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

1177 Alakea St., #402, Honolulu, HI 96813 Phone: 587-0788 Fax: 587-0783 www.shpda.org

March 25, 2025

To: SENATE COMMITTEE ON COMMERCE AND CONSUMER PROTECTION
Senator Jarrett Keohokalole, Chair
Senator Carol Fukunaga, Vice Chair, and
Honorable Members

From: John C (Jack) Lewin, MD, Administrator, SHPDA

Re: **SCR 10, SD1 – Urging the Director of Health to Establish a Working Group on Health Insurance Reform to Provide Recommendations for Reducing the Impact of Prior Authorization Requirement on the Timely Delivery of Healthcare in the State**

Hearing: Tuesday, April 1, 2025 at 10:07 am; Conference Room 229

Position: SUPPORT the INTENT, with COMMENTS

Testimony:

SHPDA supports the intent of SCR 10, SD1 to establish a working group regarding streamlining of the prior authorization (PA) process.

In terms of state background on this issue, SHPDA worked with the Department of Health to propose in legislation during this session a means to accomplish two parallel and important improvements to the controversial prior authorization (PA) issue: mandatory reporting to SHPDA on prior authorization practices (frequency of claims denials by condition, appeals, reversals of denials), which can be easily accomplished if such reporting parallels for insurers what they are already required to report to the federal government. The second improvement involves forming a work group defined in SCR10 to attempt to standardize and use the most widely accepted national peer-reviewed scientific and medical standards, guidelines, and appropriate use criteria for prior authorization determinations. This could de-mystify the process for physicians, providers, and hospitals and allow Hawai`i to become the first state to largely automate the PA process, and relieve all parties -- including the insurers -- from the burdensome nature of the PA process for all.

Please also note that HB250 and SB1449 both contain these goals and identical language for both the reporting process and the work group. Both bills, assign SHPDA to be the convenor of the work group, which we are ready and able to do, with the Director of Health, the Med-QUEST Administrator, and the Insurance Commissioner as ex-officio

participants. We firmly believe this process can lead to constructive results and satisfy the intent of this concurrent resolution.

We note that PA dissatisfaction among providers and consumers of healthcare services nationally has resulted in the tragic murder of an insurance executive, and has further resulted in numerous state bills to accelerate PA adjudications and to make the process more transparent to physicians, hospitals, other providers, and patients. The PA process also often delays essential healthcare. It is time to build trust regarding this PA process in our state among all involved parties, (providers (physicians, clinicians, and hospitals); insurers, and purchasers of health insurance (patients, employers like EUTF, and concerned consumer groups).

Additional important federal background is that the Centers for Medicare and Medicaid services (CMS) published in 2023 a new Final Rule, CMS-0057-F to expedite PA processes and interoperability standards in federal programs (Medicare, Medicaid, CHIP, and ACA Exchanges). The Rule takes full effect in 2027 but does not cover private commercial insurance. It also creates timeline for PA determinations, that while expedited, are not fast enough to satisfy physicians, hospitals, other providers, and consumers. Hence, the many state legislative bills and American Medical Association recommendations to further shorten PA determination timelines, to include all insurers, and to accelerate implementation. The workgroup could also work on voluntary improvements to the process, including timelines, which are not included in the latest versions of either HB250 or SB1449.

SHPDA did not request new staff or resources to manage the required reporting or to convene and staff the "health care appropriateness and necessity work group." While medical conditions are complex, associated with personal and genetic individualities, and with many possible co-morbidities and/or social factors attached to any medical diagnosis or recommended treatment, we live in the information age.

National academic, federal, and professional organizations have created sophisticated peer-reviewed guidelines and standards that reflect this complexity already. For the working group proposed to succeed, SHPDA believes no special consulting services or scientific consultants will be needed for determining scientific and clinical consensus on best standards to apply to unique PA determinations. We have the scientific and clinical expertise to do this among our providers, insurers, and employers/consumer groups now to achieve consensus of best standards. And SHPDA has staff capable of convening the working group.

