

DATE: January 21, 2026

TO: Honorable Members of the House Commerce and Consumer Affairs Committee

FROM: Representative Trinidad Tellez, the bill's prime sponsor

RE: HB1463, Requiring the insurance department to conduct an analysis and produce a report detailing compliance with the states managed care and medical utilization review laws.

Background

In 2024, SB561, relative to prior authorization for health care services, was passed. This was important because the prior authorization process was problematic, frustrating and costly for both healthcare providers, consumers and the insurance companies, often adding avoidable delays and unnecessary costs and even denials. This bill had bipartisan and cross-stakeholder support and led to statewide standards for prior authorizations across commercial insurers in New Hampshire.

The new law was effective January 1, 2025, and requirements were codified in [NH RSA 420-J:6](#).¹ The new law consisted of three parts: shortening the time allowed by health carriers to make decisions regarding prior authorizations, allowing providers broader access to peer-to-peer review, and requiring the Insurance Department to collect and disclose certain metrics relating to prior authorizations.

The Problem

This bill specifically addresses Section IIa which states “A health carrier conducting utilization review directly, or indirectly through a contracted utilization review entity, shall make any current prior authorization requirements and restrictions readily accessible on its website to enrollees, health care professionals, and the general public. This includes the written clinical criteria. Requirements shall be described in detail, but also in easily understandable language.”

The Commissioner of the Insurance Department released a [Guidance Bulletin](#)² on January 2, 2025, the beginning of last year, which included the [data reporting template](#)³ that insurance carriers are required to use in accordance with Section IIc. Insurers will submit their metrics for 2025 on the data reporting template by April 1 of 2026. The Insurance Department will then compile that information into a report that will be available on the Department's [NH HealthCost website](#).⁴ This report will include the insurance carriers' self-reported data including the aggregate numbers of prior authorizations submitted, and

¹ <https://www.gc.nh.gov/rsa/html/XXXVII/420-J/420-J-6.htm>

² <https://mm.nh.gov/files/uploads/nhid/documents/ins-25-001-ab-prior-auth.pdf>

³ https://www.insurance.nh.gov/sites/g/files/ehbemt861/files/media/media_document/prior-authorization-reporting-template.xlsx

⁴ <https://nhhealthcost.nh.gov>

the number and percent that were approved, denied and appealed, and other similar metrics.

However, that report will not convey the information that is required in Section IIa, and that is the intended purpose of this bill – to assess health care professional perspectives on insurance carriers’ compliance with the requirement to have readily accessible information about criteria for prior authorization requirements and restrictions so that enrollees, health care professionals, and the general public can understand and meet them, prior to submitting the requests, and thus decrease frustrating and problematic delays and denials.

Why this Matters

The current reality is that doctors, nurse practitioners and PAs caring for patients, must deal with each insurer having their own criteria for approval, and, without transparency, the clinicians are left guessing what is needed in order to have health insurance cover the necessary care for their patients. Healthcare providers employ administrative staff to help navigate the complex and unclear process for each of the insurers, thus adding to the cost of care. Additionally, dealing with prior authorizations is a driver in healthcare employee burnout. [The American Medical Association’s annual nationwide prior authorization survey](#) of 1000 practicing physicians in 2024 revealed that “On average, their practices complete 43 prior authorizations per physician per week”, and “They and their staff spend 12 hours completing prior authorizations each week”; additionally, “78% of physicians reported that prior authorization often or sometimes results in their patients abandoning a recommended course of treatment”.⁵

Findings

I spent a few hours doing my own exploration of the [7 top insurers in NH as identified on the Insurance Department’s website](#).⁶ For each of the insurers, I searched for readily available information online about prior authorization criteria for knee MRI, using the Google search term “[carrier] NH prior authorization criteria knee mri”. This was difficult to find, if at all, and in circumstances where I was able to find any information, it was often difficult to make sense of – whether because Requirements were not *clearly described in detail*, or because they were not written in *easily understandable language* – both of which are provisions of RSA 420-J:6.

I was able to find only one excellent sample in [CIGNA MEDICAL COVERAGE POLICIES - RADIOLOGY Musculoskeletal Imaging Guidelines](#), which clearly laid out the information about the knee beginning on page 157, both described in detail and written in easily understandable language.⁷

⁵ <https://www.ama-assn.org/practice-management/prior-authorization/exhausted-prior-auth-many-patients-abandon-care-ama-survey>

⁶ <https://nhhealthcost.nh.gov/guide/question/what-health-insurance-companies-are-new-hampshire>

⁷ https://www.evicore.com/sites/default/files/clinical-guidelines/2024-11/igna_Musculoskeletal%20Imaging%20Guidelines_V1.1.2025_Eff02.14.2025_pub11.27.2024.pdf

The Gap

The current Insurance Department reporting process is missing vital feedback by hearing from health care professionals about the insurance carriers' fulfillment of the spirit and letter of the law: readily accessible information on the requirements for prior authorization, so that people can use that information to then submit prior authorization requests that will not be denied or delayed.

Recommendations

1. **At a minimum, add to the existing Insurance Department's reporting template**, that insurers are already required to complete, a place for each insurer to indicate **where the information described in RSA 420-J:6, Section IIa can be found on their respective websites** so that it is at least readily accessible to both consumers and healthcare professionals.
2. **Get input from providers by adding to something else so the cost can be lower** such as by surveying a **sample** of licensed practicing clinical providers in the state, perhaps by working with the professional associations to survey their members – the goal is to learn about the real *experiences* of practicing community physicians, NPs and PAs in every New Hampshire county and health system.

Suggested potential revised bill wording with a clearer, limited scope:

The insurance department shall assess compliance with RSA 420-J:6, Section IIa by: requiring insurers and insurance carriers to report annually to the insurance department the web addresses where the readily accessible criteria for prior authorization requirements and restrictions can be found by enrollees, health care professionals, and the general public; and, soliciting clinician experience input from a sampling of practicing community health care professionals in every New Hampshire county and health system and reporting annually.

The insurance department shall make recommendations for appropriate penalties for insurers and insurance carriers not in compliance.

Conclusion

SB561 was an important bipartisan effort to improve prior authorization in healthcare. This bill proposes to build on the important data collection the Insurance Department is already doing and close an important gap that addresses the opaque, patchwork quilt of prior authorization criteria from the various insurance carriers. This bill merely asks for Section II a to be effectualized as required. The bottom line is we need to know *if* the information is readily available on the insurer's websites for the public and providers – this simple step to increase transparency will improve care and decrease unnecessary delays and costs and keep our busy healthcare professionals focused on their patients.