SB-1449-SD-1
Submitted on: 2/16/2025 4:53:55 PM
Testimony for CPN on 2/20/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Ruth Love	Individual	Support	Written Testimony Only

Comments:

I support data collection regarding prior authorizations provided that the Healthcare providers are not required to do the data collection.

Frankly, the prior authorizations, in my opinion, are a mechanism to decrease costs for insurance companies. If a licensed physician or provider orders a medication or piece of equipment for a patient, they have already made a determination of patient need. Physicians and providers should not have to reauthorize what they have already authorized. Prior authorization requests should be outlawed.

I say this as a patient (and ER nurse of 35 years). I have been prescribed enbrel more than 20 years. Every January both myself and my doctors (and their staff) have had to jump through ASININE hoops so I may have my medication. There is already a shortage of physicians and providers. Why are we taking up their available time and making them do redundant paperwork (cutting into the next patients time)? Often my January refill would be up to 6 weeks late. Now, if your medication costs $1200.00 a week, the insurance company saves $1200.00 to 7200.00 by doing this lollygagging. The longer they made me wait, the longer I had pain that could have been controlled or eliminated. When I had rheumatoid flares (pain all over), I was also incurring joint damage that would be permanent because of insurance companies.

Have you ever been referred to as one of "THOSE ENBREL PATIENTS" by your doctors office staff because they know they will be forced to do a bunch of extra and unnecessary paperwork which is a pain in the ass? I have.

Thank you

Mrs Ruth Love

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
DEPARTMENT OF HEALTH - *KA ʻOIHANA OLAKINO*

JOSH GREEN, M.D.
GOVERNOR OF HAWAIʻI
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

KENNETH S. FINK, MD, MGA, MPH
DIRECTOR OF HEALTH
KA LUNA HOʻOKELE

JOHN C. (JACK) LEWIN, M.D.
ADMINISTRATOR

LATE

February 18, 2025

To: Committee on Commerce and Consumer Protection
Senator Jarrett Keohokalole, Chair
Senator Carol Fukunaga, Vice Chair, and
Honorable Members

From: Jack Lewin MD, Administrator, SHPDA, and Sr. Advisor to Governor Josh Green MD on Healthcare Innovation

Re: SB 1449, SD1 -- RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES

Position: SUPPORT, with COMMENTS

Testimony:

SB 1449 SD1 requires utilization review entities (health insurers) to submit data relating to the prior authorization (PA) of health care services to the State Health Planning and Development Agency (SHPDA).

Prior authorization (PA), first created by health insurers in the 1980s, was intended to identify and deny payment to doctors, hospitals and health care providers that was deemed not medically necessary or appropriate. The practice has become much more frequently applied to denial of medical claims over the years, and the process of attempting to appeal or reverse the denials has become a major source of frustration, and a time-consuming and expensive burden for physicians, hospitals, and other providers.

In addition, since the clinical standards, guidelines, or scientific bases for such denials varies from insurer to insurer, are generally not published or clearly defined, physicians and other providers are forced to navigate the increasing complexity of this process, and many providers do not have the time or resources to challenge the denials on behalf of their patients. Meanwhile, insurers

increasingly contract out their prior authorization determinations to other private companies that providers believe to be increasing denial rates with what appear to be perverse financial incentives to do so.

Patients and the members of the public have also recently become aware of and frustrated by prior authorization denials of care that physicians have prescribed for them or their family members, as was tragically apparent in the public response to the recent murder of an insurance executive in New York.

It is time to build trust back between the public, providers of care, and insurers by streamlining the prior authorization process. The first step in moving in a direction to improve and streamline the PA process is to understand its current uses by requiring a reporting process to SHPDA. This will facilitate accurate understanding of the frequency of PA claims by insurer; the top 100 diagnostic and therapeutic triggers of PA; the numbers of PA determinations that are challenged by providers; the numbers of PA determinations that are overturned; and so on. In other words, this required reporting will develop transparency and accuracy around the use of PA in Hawaii.

Based on what is learned by this reporting requirement, SHPDA will develop a strategy to streamline and automate PA determinations to discuss with insurers; physicians, hospitals and other providers; and consumers/employers to collaborate on potential solutions and to present to the next legislative session for action as needed.

We suggest amending this bill to include “laboratory and diagnostic tests” in the list of things which commonly trigger prior authorizations listed on page 5 under “prior authorization data” in line 13.

And we also add a comment to share that we prefer HB 250 to this bill in its original form (before HD1 amendments) because, in addition to requiring the same PA reporting requirements to SHPDA as does this bill and its companion, HB 1130, HB 250 suggests a solution to this problem by forming a work group of insurers, provider and consumers to agree upon PA peer-reviewed national and professional standards to be applied statewide to claims determinations to allow the process to be automated.

