transferred to an available inpatient bed without enduring the lengthy delays, paperwork burdens, and frustrations that prior authorizations caused. Now, under the law, a hospital could just notify the insurer within 72 hours of an admission: “We have a patient in need and we’ve admitted her.”

But that hasn’t been the case.

“Chapter 177’s ‘notification’ is just a rebranding of ‘prior auth,’” one hospital caregiver said. “Instead of ED staff compiling reams of paperwork, spending time on the phone with insurers, and getting the runaround before we could make a patient transfer, now it’s the caregivers on the *inpatient* floor enduring the same red tape, *post transfer*.” With behavioral health staffed beds in short supply, and more than 500 behavioral health patients boarding each day in hospitals as they await a bed, the inpatient staff time devoted to insurers rather than patients is especially harmful to timely care.

Under MHA proposed legislation, *An Act Expanding Access to Mental Health Services* (H.4058 and S.1267) filed by Representative Marjorie Decker and Senator Jake Oliveira, Chapter 177 would be refined to require that the provider notify the insurer of just the admission’s basics: patient’s name, facility name, time of admission, diagnosis, and initial treatment plan. Insurers can still conduct utilization reviews, but the paperwork burden on providers and preventable delays to patient care would be lifted. Also, the law’s intent of removing prior authorization for acute psychiatric treatment would be met.

Other MHA proposed legislation, *An Act Removing Barriers to Behavioral Health Services* (H.1145) filed by Representative Adam Scanlon, and *An Act to Remove Administrative Barriers to Behavioral Health Services* (S.1253) filed by Senator John Keenan, would require medical necessity for behavioral healthcare to be determined by the patient’s treating clinician – not the insurer.

Prior authorization delays are also problematic when transferring geriatric psychiatric patients from an acute care hospital to a post-acute care facility. Delays for these patients are especially concerning since beds for such patients are in short supply. Private insurance administrative barriers (delayed response from insurer or denial of authorization request) are [the most frequently cited cause of discharge challenges](#) that providers report.

Medicare Advantage Plans

While the focus of this report is commercial health plans, it is also important to highlight the challenges providers encounter with Medicare Advantage (MA) plans, which commercial plans market. According to KFF, in 2023, 30.8 million people are enrolled in a Medicare Advantage plan, accounting for 51% of the eligible Medicare population and \$454 billion (or 54%) of total federal Medicare spending (net of premiums).⁸ In Massachusetts, 33% of the Medicare eligible population is enrolled in an MA plan.

As MA plans have grown, so too have the issues patients and providers have encountered. In 2022, a report by the U.S. Office of the Inspector General found that Medicare Advantage plans sometimes delayed or denied beneficiaries’ access to services, even though the requests met Medicare coverage rules.⁹ Denying requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and serve as yet another source of burden for providers.

As a result, the Centers for Medicare and Medicaid Services has issued a final rule, effective January 2024, that among other things streamlines prior authorization requirements. It requires that a granted prior authorization approval remains valid for as long as medically necessary to avoid disruptions in care, and that denials of coverage based on medical necessity must be reviewed by healthcare professionals with relevant expertise.

⁸ “[Medicare Advantage in 2023: Enrollment Update and Key Trends](#),” KFF, August 2023

⁹ “[Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care](#),” U.S. Health & Human Services, Office of the Inspector General, April 2022.

Medicare Advantage and Predictive Software

While not as common with local Massachusetts plans, national Medicare Advantage health insurance companies are facing criticism and lawsuits for their use of predictive software to issue claims denials. An investigation by [ProPublica](#) this year found that one national insurer, Cigna, engages in rapid-fire “click and submit” denials of coverage without even reviewing a patient’s case.

“The company has built a system that allows its doctors to instantly reject a claim on medical grounds without opening the patient file, leaving people with unexpected bills,” ProPublica found, saying that the insurer’s doctors spent an average of 1.2 seconds on each case. Cigna Healthcare is facing a federal class action lawsuit because of its automated claims decision process.

The large national carrier UnitedHealthcare (UHC) uses naviHealth, a care management company bought by UHC’s sister company, Optum, in 2020. [KFF research](#) found that the proprietary “nH Predict” tool “sifts through millions of medical records to match patients with similar diagnoses and characteristics, including age, pre-existing health conditions, and other factors. Based on these comparisons, an algorithm anticipates what kind of care a specific patient will need and for how long. But patients, providers, and patient advocates in several states said they have noticed a suspicious coincidence: The tool often predicts a patient’s date of discharge, which coincides with the date their insurer cuts off coverage, even if the patient needs further treatment that government-run Medicare would provide.”

Massachusetts Can Lead: Reducing Administrative Burden

The tangled web of administrative processes that health insurers have put in place is, in too many cases, delaying necessary patient care, adding to the financial pressures on the system, and contributing to clinician burnout.

There are a series of solutions the commonwealth can embrace to address these issues on behalf of healthcare providers and the people they serve – all while re-directing precious resources back to medical care.

Pending State Legislation

The healthcare community is supporting several priority bills that would address administrative complexity, address clinician burnout, and improve access to care for patients.

While there is a necessary role for prior authorization, there is a critical need for reforms that streamline or eliminate low-value prior authorization requirements to minimize waste, delays, and disruptions in access to care.