We therefore recommend that this SCR10 be amended to be consistent with the language SB1449 regarding the work group to be convened by SHPDA as follows:

1. The §323D- Health care appropriateness and necessity working group; appointment process shall appear as in SB1449 (or HB250) as:

(b) The administrator of the State Health Planning and Development Agency shall invite the following to be members of the working group:

(1) Five members representing the insurance industry, to be selected by the Hawaii Association of Health Plans;

(2) Five members representing licensed health care professionals, two of whom shall be selected by the Hawaii Medical Association, two of whom shall be selected by the Healthcare Association of Hawaii, and one of whom shall be selected by the Hawaii State center for nursing; and

(3) Five members representing consumers of health care or employers, two of whom shall be selected by the board of trustees of the employer-union health benefits trust fund, one of whom shall be a consumer selected by the statewide health coordinating council, one of whom shall be selected by the Hawaii Primary Care Association, and one of whom shall be selected by Papa Ola Lokahi.

The Director of Health, the Insurance Commissioner, and the Administrator of the Med-Quest Division of DHS or their designees will be ex-officio members of the working group.

I apologize for the complexity. However, mahalo for the opportunity to testify on this very important issue.

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

Testimony to the Senate Committee on Commerce and Consumer Protection
Tuesday, April 1, 2025; 10:07 a.m.
State Capitol, Conference Room 229
Via Videoconference

RE: SENATE CONCURRENT RESOLUTION NO. 010, SENATE DRAFT 1/SENATE RESOLUTION NO. 006, SENATE DRAFT 1, URGING THE DIRECTOR OF HEALTH TO ESTABLISH A WORKING GROUP ON HEALTH INSURANCE REFORM TO PROVIDE RECOMMENDATIONS FOR REDUCING THE IMPACT OF PRIOR AUTHORIZATION REQUIREMENTS ON THE TIMELY DELIVERY OF HEALTHCARE IN THE STATE.

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

The Hawaii Primary Care Association (HPCA) is a 501(c)(3) organization established to advocate for, expand access to, and sustain high quality care through the statewide network of Community Health Centers throughout the State of Hawaii. The HPCA **SUPPORTS** Senate Concurrent Resolution No. 010 and Senate Resolution No. 006, URGING THE DIRECTOR OF HEALTH TO ESTABLISH A WORKING GROUP ON HEALTH INSURANCE REFORM TO PROVIDE RECOMMENDATIONS FOR REDUCING THE IMPACT OF PRIOR AUTHORIZATION REQUIREMENTS ON THE TIMELY DELIVERY OF HEALTHCARE IN THE STATE.

By way of background, the HPCA represents Hawaii's Federally Qualified Health Centers (FQHCs). FQHCs provide desperately needed medical services at the frontlines to over 150,000 patients each year who live in rural and underserved communities. Long considered champions for creating a more sustainable, integrated, and wellness-oriented system of health, FQHCs provide a more efficient, more effective and more comprehensive system of healthcare.

These resolutions, as received by your Committee, would establish a working group on health insurance reform to provide recommendations for reducing the impact of prior authorization requirements on the timely delivery of health care in the State.

The HPCA asserts that current prior authorization requirements utilized by insurers and managed care plans have greatly diminished the provision of essential services to patients on a timely basis. This has negatively impacted the health care outcomes of the most vulnerable populations in the State. Because of this, the HPCA believes that convening a panel of stakeholders to look at this issue would be beneficial to investigate ways of improving the situation for our citizens.

ADD 1003 BISHOP STREET PAUAHI TOWER SUITE 1810 HONOLULU, HI 96813 TEL 808.536.8442 WEB HAWAIIPCA.NET

We greatly appreciate the amendment made by the Senate Committee on Health and Human Services that would specify that one of the members representing consumers of health care or employers be selected by the HPCA. This would allow the HPCA to fully participate in the working group.

The HPCA urges your favorable consideration of these resolutions.

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact Public Affairs and Policy Director Erik K. Abe at 536-8442, or eabe@hawaiipca.net.

