HOUSE OF REPRESENTATIVES
TWENTY-EIGHTH LEGISLATURE, 2016
STATE OF HAWAII

H.B. NO. 2740 H.D. 1 S.D. 1

A BILL FOR AN ACT

RELATING TO LIABILITY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. The legislature finds that prior approval for
2 medical services, also known as precertification or
3 preauthorization, refers to health insurer requirements that
4 certain physician-ordered treatments or services must be
5 approved in advance by the insurer or by a medical review
6 service contracted by the insurer before the insurer will
7 provide final reimbursement or payment. Preauthorization can
8 help contain costs and ensure authorized medical treatment and
9 services are consistent with current standards of care.
10 Preauthorization can also promote accountability and mitigate
11 against the overutilization of costly, potentially harmful,
12 medical treatments and services. Furthermore, federal programs
13 such as medicaid and medicare have specific guidelines regarding
14 preauthorization of certain medical treatment and services.
15 However, the legislature further finds that
16 preauthorization requirements may also create gaps in necessary
17 and often critical health care coverage. Overly burdensome
18 preauthorization programs may create barriers to timely and

1 effective patient care. The legislature notes the importance of
2 timely responses to preauthorization requests and the need to
3 ensure that preauthorization requests and decisions are made in
4 accordance with evidence-based appropriate-use criteria or
5 guidelines. The legislature concludes that establishing basic
6 standards for preauthorization of medical treatment and services
7 is appropriate, as it is in the best interest of the State to
8 ensure that preauthorization requirements do not negatively
9 impact the health of Hawaii residents.
10 Accordingly, the purpose of this Act is to establish
11 preauthorization standards that shall apply to all health
12 insurers in the State, including health benefits plans under
13 chapter 87A, Hawaii Revised Statutes, including:
14 (1) Requiring preauthorization requests for medical
15 treatment or service to be consistent with known,
16 published, and current evidence-based appropriate-use
17 criteria or guidelines for the appropriate specialty
18 or subspecialty for which the preauthorization is
19 requested;
20 (2) Specifying requirements for insurers that require
21 preauthorization of a medical treatment or service;

1 (3) Specifying that preauthorization shall not be required
2 for delivery of emergency medical services;
3 (4) Requiring decisions on preauthorization requests to be
4 made in accordance with nationally-accepted evidence-
5 based appropriate-use criteria or guidelines and made
6 publicly available to health care providers within a
7 health insurer's network;
8 (5) Requiring complaints regarding preauthorization to be
9 filed with the insurance commissioner and inquiries
10 associated with preauthorization denial or undue delay
11 disputes to be filed with the medical inquiry and
12 conciliation panel;
13 (6) Specifying that an insurer is not prohibited from
14 implementing preauthorization and permitting insurers
15 from meeting otherwise established requirements for
16 preauthorization, as required under existing state or
17 federal programs;
18 (7) Requiring the insurance commissioner to submit a
19 report to the legislature, no later than twenty days
20 prior to the regular session of 2019, regarding the

1 preauthorization standards established by this Act;
2 and
3 (8) Including a three-year sunset date for the
4 preauthorization standards established by this Act.
5 SECTION 2. Chapter 431, Hawaii Revised Statutes, is
6 amended by adding a new section to article 10A to be
7 appropriately designated and to read as follows:
8 "**§431:10A- Preauthorization; standards.** (a) Any
9 preauthorization request for medical treatment or service shall
10 be consistent with known, published, and current evidence-based
11 appropriate-use criteria or guidelines for the appropriate
12 specialty or subspecialty for which the preauthorization is
13 requested.
14 (b) Any insurer that requires preauthorization of a
15 medical treatment or service shall:
16 (1) Ensure that such preauthorization request is in
17 accordance with evidence-based appropriate-use
18 criteria or guidelines for the appropriate specialty
19 or subspecialty;

