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

H.B. NO. 2740 H.D. 1 S.D. 2

A BILL FOR AN ACT

RELATING TO LIABILITY.

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

SECTION 1. The legislature finds that prior approval for medical services, also known as precertification or preauthorization, refers to health insurer requirements that certain physician-ordered treatments or services must be approved in advance by the insurer or by a medical review service contracted by the insurer before the insurer will provide final reimbursement or payment. Preauthorization can help contain costs and ensure authorized medical treatment and services are consistent with current standards of care. Preauthorization can also promote accountability and mitigate against the overutilization of costly, potentially harmful, medical treatments and services. Furthermore, federal programs such as medicaid and medicare have specific guidelines regarding preauthorization of certain medical treatment and services.

However, the legislature further finds that preauthorization requirements may also create gaps in necessary and often critical health care coverage. Overly burdensome preauthorization programs may create barriers to timely and

effective patient care. The legislature notes the importance of timely responses to preauthorization requests and the need to ensure that preauthorization requests and decisions are made in accordance with evidence-based appropriate-use criteria or guidelines. The legislature concludes that establishing basic standards for preauthorization of medical treatment and services is appropriate, as it is in the best interest of the State to ensure that preauthorization requirements do not negatively impact the health of Hawaii residents.

Accordingly, the purpose of this Act is to establish preauthorization standards that shall apply to all health insurers in the State, including health benefits plans under chapter 87A, Hawaii Revised Statutes.

SECTION 2. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to article 10A to be appropriately designated and to read as follows:

"**§431:10A- Preauthorization; standards; undue delay; liability.** (a) Any preauthorization request for medical treatment or service shall 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.

(b) Any insurer that requires preauthorization of a medical treatment or service shall:

(1) Ensure that the preauthorization request is in accordance with evidence-based appropriate-use criteria or guidelines for the appropriate specialty or subspecialty;

(2) Consult with health care providers in the insurer's network to ensure that evidence-based appropriate-use criteria or guidelines are known and used;

(3) Utilize evidence-based support software, if available to a specialty or subspecialty, to minimize or eliminate the time needed for a preauthorization decision;

(4) Ensure that all requests for preauthorization are completed in a timely manner and do not result in undue delay that would adversely affect patient outcome; and

(5) Ensure that response times for preauthorization requests are equal to or less than the response times

permitted for preauthorization requests by medicaid, medicare, or other federal plans or programs, for the same medical treatment or service.

(c) Preauthorization shall not be required for delivery of emergency medical services.

(d) A third party vendor that is utilized by an insurer for preauthorization requests shall:

(1) Be available to review preauthorization requests twenty-four hours a day, seven days a week;

(2) Advise the insurer of its decision regarding the preauthorization request in a timely manner, consistent with established guidelines for preauthorization review by medicaid, medicare, or other federal plans or programs; and

(3) Comply with all other requirements under this section.

(e) Decisions on preauthorization requests shall be in accordance with nationally-accepted, evidence-based appropriate-use criteria or guidelines and shall be made available to health care providers within an insurer's network.

(f) Complaints arising pursuant to this section shall be filed with the commissioner.

(g) Notwithstanding any law to the contrary, a licensed health care provider shall be defended and indemnified by an insurer for civil liability for injury to a patient that was caused by the insurer's undue delay in preauthorization of medical treatment or services.

(h) An insurer that fails to meet the standards established in this section shall be civilly liable for any injury that occurs to a patient because of undue delay in the receipt of medical treatment or services.

(i) Nothing in this section shall be construed to prohibit an insurer from implementing preauthorization.

(j) Nothing in this section shall be construed to disqualify an insurer from meeting established requirements for preauthorization as required by the department of human services for the department's medicaid QUEST or fee-for-service programs or any requirements for preauthorization as required by federal plans or programs, including medicaid or medicare.

(k) As used in this section:

"Preauthorization" means the authorization process used in determining whether medical treatment or services meet payment determination criteria under an insured's plan benefits."

SECTION 3. Chapter 432, Hawaii Revised Statutes, is amended by adding a new section to article 1 to be appropriately designated and to read as follows:

"§432:1- **Preauthorization; standards; undue delay; liability.** (a) Any preauthorization request for medical treatment or service shall 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.