SR-6-SD-1
Submitted on: 3/27/2025 4:02:41 PM
Testimony for CPN on 4/1/2025 10:07:00 AM

Submitted By	Organization	Testifier Position	Testify
B.A. McClintock	Individual	Support	Written Testimony Only

Comments:

Please support this important bill. We need all the help we can get with our broken Health insurance system. Mahalo.

Hawaii Association of Health Plans

LATE

April 1, 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: April 1, 2025; 10:07 am/Conference Room 229 & Videoconference

Re: Testimony in support of SCR10 SD1/SR6 SD1 – Relating to a working group on prior authorization impact

The Hawaii Association of Health Plans (HAHP) offers this testimony in support of SCR10 SD1 / SR6 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 improve prior authorization processes and emphasizes that prior authorization remains a critical, evolving mechanism essential for ensuring quality patient care. We recognize the importance of addressing providers' concerns and are committed to collaborating with stakeholders to enhance this process.

HAHP acknowledges the complexity of this issue and agrees that it warrants the formation of a working group to develop solutions that benefit all parties involved. Given our extensive experience with this matter, we appreciate being included in this working group and look forward to the opportunity to collaborate with lawmakers and stakeholders to ensure high-quality, affordable healthcare for our state.

Thank you for the opportunity to testify in support of SCR10 SD1/SR6 SD1.

Sincerely,

HAHP Public Policy Committee
cc: HAHP Board Members

An Independent Licensee of the Blue Cross and Blue Shield Association

LATE

April 1, 2025

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

Re: SCR10/SR6 SD1 – URGING THE DIRECTOR OF HEALTH TO ESTABLISH A WORKING GROUP ON HEALTH INSURANCE REFORM TO PROVIDE RECOMMENDATIONS FOR REDUCING THE IMPACT OF PRIOR AUTHORIZATION REQUIREMENTS ON THE TIMELY DELIVERY OF HEALTHCARE IN THE STATE

Dear Chair Keohokalole, Vice Chair Fukunaga, and members of the committee,

Hawaii Medical Service Association (HMSA) supports the intent of SCR10/SR6, urging the director of health to establish a working group on health insurance reform to provide recommendations for reducing the impact of prior authorization requirements on the timely delivery of healthcare in the state.

We support the intent of the resolutions 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.

We would like to note that two measures moving this session, SB 1449 SD1 HD1 and HB 250 HD2 SD1, look to convene a working group under SHPDA that would bring together the identified stakeholders in the SD1 draft of this resolution to work on the challenges highlighted in this resolution. While we are in support of the intent of this resolution, we would ask that the committee consider deferring these resolutions in favor of the aforementioned legislation.

We appreciate the opportunity to support this resolution and to continue to find ways to continuously improve the quality of care for our members and the residents of Hawaii.

Sincerely,

Dawn Kurisu
Assistant Vice President
Community and Government Relations

ALOHACARE

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

From: Paula Arcena, External Affairs Vice President
Mike Nguyen, Director of Public Policy
Sarielyn Curtis, External Affairs Specialist

Hearing: Tuesday, April 1, 2025, 10:07 AM, Conference Room 229

RE: **SCR10 SD1/SR6 SD1 Urging the Director of Health to Establish a Working Group on Health Insurance Reform to Provide Recommendations for Reducing the Impact of Prior Authorization Requirements on the Timely Delivery of Health Care in the State**

AlohaCare appreciates the opportunity to provide testimony in **support** of **SCR10 SD1** and **SR6 SD1.** These measures urge the Director of Health to establish a working group on health insurance reform to provide recommendations for reducing the impact of prior authorization requirements on the timely delivery of health care in the state.

Founded in 1994 by Hawai'i's community health centers, AlohaCare is a community-rooted, non-profit health plan serving over 70,000 Medicaid and dual-eligible health plan members on all islands. Approximately 37 percent of our members are keiki. We are Hawai'i's only health plan exclusively dedicated to serving Medicaid and Medicaid-Medicare dually-eligible beneficiaries. Our mission is to serve individuals and communities in the true spirit of aloha by ensuring and advocating for access to quality, whole-person care for all.