1 (2) Consult with health care providers in the insurer's
2 network to ensure that evidence-based appropriate-use
3 criteria or guidelines are known and used;
4 (3) Utilize evidence-based support software, if available
5 to a specialty or subspecialty, to minimize or
6 eliminate the time needed for a preauthorization
7 decision;
8 (4) Ensure that all requests for preauthorization are
9 completed in a timely manner and do not result in
10 undue delay that would adversely affect patient
11 outcome; and
12 (5) Ensure that response times for preauthorization
13 requests are equal to or less than the response times
14 permitted for preauthorization requests by medicaid,
15 medicare, or other federal plans or programs, for the
16 same medical treatment or service.
17 (c) Preauthorization shall not be required for delivery of
18 emergency medical services.
19 (d) A third party vendor that is utilized by an insurer
20 for preauthorization requests shall:

1 (1) Be available to review preauthorization requests
2 twenty-four hours a day, seven days a week;
3 (2) Advise the insurer of its decision regarding the
4 preauthorization request in a timely manner,
5 consistent with established guidelines for
6 preauthorization review by medicaid, medicare, or
7 other federal plans or programs; and
8 (3) Comply with all other requirements under this section.
9 (e) Decisions on preauthorization requests shall be in
10 accordance with nationally-accepted evidence-based appropriate-
11 use criteria or guidelines and shall be made publicly available
12 to health care providers within an insurer's network.
13 (f) Complaints arising pursuant to this section shall be
14 filed with the commissioner. Inquiries associated with
15 preauthorization denial or undue delay disputes pursuant to this
16 section shall be filed with the medical inquiry and conciliation
17 panel pursuant to section 671-11.
18 (g) Nothing in this section shall be construed to prohibit
19 an insurer from implementing preauthorization.
20 (h) Nothing in this section shall be construed to
21 disqualify an insurer from meeting established requirements for

1 preauthorization as required by the department of human services
2 for the department's medicaid QUEST or fee-for-service programs
3 or any requirements for preauthorization as required by federal
4 plans or programs, including medicaid or medicare.
5 (i) As used in this section:
6 "Preauthorization" means the authorization process used in
7 determining whether medical treatment or services meet payment
8 determination criteria under an insured's plan benefits."
9 SECTION 3. Chapter 432, Hawaii Revised Statutes, is
10 amended by adding a new section to be appropriately designated
11 and to read as follows:
12 "**§432- Preauthorization; undue delay; liability.** (a)
13 Any preauthorization request for medical treatment or service
14 shall be consistent with known, published, and current evidence-
15 based appropriate-use criteria or guidelines for the appropriate
16 specialty or subspecialty for which the preauthorization is
17 requested.
18 (b) Any mutual benefit society that requires
19 preauthorization of a medical treatment or service shall:
20 (1) Ensure that such preauthorization request is in
21 accordance with evidence-based appropriate-use

1 criteria or guidelines for the appropriate specialty
2 or subspecialty;
3 (2) Consult with health care providers in the mutual
4 benefit society's network to ensure that evidence-
5 based appropriate-use criteria or guidelines are known
6 and used;
7 (3) Utilize evidence-based support software, if available
8 to a specialty or subspecialty, to minimize or
9 eliminate the time needed for a preauthorization
10 decision;
11 (4) Ensure that all requests for preauthorization are
12 completed in a timely manner and do not result in
13 undue delay that would adversely affect patient
14 outcome; and
15 (5) Ensure that response times for preauthorization
16 requests are equal to or less than the response times
17 permitted for preauthorization requests by medicaid,
18 medicare, or other federal plans or programs, for the
19 same medical treatment or service.
20 (c) Preauthorization shall not be required for delivery of
21 emergency medical services.

1 (d) A third party vendor that is utilized by a mutual
2 benefit society for preauthorization requests shall:
3 (1) Be available to review preauthorization requests
4 twenty-four hours a day, seven days a week;
5 (2) Advise the mutual benefit society of its decision
6 regarding the preauthorization request in a timely
7 manner, consistent with established guidelines for
8 preauthorization review by medicaid, medicare, or
9 other federal plans or programs; and
10 (3) Comply with all other requirements under this section.
11 (e) Decisions on preauthorization requests shall be in
12 accordance with nationally-accepted evidence-based appropriate-
13 use criteria or guidelines and shall be made publicly available
14 to health care providers within a mutual benefit society's
15 network.
16 (f) Complaints arising pursuant to this section shall be
17 filed with the commissioner. Inquiries associated with
18 preauthorization denial or undue delay disputes pursuant to this
19 section shall be filed with the medical inquiry and conciliation
20 panel pursuant to section 671-11.