The HB 250 additional language to be added to HRS §323D- would create the Health Care Appropriateness and Necessity working group within SHPDA. established the working group shall:

(1) Determine by research and consensus:

(A) The most respected peer-reviewed national scientific standards; clinical guidelines; and appropriate use criteria published by federal agencies, academic institutions, and professional societies, that correspond to each of the most frequent clinical treatments, procedures, medications, diagnostic images, laboratory and diagnostic tests, or types of medical equipment prescribed by licensed physicians and other health care providers in the State that trigger prior authorization determinations by the utilization review entities;

(2) Assess whether it is appropriate to require prior authorization for each considered clinical treatment, procedure, medication, diagnostic image, or type of medical equipment prescribed by licensed physicians and other health care providers;

(3) Make recommendations on standards for third party reviewers related to the specialty expertise of those reviewing and for those discussing a patient's denial with their health care provider; and

(4) Recommend appropriate time frames within which urgent and standard requests shall be decided.

The members of the working group shall consist of the following:

(1) Five members representing insurers and utilization review entities, all of whom shall be appointed by the Hawaii Association of Health Plans,

(2) Five members representing physicians, hospitals, and other licensed health care professionals, three of whom shall be appointed by the Hawaii Medical Association, and two of whom shall be appointed by the Healthcare Association of Hawaii;

(3) Five members representing consumers of health care, three of whom shall be appointed the Administrator of the EUTF, and two whom shall be appointed by the Chair of the State Health Coordinating Council (SHCC);

The members of the working group shall elect a chairperson and vice chairperson from amongst themselves. The director of health, state insurance commissioner, administrator of the med-QUEST division of the department of

human services, and administrator of the state health planning and development agency, or their designees, shall be ex-officio, non-voting members.

The working group shall submit a report of its findings and recommendations regarding information under subsection (a), including any proposed legislation, to the legislature no later than twenty days prior to the convening of each regular session.

The recommendations of the working group shall be advisory only and not mandatory for health care facilities, health care professionals, insurers, and utilization review entities. The state agency shall promote the recommendations among health care facilities, health care professionals, insurers, and utilization review entities and shall publish annually in its report to the legislature the extent and impacts of its use in the State.

The state agency shall seek transparency and agreement among health care facilities, health care professionals, insurers, utilization review entities, and consumers related to the most respected clinical, scientific and efficacious standards, guidelines, and appropriate use criteria corresponding to medical treatments and services most commonly triggering prior authorization determinations in order to reduce uncertainty around common prior authorization processes, and also foster automation of prior authorization to the benefit of all.

The state agency shall further explore means of achieving statewide health sector agreement on means of automating prior authorization determinations in the near future.

Mahalo for the opportunity to testify.

LATE

SB-1449-SD-1
Submitted on: 2/18/2025 11:13:16 PM
Testimony for CPN on 2/20/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Rick Tabor	Testifying for PABEA (PolicyvAdvisory Board for Elderly Affairs)	Support	Written Testimony Only

Comments:

I am Rick Tabor, PABEA Legislative Committee Vice Chair, (Policy Advisory Board for Elder Affairs) which is a Governor appointed board tasked with advising the Executive Office on Aging (EOA). My testimony does not represent the views of the EOA but it does represent PABEA support. My testimony is as an individuslmand on behslf of The PABEA Legislative Committee. We strongly support bill SB1494 SD1.

For almost a decade our Hawai‘i State Legislators and the Deaf Blind Taskforce has tried to pass a bill that mandates insurance coverages, including Medicaid & Medicare to ‘adequately’ cover the cost of hearing aids. My involvement comes with many hardships leading up to my mother’s passing away a year ago, on February 7, 2025.

In 2023, about 29.2% of US adults with hearing loss used hearing aids. This number is lower for Pacific Islanders, Black, Hispanic individuals, and those with low incomes.

Hearing aid use by age;

- The percentage of people who use hearing aids increases with age.
- In 2021, only 9.2% of men and 5.5% of women aged 45 and older used hearing aids.
- In 2023, nearly two-thirds of adults aged 71 and older had hearing loss, but only 14% wore their hearing aids. Discomfort being the number one complaint.
- By age 90, nearly everyone (96.2%) had hearing loss, but most could not afford to purchase hearing aids.

Some important facts about hearing loss:

■ Hearing loss is the third most common physical condition that affects people of all ages.
■ Presbycusis (age-related hearing loss) typically begins as early as 55.
■ Individuals with mild to moderate untreated hearing loss are twice as likely to show symptoms of anxiety or depression and isolation than those with normal hearing or those who wear hearing aids.

■ Loneliness/Isolation was declared a National Crisis by the Surgeon General in May 2024. Increased Physical and Mental Health issuse are costing insurance coverages more with higher premiums than it would cost to adequately cover hearing aids in a wellness, early intervention treatment

■ According to available data, the estimated cost to the nation from not adequately covering hearing aids is several billion dollars annually due to factors like reduced workforce productivity, increased healthcare & mental health costs for related conditions, and the overall economic impact on individuals with hearing loss who cannot afford hearing aids. And that's not to mention the interpersonal relationships issues; family discord, domestic violance and, sadly, an increase in our nation's suicides.

