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

H.B. NO. 250 H.D. 1

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;

(2) Establish timelines for the approval of prior authorization requests to reduce delays for urgent and non-urgent health care services; and

(3) Establish the health care appropriateness and necessity working group to make recommendations to improve and expedite the prior authorization process.

SECTION 2. Chapter 323D, Hawaii Revised Statutes, is amended by adding four 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 state agency. 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- **Prior authorization for non-urgent health care services; submission of request; determination time frame; automatic approval.** (a) A health care professional shall submit a prior authorization request for a non-urgent health care to the utilization review entity no later than five calendar days before the provision of the health care service.

(b) A prior authorization request submitted pursuant to subsection (a) shall be deemed approved forty-eight hours after

the submission of the request if the utilization review entity fails to:

(1) Approve or deny the request and notify the enrollee or the enrollee's health care facility or health care professional;

(2) Request from the health care facility or health care professional all additional information needed to render a decision; or

(3) Notify the health care facility or health care professional that prior authorization is being questioned for medical necessity,

within the forty-eight-hour period. The utilization review entity shall have an additional twenty-four hours to process the request from the time the health care facility or health care professional submits the additional information requested pursuant to paragraph (2).

(c) Any health care facility or health care professional who fails to submit the information requested pursuant to subsection (b)(2) within twenty-four hours shall submit a new prior authorization request.

§323D- Prior authorization request for urgent health care services; determination time frame; automatic approval. (a) A prior authorization request submitted for an urgent health care service shall be deemed approved twenty-four hours after the submission of the request if the utilization review entity fails to:

(1) Approve or deny the request and notify the enrollee or the enrollee's health care provider;

(2) Request from the health care facility or health care professional all additional information needed to render a decision; or

(3) Notify the health care facility or health care professional that prior authorization is being questioned for medical necessity,

within the twenty-four-hour period. The utilization review entity shall have an additional twelve hours to process the request from the time the health care facility or health care professional submits the additional information requested pursuant to paragraph (2).

(b) Any health care facility or health care professional who fails to submit the information requested pursuant to

subsection (a)(2) within twelve hours shall submit a new prior authorization request.

§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."

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

""Enrollee" means an individual eligible to receive health care benefits from a health insurer in the State pursuant to a health plan or other health insurance coverage. "Enrollee" includes an enrollee's legally authorized representative.

"Health care professional" has the same meaning as defined in section 431:26-101.

"Health care service" means health care procedures, treatments, or services provided by:

(1) A health care facility licensed to provide health care procedures, treatments, or services in the State; or

(2) A doctor of medicine, doctor of osteopathy, or other health care professional, licensed in the State, whose scope of practice includes the provision of health care procedures, treatments, or services.

"Health care service" includes the provision of pharmaceutical products or services or durable medical equipment.

"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 facility or health care professional notify the insurer or utilization review entity before providing health care services to determine eligibility for payment or coverage.

"Urgent health care service" means a health care service which, without an expedited prior authorization could, in the opinion of a physician with knowledge of the enrollee's medical condition:

(1) Seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(2) Subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

"Urgent health care service" includes mental and behavioral health care services.

"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 facility or health care professional in the State under a policy, contract, plan, or agreement."

SECTION 4. New statutory material is underscored.

SECTION 5. This Act shall take effect on July 1, 3000.

H.B. NO. 250 H.D. 1

Report Title:
Prior Authorization; Utilization Review Entities; Reporting; Health Care Appropriateness and Necessity Working Group; 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 timelines for the approval of prior authorization requests for urgent and non-urgent health care services. Establishes the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency. Effective 7/1/3000. (HD1)

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