1 (g) Nothing in this section shall be construed to prohibit
2 a mutual benefit society from implementing preauthorization.
3 (h) Nothing in this section shall be construed to
4 disqualify a mutual benefit society from meeting established
5 requirements for preauthorization as required by the department
6 of human services for the department's medicaid QUEST or fee-
7 for-service programs or any requirements for preauthorization as
8 required by federal plans or programs, including medicaid or
9 medicare.
10 (i) As used in this section:
11 "Preauthorization" means the authorization process used in
12 determining whether medical treatment or services meet payment
13 determination criteria under a mutual benefit society's plan
14 benefits."
15 SECTION 4. Section 432D-23, Hawaii Revised Statutes, is
16 amended to read as follows:
17 "**§432D-23 Required provisions and benefits.**
18 Notwithstanding any provision of law to the contrary, each
19 policy, contract, plan, or agreement issued in the State after
20 January 1, 1995, by health maintenance organizations pursuant to
21 this chapter, shall include benefits provided in sections

1 431:10-212, 431:10A-115, 431:10A-115.5, 431:10A-116, 431:10A-
2 116.2, 431:10A-116.5, 431:10A-116.6, 431:10A-119, 431:10A-120,
3 431:10A-121, 431:10A-122, 431:10A-125, 431:10A-126, 431:10A-132,
4 431:10A-133, and 431:10A-140, 431:10- , and chapter 431M."
5 SECTION 5. Notwithstanding any other law to the contrary,
6 the preauthorization standards established under sections 2, 3,
7 and 4 of this Act shall apply to all health benefits plans under
8 chapter 87A, Hawaii Revised Statutes, issued, renewed, modified,
9 altered, or amended on or after the effective date of this Act.
10 SECTION 6. The insurance commissioner shall submit a
11 report to the legislature, no later than twenty days prior to
12 the convening of the regular session of 2019, regarding the
13 preauthorization standards established by this Act. The report
14 shall contain information on compliance, complaints, or any
15 other issues associated with the preauthorization standard
16 requirements required by this Act and reported to the insurance
17 commissioner.
18 SECTION 7. This Act does not affect rights and duties that
19 matured, penalties that were incurred, and proceedings that were
20 begun before its effective date.
21 SECTION 8. New statutory material is underscored.

1 SECTION 9. This Act shall take effect on July 1, 2050, and
2 shall be repealed on July 1, 2019; provided that section
3 432D-23, Hawaii Revised Statutes, shall be reenacted in the form
4 in which it read on the day prior to the effective date of this
5 Act.
6

H.B. NO. 2740 H.D. 1 S.D. 1

Report Title:
Preauthorization; Health Insurance; Health Insurers; Standards; Establishment; Medical Treatment or Service; Guidelines

Description:
Establishes preauthorization standards for all health insurers in the State, including health benefits plans under chapter 87A, HRS. Requires preauthorization requests for medical treatment or service to be consistent with known, published, and current evidence-based appropriate-use criteria or guidelines for the appropriate specialty or subspecialty for which the preauthorization is requested. Specifies requirements for insurers that require preauthorization. Specifies that preauthorization is not required for delivery of emergency medical services. Requires decisions on preauthorization requests to be made in accordance with nationally-accepted evidence-based appropriate-use criteria or guidelines and made publicly available to health care providers within a health insurer's network. Requires complaints regarding preauthorization to be filed with the insurance commissioner and inquiries associated with preauthorization denial or undue delay disputes to be filed with the medical inquiry and conciliation panel. Specifies that an insurer is not prohibited from implementing preauthorization or otherwise meeting established requirements for preauthorization, as required under existing state or federal programs. Requires the insurance commissioner to submit a report to the legislature. Sunsets 7/1/2019. Effective 7/1/2050. (SD1)

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