Key uncovered cost points to consider:

- Average hearing aid cost:
  Hearing aid prices vary greatly depending on a number of factors. But generally speaking, a pair of hearing aids can cost anywhere from $1,000 to $8,000, with some models going up to $10,000, depending on style and features included, as well as whether service and aftercare are part of the purchase price. Meaning a significant upfront cost for individuals without adequate insurance coverage.
- Medicare & health insurances lack coverage: Currently, Medicare does not cover hearing aids under Parts A or B, and most private health insurance plans offer limited or no coverage, leaving many individuals to pay out-of-pocket.
- Impact on workforce productivity:
  Studies show that untreated hearing loss can lead to reduced job performance and potential career limitations, impacting the economy as a whole.
- Social and mental health implications:
  Hearing loss can contribute to social isolation, depression, and anxiety, further impacting healthcare costs.
- Hearing loss can lead to deadly falls, but hearing aids may cut the risk. Falling is the top cause of accidental injury for older adults. Even mild hearing loss can increase the risk of falls.
- Studies have shown, consistently wearing hearing aids has been shown to improve balance and prevent falls.
- Studies have shown a 70% increase in Dementia issues for folks living with uncorrected hearing issues.

- Most of those with hearing loss wait seven to 10 years before getting help. Delaying corrective action may result in irreversible hearing loss.
- Less than 30 percent of our kūpuna use hearing devices due to:
- Lack of means to purchase
- Stigma
- Avoidance and denial of hearing issues
- Unfamiliar with where to go for help
- Misdiagnosed or untested due to assumptions of other issues

In closing; please support our 2025 Hawai‘i State Legislative Session Hearing Aid Bills. And this thought; Being heard is so close to being loved that, for most of us, the two are almost indistinguishable. Because, after all, Knowledge speaks, but wisdom listens. Thanks for listening. And Thank you for all you do. Take Care.

JOSH GREEN, M.D.
GOVERNOR OF HAWAI'I
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I

KENNETH S. FINK, M.D., M.G.A., M.P.H.
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LATE

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LATE

Testimony in SUPPORT of SB1449 SD1
RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES.

SEN. JARRETT KEOHOKALOLE, CHAIR
SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION

Hearing Date: February 20, 2025 Room Number: 229

Department Testimony: Department Testimony: The Department of Health (DOH) supports SB1449 SD1 and recommends amendments to accelerate and improve it impact.

Feedback from the healthcare provider community is very strong and clear that the administrative burden from prior authorization of healthcare services is leading to provider burnout, delays in care, and diminished productivity that impacts direct patient care.

Although prior authorization is a legitimate cost control tool, the fact that 83% of requests are subsequently overturned by the health plan that originally denied the service, according to a national survey administered by the American Medical Association, compels further examination of this practice.

Making prior authorization statistics available will help consumers make more informed choices when choosing their health plan, and can contribute to creating community standards and practices that are more effective, return more value, and that are simpler to administer.

Lastly, the Department recommends against establishing a commission due to the advice and consent requirement, and proposes that a task force take its place.

Thank you for the opportunity to testify.

Offered Amendments:

"**§323D-** Health care appropriateness and necessity working group; established. (a) There is established the health care appropriateness and necessity working group within the state agency. The working group shall:

(1) Determine by research and consensus:

(A) The most respected peer-reviewed national scientific standards;

(B) Clinical guidelines; and

(C) Appropriate use criteria published by federal agencies, academic institutions, and professional societies,

that correspond to each of the most frequent clinical treatments, procedures, medications, diagnostic images, laboratory and diagnostic tests, or types of medical equipment prescribed by licensed physicians and other health care providers in the State that trigger prior authorization determinations by the utilization review entities;

(2) Assess whether it is appropriate to require prior authorization for each considered clinical treatment, procedure, medication, diagnostic image, or type of medical equipment prescribed by licensed physicians and other health care providers;

(3) Make recommendations on standards for third party reviewers related to the specialty expertise of those reviewing and for those discussing a patient's denial with their health care provider; and

(4) Recommend appropriate time frames within which urgent and standard requests shall be decided.

(b) The members of the working group shall consist of the following:

(1) Five members representing insurers and utilization review entities, three of whom shall be appointed by the governor, one of whom shall be appointed by the president of the senate, and one of whom shall be appointed by the speaker of the house of representatives;

(2) Five members representing physicians, hospitals, and other licensed health care professionals, three of whom shall be appointed by the governor, one of whom shall be appointed by the president of the senate, and one of whom shall be appointed by the speaker of the house of representatives; and

(3) Five members representing consumers of health care, three of whom shall be appointed by the governor, one of whom shall be appointed by the president of the senate, and one of whom shall be appointed by the speaker of the house of representatives.

The members of the working group shall elect a chairperson and vice chairperson from amongst themselves. The director of health, state insurance commissioner, administrator of the med-QUEST division of the department of human services, and administrator of the state health planning and development agency, or their designees, shall be ex-officio, non-voting members.

(c) The working group shall submit a report of its findings and recommendations regarding information under subsection (a), including any proposed legislation, to the

legislature no later than twenty days prior to the convening of each regular session.

(d) The recommendations of the working group shall be advisory only and not mandatory for health care facilities, health care professionals, insurers, and utilization review entities. The state agency shall promote the recommendations among health care facilities, health care professionals, insurers, and utilization review entities and shall publish annually in its report to the legislature the extent and impacts of its use in the State.

