HOUSE OF REPRESENTATIVES
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

H.B. NO. 250

A BILL FOR AN ACT

RELATING TO HEALTH.

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

SECTION 1. The legislature finds that prior authorization is a health plan cost control process that requires physicians, health care professionals, and hospitals to obtain advance approval from a health plan before a specific service to a patient to qualify for payment or coverage. Each plan has its own policies and procedures that health care providers are required to navigate to have services they prescribe for their patients approved for payment before being provided to the patient. Each health plan uses its own standards, methods, the individual judgment of an employed medical director, or advice from a contracted firm for determining the medical necessity of the services prescribed, which are not transparent or clear to the prescribing clinician or health care provider.

The legislature further finds that there is emerging consensus among health care providers that prior authorization increases administrative burdens and costs. In the 2023 physician workforce report published by the university of Hawaii

John A. Burns school of medicine, physicians voted prior authorization as their top concern regarding administrative burden. Furthermore, a physician survey conducted by the American Medical Association reported that ninety-five per cent of physicians attribute prior authorization to somewhat or significantly increased physician burnout, and that more than one-in-three have staff who work exclusively on prior authorization. The survey also found that:

(1) Eighty-three per cent of prior authorization denials were subsequently overturned by health plans;

(2) Ninety-four per cent of respondents said that the prior authorization process always, often, or sometimes delays care;

(3) Nineteen per cent of respondents said prior authorization resulted in a serious adverse event leading to a patient being hospitalized;

(4) Thirteen per cent of respondents said prior authorization resulted in a serious adverse event leading to a life-threatening event or requiring intervention to prevent permanent impairment or damage; and

(5) Seven per cent of respondents said prior authorization resulted in a serious adverse event leading to a patient's disability, permanent body damage, congenital anomaly, birth defect, or death.

The legislature believes that reducing the burdens of prior authorization will assist health care providers, thereby ensuring the health and safety of their patients.

Accordingly, the purpose of this Act is to:

(1) Examine prior authorization practices in the State by requiring utilization review entities to report certain data to the state health planning and development agency; and

(2) Establish the health care appropriateness and necessity commission to make recommendations to improve and expedite the prior authorization process.

SECTION 2. Chapter 323D, Hawaii Revised Statutes, is amended by adding two new sections to part II to be appropriately designated and to read as follows:

"**§323D- Prior authorization; reporting.** (a) Each utilization review entity doing business in the State shall file an annual report containing data related to the prior

authorization of health care services for the preceding calendar year with the state agency no later than January 1 of each year, in a form and manner prescribed by the commissioner. The state agency shall post each report on its website no later than three months before the start of the reporting period.

(b) The state agency shall compile the data in each report by provider of health insurance, health care setting, and line of business, and shall post a report of findings, including recommendations, on its website no later than March 1 of the following year after the reporting period.

§323D- Health care appropriateness and necessity commission; established. (a) There is established the health care appropriateness and necessity commission within the state agency. The commission 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, 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 commission 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 providers, 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 commission 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 commission 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 commission shall be advisory only and not mandatory for health care providers, insurers, and utilization review entities. The state agency shall promote the recommendations among health care providers, 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 providers, 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 the current unrest 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."

SECTION 3. Section 323D-2, Hawaii Revised Statutes, is amended by adding two new definitions to be appropriately inserted and to read as follows:

""Prior authorization" means the process by which a utilization review entity determines the medical necessity or medical appropriateness of otherwise covered health care services before rendering the health care services. "Prior authorization" includes any health insurer's or utilization review entity's requirement that an insured or a health care provider notify the insurer or utilization review entity before providing health care services to determine eligibility for payment or coverage.

"Utilization review entity" means an individual or entity that performs prior authorization for one or more of the following entities:

(1) An insurer governed by chapter 431, article 10A; a mutual benefit society governed by chapter 432,

article 1; a fraternal benefit society governed by chapter 432, article 2; or a health maintenance organization governed by chapter 432D; or

(2) Any other individual that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health benefits to a person treated by a health care provider in the State under a policy, contract, plan, or agreement."

SECTION 4. New statutory material is underscored.

SECTION 5. This Act shall take effect upon its approval.

INTRODUCED BY: Lisa Mates

JAN 16 2025

H.B. NO. 250

Report Title:
Prior Authorization; Utilization Review Entities; Reporting; Health Care Appropriateness and Necessity Commission; State Health Planning and Development Agency

Description:
Requires utilization review entities to submit data relating to the prior authorization of health care services to the State Health Planning and Development Agency. Establishes the Health Care Appropriateness and Necessity Commission within the State Health Planning and Development Agency.

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.