(b) Any mutual benefit society that requires preauthorization of a medical treatment or service shall:

(1) Ensure that the preauthorization request is in accordance with evidence-based appropriate-use criteria or guidelines for the appropriate specialty or subspecialty;

(2) Consult with health care providers in the mutual benefit society's network to ensure that evidence-based appropriate-use criteria or guidelines are known and used;

(3) Utilize evidence-based support software, if available to a specialty or subspecialty, to minimize or

eliminate the time needed for a preauthorization decision;

(4) Ensure that all requests for preauthorization are completed in a timely manner and do not result in undue delay that would adversely affect patient outcome; and

(5) Ensure that response times for preauthorization requests are equal to or less than the response times permitted for preauthorization requests by medicaid, medicare, or other federal plans or programs, for the same medical treatment or service.

(c) Preauthorization shall not be required for delivery of emergency medical services.

(d) A third party vendor that is utilized by a mutual benefit society for preauthorization requests shall:

(1) Be available to review preauthorization requests twenty-four hours a day, seven days a week;

(2) Advise the mutual benefit society of its decision regarding the preauthorization request in a timely manner, consistent with established guidelines for

preauthorization review by medicaid, medicare, or other federal plans or programs; and

(3) Comply with all other requirements under this section.

(e) Decisions on preauthorization requests shall be in accordance with nationally-accepted, evidence-based appropriate-use criteria or guidelines and shall be made available to health care providers within a mutual benefit society's network.

(f) Complaints arising pursuant to this section shall be filed with the commissioner.

(g) Notwithstanding any law to the contrary, a licensed health care provider shall be defended and indemnified by an insurer for civil liability for injury to a patient that was caused by the insurer's undue delay in preauthorization of medical treatment or services.

(h) An insurer that fails to meet the standards established in this section shall be civilly liable for any injury that occurs to a patient because of undue delay in the receipt of medical treatment or services.

(i) Nothing in this section shall be construed to prohibit a mutual benefit society from implementing preauthorization.

(j) Nothing in this section shall be construed to disqualify a mutual benefit society from meeting established requirements for preauthorization as required by the department of human services for the department's medicaid QUEST or fee-for-service programs or any requirements for preauthorization as required by federal plans or programs, including medicaid or medicare.

(k) As used in this section:

"Preauthorization" means the authorization process used in determining whether medical treatment or services meet payment determination criteria under a mutual benefit society's plan benefits."

SECTION 4. Section 432D-23, Hawaii Revised Statutes, is amended to read as follows:

"**§432D-23 Required provisions and benefits.** Notwithstanding any [~~provision of~~] law to the contrary, each policy, contract, plan, or agreement issued in the State after January 1, 1995, by health maintenance organizations pursuant to this chapter, shall include benefits provided in sections 431:10-212, 431:10A-115, 431:10A-115.5, 431:10A-116, 431:10A-116.2, 431:10A-116.5, 431:10A-116.6, 431:10A-119, 431:10A-120,

431:10A-121, 431:10A-122, 431:10A-125, 431:10A-126, 431:10A-132, 431:10A-133, and 431:10A-140, 431:10A- , and chapter 431M."

SECTION 5. Notwithstanding any other law to the contrary, the preauthorization standards established under sections 2, 3, and 4 of this Act shall apply to all health benefits plans under chapter 87A, Hawaii Revised Statutes, issued, renewed, modified, altered, or amended on or after the effective date of this Act.

SECTION 6. The insurance commissioner shall submit a report to the legislature, no later than twenty days prior to the convening of the regular session of 2019, regarding the preauthorization standards established by this Act. The report shall contain information on compliance, complaints, or any other issues associated with the preauthorization standard requirements required by this Act and reported to the insurance commissioner.

SECTION 7. This Act does not affect rights and duties that matured, penalties that were incurred, and proceedings that were begun before its effective date.

SECTION 8. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

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

H.B. NO. 2740 H.D. 1 S.D. 2

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 available to health care providers within a health insurer's network. Requires that licensed health care providers be defended and indemnified by an insurer for civil liability for injury to a patient that was caused by the insurer's undue delay in preauthorization. Establishes that an insurer that fails to meet the standards is civilly liable for any injury that occurs to a patient due to undue delay in receipt of medical treatment or services. 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. (SD2)

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