(e) The state agency shall seek transparency and agreement among health care facilities, health care professionals, insurers, utilization review entities, and consumers related to the most respected clinical, scientific and efficacious standards, guidelines, and appropriate use criteria corresponding to medical treatments and services most commonly triggering prior authorization determinations in order to reduce uncertainty around common prior authorization processes, and also foster automation of prior authorization to the benefit of all. The state agency shall explore means of achieving

statewide health sector agreement on means of automating prior authorization determinations in the near future."

Hawaii Medical Association
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SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Jarrett Keohokalole, Chair
Senator Carol Fukunaga, Vice Chair

Date: Feb 20, 2025
From: Hawaii Medical Association (HMA)
Jerald Garcia MD - Chair, HMA Public Policy Committee

Re: SB 1449 SD1 RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES - SHPDA; Prior Authorization; Utilization Review Entity; Reporting
Position: Support with amendments

This measure would require utilization review entities in the State to submit to the State Health Planning and Development Agency data relating to prior authorization of health care services.

Time-consuming Prior Authorization (PA) processes delay patient care. Healthcare providers struggle to overcome PA barriers that impede the evaluation, diagnosis and treatment of their patients and divert valuable time and resources from direct patient care. This leads to lower rates of patient adherence to treatment and harmful negative clinical outcomes, as well as excessive administrative burden for physicians already laboring under critical workforce shortages.

The disclosure and reporting of the relevant payor utilization data of PA is imperative for transparency, accountability and meaningful analyses of challenges, Additionally, a body for oversight is necessary to address deficiencies and monitor progress. Given the complexities of PA and healthcare delivery, modifications and revisal will require ongoing assessment and review over time. HMA supports the intent of this measure. The work to eliminate PA barriers should also include specific provisions to reduce time delays and volumes of PA, improve transparency and ensure high quality review of care delivery for Hawaii patients, bridging PA policy gaps that may continue to exist otherwise.

HMA respectfully requests these additions/amendments for consideration:

REDUCTION OF PA DELAY AND UNNECESSARY VOLUME (language is taken from SB 1519)

Prior authorization request for urgent health care services; determination time frame; automatic approval.

(1) Urgent requests will be decided within twenty-four hours of receipt; and
(2) Non-urgent requests will be decided within three calendar days of receipt.

If an insurer fails to respond to a prior authorization request within the required timeframe, the request shall be deemed approved.

Repeat prior authorization is prohibited for chronic unchanged conditions.

Retroactive or retrospective prior authorization denials are prohibited, unless:
(1) The health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from a utilization review entity;
(2) The health care service was no longer a covered benefit on the day it was provided;
(3) The health care provider was no longer contracted with the patients' health insurance plan on the date the care was provided;
(4) The health care provider failed to meet the utilization review entity's timely filing requirements;
(5) The utilization review entity is not liable for the claim; or
(6) The patient was no longer eligible for health care coverage on the day the health care was provided.

Length of prior authorization. A prior authorization shall be valid for a minimum of one year from the date the enrollee or the enrollee's health care provider receives the prior authorization and shall be effective regardless of any changes in dosage for a prescription drug prescribed by the health care provider.

Duration of prior authorization for treatment for chronic or long-term care conditions. If a utilization review entity requires a prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization shall remain valid for the duration of the treatment and the utilization review entity shall not require the enrollee to obtain a new prior authorization again for the health care service.

Continuity of care for enrollees; prior authorization transfers.
(a) Upon receipt of information documenting a prior authorization from the enrollee or from the enrollee's health care provider, a utilization review entity shall honor a prior authorization granted to an enrollee from a previous utilization review entity for at least the initial ninety days of an enrollee's coverage under a new health plan.
(b) During the time period described in subsection (a), a utilization review entity may perform its own review to grant a prior authorization.
(c) If there is a change in coverage of, or approval criteria for, a previously authorized health care service, the change in coverage or approval criteria shall not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's plan year.
(d) A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same health insurance company.

Gold card or exemption program for providers
Prior authorization exemptions for health care providers.
(a) A utilization review entity shall not require a health care provider to complete a prior authorization request for a health care service for an enrollee to receive coverage; provided that in the most recent twelve-month period, the utilization review entity has approved or would have approved not less than eighty per cent of the prior authorization requests submitted by the health care provider for that health care service, including any approval granted after an appeal.

(b) A utilization review entity may evaluate whether a health care provider continues to qualify for exemptions as described in subsection (a) not more than once every twelve months. Nothing in this subsection shall be construed to require a utilization review entity to evaluate an existing exemption or prevent a utilization review entity from establishing a longer exemption period.

(c) A health care provider shall not be required to request for an exemption to qualify for an exemption pursuant to this section.

(d) A health care provider who is denied an exemption pursuant to this section may request evidence from the utilization review entity to support the utilization review entity's decision at any time, but not more than once per year per service. A health care provider may appeal a utilization review entity's decision to deny an exemption.

(e) A utilization review entity may revoke an exemption only at the end of the twelve-month period described in subsection (b) if the utilization review entity:

(1) Determines that the health care provider would not have met the eighty per cent approval criteria based on a retrospective review of the claims for the particular service for which the exemption applies for the previous three months, or for a longer period if needed to reach a minimum of ten claims for review;

(2) Provides the health care provider with the information the utilization review entity relied upon in making its determination to revoke the exemption; and

(3) Provides the health care provider a plain language explanation of how to appeal the decision.