An Act Relative to Reducing Administrative Burden (S.1249) and An Act to Improve the Health Insurance Prior Authorization Process (H.1143), from Senator Cindy Friedman and former Representative Jon Santiago, respectively, would, among other things:

- › prohibit prior authorization (PA) for generic medications and treatments that currently have low denial rates, low variation in utilization, or an evidence-base to treat chronic illness;
- › require PA to be valid for the duration of treatment or at least one year;
- › require insurers to honor the patient’s PA from another insurer for at least 90 days;
- › require public PA data from insurers relating to approvals, denials, appeals, wait times, and more;
- › prohibit retrospective denials if care is preauthorized;
- › establish a 24-hour response time to authorize urgent care; and
- › require insurers to adopt software to facilitate automated, electronic processing of PA and the Division of Insurance to implement a standardized PA form.

These proposals are supported in partnership with Health Care For All, the Massachusetts Medical Society, and provider organizations across the commonwealth.

Insurance companies should not be able to deny claims for medically necessary covered services based solely on a healthcare provider’s technical error in the claim submission, failure to overcome an unreasonable administrative hurdle, or for the insurer’s retroactive decision to deny previously approved services. These situations frequently occur and a large percentage of those denials are eventually overturned.

An Act to Prevent Inappropriate Denials for Medically Necessary Services (H.1087/S.663), sponsored by Representative Kate Lipper-Garabedian and Senator John Keenan, would, among things:

- › ensure that hospitals are reimbursed appropriately for the good-faith delivery of medically necessary services that are covered under the patient’s insurance contract;
- › give providers needed protection from arbitrary, unfair, and retroactive decisions rendered by insurance companies, often for services that even the insurer had agreed were medically necessary; and
- › provide incentives for insurers to work closely with employer groups to ensure that they are promptly notified when an employer is terminated from a group health insurance plan or when the terms of the plan are expected to change in a new contract year.

Gold Carding

In a “Gold Carding” system, clinicians who have consistently demonstrated adherence to an insurer’s requirements for prescribing medications and medical procedures should not have to go through the burdensome prior authorization process.

Under a first-of-its-kind law in Texas, physicians who have a 90% prior authorization approval rate over a six-month period on certain services will be exempt – or gold carded – from prior authorization requirements for those services. In Congress, lawmakers have introduced the GOLD Card Act of 2023 to exempt qualifying physicians from PA requirements in Medicare Advantage plans. While this would reduce the need for prior authorizations for some services, absent federal and/or state laws, each insurer would likely keep different standards for gold carding physicians, so an industry standard would be necessary if this is to truly be an effective tool.

Improving Standardization & Responsiveness

Every insurer offers multiple products and often further customizes products to individual purchasers (such as a large employer). These may contain different carve outs for radiology, prescription drugs, behavioral health, and other services.

Each provider deals with dozens to hundreds of different plans and their vendors. They must track plan-specific benefits and reimbursement rules, maintain special databases and benefit experts, and conduct time-consuming checks of plan details prospectively and in response to claims denials. All of this leads to added costs, delays and denials of care, as well as clinician and staff burnout.

The Health Policy Commission in its [2023 Cost Trends Report](#), proposes several solutions:

- › Require greater standardization in payer processes through uniform medical necessity criteria and a uniform set of limited services appropriate for prior authorization.
- › Automate prior authorization to reduce uncertainty and expediting decision making.
- › Mandate adoption of the Aligned Quality Measure Set, which is used in global budget-based risk contracts. Payer adherence to the measure set remains variable, even after several years.

There are other important reforms that can help improve coordination between providers and health plans and respond to patients' real-time care needs:

- › Require 24/7 prior authorization capabilities. Insurers should be required to have staff available around-the-clock to respond to prior authorization requests.
- › Bring back provider relations staff who worked directly with hospitals and physician practices. These professionals were a key factor in developing relationships between insurers and providers and enabled hospitals to get problems addressed quickly and efficiently. Outsourcing provider relations and requiring long waits on hold are not effective solutions.
- › Standardize appeals processes. Unlike the patient appeal process, there is no legal requirement or state law that mandates the time frame or process for provider appeals. Insurers should follow a standard appeals process, which should include a time frame for submission and response, a detailed rationale for the decision if the denial is not going to be overturned, and an opportunity for external review of denials. In addition, insurers must have the ability to conduct timely peer-to-peer consultations with appeals reviewed by someone who practices in the same or similar specialty as the service being denied.

Conclusion

The Massachusetts provider community remains a leading supporter of efforts to lower healthcare costs. Every part of the system has a role to play. A relatively easy cost-reduction strategy – and one that would benefit providers, patients, as well as insurers – is to reduce the administrative burdens weighing on the healthcare system.

Prior authorization requirements for routine procedures. Automatic claims denials. Varying medical necessity criteria among insurers. Lengthy and time-consuming documentation and appeals processes. Each of these burdens add cost and complexity to the system, while taxing both clinicians and patients in the process. **Through a series of coordinated actions outlined in this report, as much as \$1.75 billion in waste could potentially be removed from the system, helping to relieve clinician burnout and avoid care delays while still allowing insurers to monitor costs.**

The Massachusetts healthcare ecosystem – consisting of providers, patients, advocates, employers, state government, insurers, academics, and affiliated interests – has proven time and again its resolve and intelligence in tackling the most complex issues affecting care quality and affordability. **By coming together yet again, the commonwealth would be well equipped to quickly address the “low-hanging fruit” of administrative simplification and set an example for the rest of the nation to follow.**



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