AlohaCare is committed partnering with community healthcare providers to advance the goals of the triple aim: improving the patient experience of care including quality and satisfaction, improving the health of the population, and reducing per capita cost of care. While we support efforts to reduce administraive burdens on providers, we would note that prior authorization is one tool in a broad strategy to ensure delivery of safe and necessary care consistent with evidence-based guidelines and best practices. At AlohaCare, we use prior authorization on a limited basis to maintain high standards of care and gauge medical necessity or appropriateness, directing care to cost-effective, higher-quality, and in-network settings and avoiding potentially harmful care. For example, prior authorization allows AlohaCare to prevent harmful drug interactions and to ensure that prescribed services are the right fit for members, such as confirming that

wheelchairs can fit through the door of a member's home. Further, we utilize prior authorization data internally to allow care managers to better understand a member's needs and care, and we share data with network providers to enhance the provision of care and to assist with discharges and transitions in care settings. Prior authorization may also shield families from unnecessary health care bills, protect patients from bad actors in the health care provider community, and help ensure that limited health care dollars are wisely spent.

Consistent with the intent of these measures to reduce administrative burdens on provider, and in recognition of our providers that consistently provide care consistent with evidence-based guidelines and best practices, we have begun to implement a "gold carding" pilot. Gold carding is a process where prior authorization requirements are lifted for providers who consistently practice evidence-based medicine and rarely receive denials for their service requests. This approach recognizes the high standards of care provided by these physicians, streamlines the prior authorization process, improves efficiency, and reduces the administrative load on healthcare providers.

We would note that we also use prior authorization data to understand where the plan-provider relationship can be enhanced, how provider education can be improved, and how provider burden can be reduced. For example, linking prior authorization processes and data with claims systems ensures claims are paid quickly and accurately. Prior authorization can also help to ensure access to payment, avoid backend disputes, and can even encourage some providers to accept patients because they can be assured of payment in advance.

Finally, recognizing the importance of addressing providers' concerns, we are committed to working with our provider partners and other stakeholders to improve this process.

Given the complexity of this issue, we support convening a working group toward developing multi-stakeholder consensus solutions. AlohaCare would appreciate being included in this working group, and we look forward to the opportunity to collaborate with policymakers and stakeholders to ensure quality, appropriate and cost-effective care for our state's residents.

Mahalo for this opportunity to provide testimony in **support** of **SCR10 SD1** and **SR6 SD1.** Below we offer additional background and context.

Government Oversight for Medicaid Managed Care. State Medicaid agencies are required by federal rules to collect and review data on appeals of denials and state fair hearings, conduct external quality reviews of Medicaid health plans, and assess timeliness requirements, plus have discretion to conduct additional oversight activities. Accordingly, Medicaid health plans submit prior authorization policies and data for review to state Medicaid agencies when required, complying with state and federal laws on utilization management and prior authorization and following state contracts and guidelines.[1]

Medicaid health plans are subject to additional requirements meant to ensure that they do not use prior authorization to restrict access to medically necessary care. Medicaid health plans must adopt practice guidelines that reflect clinical evidence and expert consensus, and use those guidelines for making utilization management decisions (42 CFR §438.236). Federal regulations also detail the processes and timelines by which Medicaid health plans must make prior authorization decisions. Medicaid health plans must have tools in place to ensure that prior authorization review criteria are applied consistently, and any Medicaid health plans decisions to deny services must be made by individuals with appropriate clinical expertise to address the beneficiary's health care needs. Medicaid health plans must also supply denial notifications to requesting providers and give beneficiaries a notice of denial in writing. Current regulations require that standard decisions be made within 14 days and expedited decisions be made within 72 hours, though these time frames will be reduced by the new requirements from the 2024 Interoperability and Prior Authorization final rule, which will take effect January 2026 (42 CFR § 438.210, CMS 2024a). Starting January 1, 2026, the rule requires impacted health plans to make prior authorization decisions within 7 calendar days for standard requests and 72 hours for expedited requests.

[1] Medicaid and CHIP Payment and Access Commission (MACPAC). *Prior Authorization in Medicaid.* August 2024. https://www.macpac.gov/publication/prior-authorization-in-medicaid-2/