(f) An exemption shall remain in effect until the thirtieth day after the date the utilization review entity notifies the health care provider of its determination to revoke the exemption or, if the health care provider appeals the determination, the fifth day after the revocation is upheld on appeal.

(g) A determination to revoke or deny an exemption shall be made by a health care provider licensed in the State of the same or similar specialty as the health care provider being considered for an exemption and have experience in providing the service for which the potential exemption applies.

(h) A utilization review entity shall provide a health care provider that receives an exemption a notice that includes:

(1) A statement that the health care provider qualifies for an exemption from preauthorization requirements;

(2) A list of services to which the exemptions apply; and

(3) A statement of the duration of the exemption.

(i) A utilization review entity shall not deny or reduce payment for a health care service exempted from a prior authorization requirement under this section, including a health care service performed or supervised by another health care provider when the health care provider who ordered the health care service received a prior authorization exemption, unless the rendering health care provider:

(1) Knowingly and materially misrepresented the health care service in request for payment submitted to the utilization review entity with the specific intent to deceive and obtain an unlawful payment from the utilization review entity; or

(2) Failed to substantially perform the health care service.

QUALITY (language is taken from SB 1519)

Medically necessary; Clinical criteria – Utilization review entities must use appropriate criteria that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

(1) In accordance with generally accepted standards of medical practice;

(2) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

Prior authorization review; adverse determination personnel; qualifications; criteria. A utilization review entity shall ensure that all adverse determinations are made by a physician who:

(1) Possesses a current and valid non-restricted license issued pursuant to chapter 453;

(2) Is of the same specialty as a physician who typically manages the medical condition or disease or provides the health care service subject to the review;

(3) Have experience treating patients with the medical condition or disease for which the health care service is being requested.

TRANSPARENCY (language is taken from SB 1519)

Prior Authorization Transparency - Prior authorization requirements and restrictions; disclosure and notice required.

(a) A 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, including the written clinical criteria; provided that requirements shall be described in detail but also in easily understandable language.

(b) A utilization review entity that intends to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction shall:

(1) Ensure that the new or amended requirement or restriction is not implemented until the utilization review entity's website has been updated to reflect the new or amended requirement or restriction; and

(2) Provide contracted health care providers of enrollees with written notice of the new or amended requirement or amendment no later than sixty days before the implementation of the requirement or restriction.

(c) Any entity requiring prior authorization of any health care service shall make statistics on prior authorization approvals and denials available to the public on their website in a readily accessible format; provided that the statistics shall include categories for:

(1) Physician specialty;

(2) Medication or diagnostic test or procedure;

(3) Indication offered;

(4) Reason for prior authorization denial;

(5) If a prior authorization was appealed;

(6) If a prior authorization was approved or denied on appeal; and

(7) The time between the submission and subsequent response for a prior authorization request.

Denials - Adverse determination; notice and discussion required. Any utilization review entity questioning the medical necessity of a health care service shall notify the enrollee's

physician that medical necessity is being questioned. Before issuing an adverse determination, the enrollee's physician shall have the opportunity to discuss the medical necessity of the health care service on the telephone with the physician who will be responsible for determining authorization of the health care service under review. The utilization review entity should provide justification for denials, relevant plan provision, coverage criteria citation, narrative explanation; also provide covered alternative treatment; and detail appeal options, actions needed to obtain coverage or additional information or selecting an alternative treatment option identified by the plan.

OVERSIGHT (language is taken from SB 1519)

Utilization review entities; annual report to insurance commissioner [and oversight Work Group]. (a) No later than March 1 of each year, each utilization review entity shall submit a report to the insurance commissioner on prior authorization requests for the previous calendar year using forms and in a manner prescribed by the insurance commissioner, which shall include:

(1) A list of all health care services that require prior authorization;

(2) The number and percentage of prior authorization requests that were approved;

(3) The number and percentage of prior authorization requests that were denied;

(4) The number and percentage of prior authorization requests that were initially denied and approved after appeal;

(5) The number and percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved;

(6) The average and median time that elapsed between the submission of a non-urgent prior authorization request and a determination by a utilization review entity;

(7) The average and median time that elapsed between the submission of an urgent prior authorization request and a determination by the utilization review entity;

(8) The average and median time that elapsed to process an appeal submitted by a health care professional initially denied by the utilization review entity for non-urgent prior authorizations; and

(9) The average and median time that elapsed to process an appeal submitted by a health care professional initially denied by the utilization review entity for urgent prior authorizations;

provided that the information required by paragraphs (2) through (9) shall be individualized for each listed health care service for each health care service listed in paragraph (1).

(b) Each utilization review entity shall make the report required pursuant to subsection (a) available to the public through the utilization review entity's website in the format prescribed by the insurance commissioner.

HMA recommends that the utilization review entities doing business in the State shall submit data to a Work Group relating to prior authorization of health care services, in a format specified by the Work Group with the following composition of members:

-Director of Health, or the Director's designee

-The Insurance Commissioner, or the Insurance Commissioner's designee

-Administrator of the Med-QUEST Division of the Department of Human Services, or the Administrator's designee

-Representative from the Professional and Vocational Licensing Division of the Department of Commerce and Consumer Affairs

-Representative from the Hawaii Association of Health Plans

-Healthcare organizations (each with a representative):
Hawaii State Center for Nursing
Hawaii Medical Association (HMA)
Hawaii State Rural Health Association
Healthcare Association of Hawaii

The Work Group will regularly review PA policies and make recommendations for
Ongoing reduction of volume. This requires coordinated review of PA data, trends, population health characteristics and standards of care as well as utilization use and overuse.
- Identifying drugs and services for which PA is rarely denied, have high approval rates on appeal, are important to provide expeditiously
- Examine PA that disproportionately impacts marginalized patients

Review of validity, clinical criteria. Regular systematic review and updates for changes in population health characteristics, standards of care and scientific information that will allow for continued informed decisions on the safety and needs to apply PA or lift PA restrictions.

HMA strongly supports Prior Authorization reform policies and continued oversight that may reduce patient and provider burdens, improve patient access and facilitate the timely delivery of high quality and safe medical care.

Thank you for allowing the Hawaii Medical Association to testify in support of this measure with amendments.

REFERENCES AND QUICK LINKS

Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). CMS Interoperability and Prior Authorization Final Rule (CMS-0057-Fhttps://www.cms.gov/files/document/cms-0057-f.pdf Accessed Jan 28 2025.

American Medical Association. Issue Brief: Federal Changes to Prior Authorization Rules and their Impact on State Legislative Efforts. https://cdn.ymaws.com/hawaiimedicalassociation.org/resource/resmgr/advocacy/prior_auth_issue_brief_on_fe.pdf Accessed Jan 28 2025.

Pestaina K et al. Final Prior Authorization Rules Look to Streamline the Process, but Issues Remain. KFF.org May 2 2024. Accessed Feb 4 2025.

American Medical Association. 2023 AMA Prior Authorization (PA) Physician Survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf Accessed Jan 28 2025.

American Association of Family Physicians (AAFP). Prior Authorization. https://www.aafp.org/family-physician/practice-and-career/administrative-simplification/prior-authorization.html Accessed Jan 28 2025.

Hawaii Association of Health Plans

LATE

February 20, 2025

To: Chair Keohokalole, Vice Chair Fukunaga, and Members of the Senate Committee on Commerce and Consumer Protection (CPN)
From: Hawaii Association of Health Plans Public Policy Committee
Date/Location: February 20, 2025; 9:30 am/Conference Room 229 & Videoconference

Re: Testimony with comments on SB 1449 SD1 – Relating to Prior Authorization of Health Care Services

The Hawaii Association of Health Plans (HAHP) appreciates the opportunity to offer comments on SB 1449 SD1. HAHP is a statewide partnership that unifies Hawaii's health plans to improve the health of Hawaii's communities together. A majority of Hawaii residents receive their health coverage through a plan associated with one of our organizations.

HAHP appreciates the efforts of lawmakers to address prior authorization improvements and want to emphasize that we believe prior authorization continues to be a critical process that is constantly evolving and is critical to ensuring quality patient care. We recognize the importance of addressing concerns of providers and are committed to continuing to work with stakeholders to improve the issue. HAHP believes this is a nuanced and complicated issue, with multiple bills introduced in both houses this session.

We would like to ensure that the reporting noted in this bill aligns with current CMS regulations set to be implemented in 2026 and note that we would be willing to participate in further conversations with lawmakers and stakeholders.

Thank you for the opportunity to testify on SB 1449 SD1.

Sincerely,

HAHP Public Policy Committee
cc: HAHP Board Members

LATE

February 20, 2025

The Honorable Jarrett Keohokalole, Chair
The Honorable Carol Fukunaga, Vice Chair
Senate Committee on Commerce and Consumer Protection

Re: SB 1449 SD1 – RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES

Dear Chair Keohokalole, Vice Chair Fukunaga, and Members of the Committee:

Hawaii Medical Service Association (HMSA) appreciates the opportunity to provide comments and suggestions to improve prior authorization reporting as stated in SB 1449 SD1, which will require utilization review entities in the State to submit to the State Health Planning and Development Agency data relating to prior authorization of health care services.

We support the intent of this measure and appreciate the legislature's recognition of the importance of prior authorization (PA). It is one of many important components that help to keep health care premiums affordable and will continue to help ensure the long-term sustainability of Hawaii's overall healthcare system. As a health organization partnering with over 7,500 providers across the state, we understand the challenges and are committed to working collaboratively to improve the prior authorization process and transparency of reporting while ensuring the highest quality of care for our members.

2026 Prior Authorization Improvement Requirements
We want to note for the committee that there are already pending new requirements for prior authorization on the near horizon that will address many of concerns raised about PA. Beginning in 2026, new CMS requirements[1] will streamline and reduce the burden associated with PA processes by including shortening the timeframe for PA decisions, promoting greater transparency for medical necessity criteria, strengthening PA reporting, and improving the adoption of electronic PA processes and the electronic exchange of health care information. With the new 2026 requirements quickly approaching, we believe that aligning with these requirements (particularly for reporting) would be prudent and any additional statutory changes would be unnecessary and premature as health plans are already working towards alignment with these new regulations.

HMSA Prior Authorization
HMSA currently meets, and typically exceeds, Centers for Medicare & Medicaid Services and National Committee for Quality Assurance timeliness requirements for PA. PA does not apply to emergency care or care that members receive when hospitalized. Of our 17 million claims processed last year, only 204,000 (1%) required PA. Of these 81,600 (40%) did not require submission. 163,200 (80%) of the PA submissions we receive are via fax machine despite the availability of an online option increasing errors and requiring additional time for review and

[1] https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

communication. Large numbers of claims are also incomplete or have incorrect documentation and require multiple back and forth communications forcing longer timeframes for decisions. We want to thank Hawaii Medical Association (HMA) for their leadership and partnership as we continue to work with our provider partners to make progress in these areas. HMSA is committed to forward progress and we have already participated in and convened conversations around solutioning around administrative burden, eliminated PA requirements for certain procedures, expanded our Fast Pass Program for qualifying providers, and are moving towards a fully integrated and digitized PA process to further improve accuracy, efficiency, and turnaround time and minimize errors and administrative burden. We are certainly open to continuing the conversations around PA improvement, again, noting above that this measure may be premature given the approaching federal regulations.

With that in mind, and should the committee choose to move this measure forward, we ask the committee to consider the following suggested amendments:

1. Amending Section 2 to be applicable to 431:2, as the insurance division is the regulating body of health plans in the state.
2. In section 2 **Prior authorization; reporting** (parts a and b)
    i. to replace "utilization review entity" with "health plan".
3. Aligning reporting requirements as set out by CMS as found in 45 CFR §156.223 [2] as plans will need to start reporting this data in March of 2026.

We are happy to provide the committee with a proposed draft that incorporates the requested amendments. Thank you for the opportunity to testify on this measure.

Sincerely,

Dawn Kurisu
Assistant Vice President
Community and Government Relations

[2] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-C/section-156.223

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SB-1449-SD-1
Submitted on: 2/19/2025 12:19:20 PM
Testimony for CPN on 2/20/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Kaohimanu Lydia K Dang Akiona	Testifying for Kohala Coast Urgent Care & Mobile Health, Moloka`i Family & Urgent Care	Support	Written Testimony Only

Comments:

Aloha esteemed Senators,

My name is Ka`ohimanu Dang Akiona, I am a family physician, mother and community advocate, and I provide direct care in rural parts of the state on Hawai`i Island and Moloka`i. I am submitting this testimony in **support** of SB1449 SD1, which seeks to improve transparency and accountability in prior authorization practices.

I am writing in strong support of SB1449. Please note I, among many physicians, would prefer the HB250 HD2 version to SB 1449 because it contains the same language on prior authorization reporting and transparency to SHPDA, but also presents a solution with the goal of having the process be automated in the near future, with PA decisions made while the patient is still in the office or while being admitted to the hospital. As a physician serving primarily rural, underserved and vulnerable populations in Hawaii, I have witnessed firsthand how prior authorization delays prevent patients from receiving necessary care. The lack of transparency in these processes creates undue administrative burdens on providers like me and unnecessary roadblocks for patients. This has **directly interfered with and delayed medically necessary care,** contributed to preventable health complications and death and has caused the closure of many independent practices, disproportionately moreso in the rural areas I serve. .

I strongly urge the committee to pass SB1449 SD1, to protect patient care quality and reduce unnecessary burdens on healthcare providers. This is a crucial necessary step forward—to hold utilization review entities accountable, to ensure oversight, and to truly prioritize patient care over bureaucratic inefficiencies. I strongly urge lawmakers to support this bill to improve healthcare access and outcomes in our state

Mahalo for your time and consideration and for the opportunity to submit my testimony on this very important issue impacting healthcare in Hawai`i,

`O au iho no,

Ka`ohimanu Dang Akiona, MD- Physician/Owner Kohala Coast Urgent & Mobile Health, Moloka`i Family & Urgent Care

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SB-1449-SD-1
Submitted on: 2/19/2025 1:34:23 PM
Testimony for CPN on 2/20/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Matthew Dykema	Testifying for Joyful Living, LLC	Support	Written Testimony Only

Comments:

I support SB 1449 SD1 to streamline and improve Prior authorization effectively. And, I prefer the HB250 HD2 version to SB 1449 because it contains the same language on prior authorization reporting and transparency to SHPDA, but also has a solution with a goal of having the process be automated in the near future, with PA decisions made while the patient is still in the office or while being admitted to the hospital.

Thank you for your service to our community

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SB-1449-SD-1
Submitted on: 2/19/2025 12:15:06 PM
Testimony for CPN on 2/20/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Colleen Inouye	Individual	Support	Written Testimony Only

Comments:

Dear Senators Keohokalole and Fukunaga and the Committee on Commerce and Consumer Protection,

Please support SB1449 SD!. It is designed to make Prior Authorization more efficient and effective.

Transparent reporting about Prior Authorization to SHPDA would be beneficial, with the future goal of automation of the Prior Authorization process to decrease the time delay of the decision-making process.

Again, please support SB1449 SD1.

Thank you for your kind attention,

Colleen F Inouye MD MMM MS-PopH FACHE FAAPL FACOG

LATE LATE

Alistair W Bairos, MD, CWSP, FACCWS

General Surgery, Wound Care Specialist

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2/19/2025

RE: SB1449 SD1

Dear Senators:

[1] I am writing in support SB 1449 SD1 to streamline and improve Prior Authorization effectively

[2] I do, however, prefer the HB250 HD2 version to SB 1449 - it contains the same language on prior authorization reporting and transparency to SHPDA, but also has a solution with a goal of future automation of the process, allowing for Prior Authorization decisions to be made while the patient is still in the office or while being admitted to the hospital.

PLEASE, KEEP READING: this may seem, to nonmedical members, a rather boring issue whose primary benefit is to make life easier for health care practitioners – little could be further from the truth – this is in fact a vital issue that not infrequently touches on the very life and limb of patients.

Through forty (count 'em, f-o-r-t-y) years of practice on the Big Island, I have seen prior authorization morph from an infrequent, sometimes justifiable, requirement to an outright scourge inappropriately applied across a range of routine procedures.

Just last week I had a delightful 91 year old gentleman with a non-healing diabetic foot ulcer, urgently referred by me – a board-verified wound care specialist - to a board certified vascular surgeon for urgent angioplasty – the referral was delayed, 2 days beyond the supposed two day response time for urgent prior authorization requests, causing the patient to miss the vascular surgeon's Big Island schedule and delaying the procedure for two weeks, until the surgeon's next Big Island visit, putting the patient at serious risk of losing his foot, his leg, his life – all because of the insipid prior authorization regulation that should never have been applied in such a case. [The patient, for other medical reasons, was not able to travel to O'ahu for more timely treatment.]

The above is an oft-repeated reality of the effects of prior authorization – not some abstract irritation for providers – this is where the rubber meets the road – or, in this case, where the foot meets the leg, where the leg meets the body…

End this now…please. Pass his bill and help make a start to resolving this issue.

Yours truly and aloha,

Ali Bairos, MD

Alistair W Bairos, MD, CWSP, FACCWS
President
American Board of Wound Management
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Electronically signed 02/29/2025, 11:47:18PM

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SB-1449-SD-1
Submitted on: 2/19/2025 1:45:56 PM
Testimony for CPN on 2/20/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Richard Lee	Individual	Support	Written Testimony Only

Comments:

I support SB 1449 SD1 to streamline and improve Prior authorization effectively. And, I prefer the HB250 HD2 version to SB 1449 because it contains the same language on prior authorization reporting and transparency to SHPDA, but also has a solution with a goal of having the process be automated in the near future, with PA decisions made while the patient is still in the office or while being admitted to the hospital.

Sincerely,

Dr. Richard Lee, Radiation Oncologist.

LATE

LATE

SB-1449-SD-1
Submitted on: 2/19/2025 2:24:37 PM
Testimony for CPN on 2/20/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Laeton J Pang	Individual	Support	Written Testimony Only

Comments:

I'm writing in support of SB 1449 SD1 to streamline and improve Prior authorization effectively, although I, like many others in the provider community prefer the HB250 HD2 version to SB 1449 because it contains the same language on prior authorization reporting and transparency to SHPDA, and it also has a solution with a goal of having the process be automated in the near future, with PA decisions made while the patient is still in the office or while being admitted to the hospital.

Laeton J Pang, MD, MPH, FACR, FACRO, FASTRO, FACCC

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SB-1449-SD-1
Submitted on: 2/19/2025 2:27:57 PM
Testimony for CPN on 2/20/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Kelley Withy	Individual	Support	Written Testimony Only

Comments:

Aloha and Mahalo for hearing this bill. Prior Authorization is the #1 thing that doctors in Hawai‘i report as problematic in their work. It takes time 20 hours a week of work, and that is time away from patients. Almost half of patients end up abandoning physician recommendations because of prior authorization. And it makes it harder to make ends meet in a state where we are short 786 physicians. This bill is excellent to get the data available, however if we had a well educated group meet to discuss solutions, that would be even better. HB250 has that and I recommend adding that language into this bill. Mahalo!!

LATE LATE

SB-1449-SD-1
Submitted on: 2/19/2025 4:33:41 PM
Testimony for CPN on 2/20/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
john lederer	Individual	Support	Written Testimony Only

Comments:

I support SB 1449 SD1 regarding preauthorization . The wording of HB 250 HD2 may be better for facilitating future automation of the process .

LATE LATE

SB-1449-SD-1
Submitted on: 2/19/2025 8:44:30 PM
Testimony for CPN on 2/20/2025 9:30:00 AM

Submitted By	Organization	Testifier Position	Testify
Christina Speirs	Individual	Support	Written Testimony Only

Comments:

1. We support SB 1449 SD1 to streamline and improve Prior authorization effectively. And,
2. We prefer the HB250 HD2 version to SB 1449 because it contains the same language on prior authorization reporting and transparency to SHPDA, but also has a solution with a goal of having the process be automated in the near future, with PA decisions made while the patient is still in the office or while being admitted to the hospital.