
A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

1 SECTION 1. The purpose of this Act is to require all
2 accident and health or sickness insurers, mutual benefit
3 societies, and health maintenance organizations operating in the
4 State to adopt policies, procedures, and criteria for approving
5 or denying requests for prior authorization that are the
6 equivalent to the guidelines for prior authorization established
7 by medicare.

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

11 "§431:10A- **Prior authorization; procedures; alignment**
12 with medicare guidelines. (a) Each individual or group policy
13 of accident and health or sickness insurance issued or renewed
14 in the State after December 31, 2025, shall establish policies,
15 procedures, and criteria for approving or denying requests for
16 prior authorization that are equivalent to the guidelines for
17 prior authorization used by medicare plans.



1 (b) The policies, procedures, and criteria shall include
2 but not be limited to:

3 (1) Time frames for decision making for initial requests
4 and appeals, which shall be as follows:

5 (A) For urgent requests: Within twenty-four hours of
6 receipt of the request; and

7 (B) For non-urgent requests: Within three calendar
8 days of receipt of the request;

9 provided that if an insurer fails to respond to a
10 request for prior authorization within the required
11 time frame, the request shall be automatically deemed
12 approved;

13 (2) Approval criteria, which shall be based on nationally
14 recognized evidence-based guidelines and medicare's
15 standards of medical necessity; provided that policies
16 that provide medicare advantage (medicare part C)
17 coverage shall not limit or require prior
18 authorization for tests that are allowed under
19 medicare guidelines;

20 (3) Required documentation, which shall be no more than
21 the level of documentation required by medicare; and



1 (4) Duration, which shall be for ninety days or the entire
2 course of treatment, whichever is longer.

3 (c) Each insurer shall prominently publish the criteria
4 for prior authorization and the process for requesting prior
5 authorization on the insurer's website.

6 (d) Each insurer shall provide written notice to its
7 policyholders at least weeks prior to any changes of any
8 criteria for prior authorization established pursuant to
9 subsection (b).

10 (e) No insurer shall retroactively deny payment for any
11 service, medication, or procedure that received prior
12 authorization except in cases of fraud, intentional
13 misrepresentation, or non-compliance with the terms of the
14 policy that were explicitly stated at the time the prior
15 authorization was requested and approved.

16 (f) Each insurer shall provide a peer-to-peer review of a
17 claim when requested by a health care provider if the claim is
18 denied within twenty-four hours of filing. Each insurer shall
19 allow the provision of basic patient information by a health
20 care provider's support staff prior to a peer-to-peer review.



1 (g) If, after a peer-to-peer review of the denial has been
2 requested and completed, a policyholder or health care provider
3 objects to the denial of a prior authorization by an insurer and
4 desires an administrative hearing, the policyholder or health
5 care provider shall file with the commissioner, within sixty
6 days after the date of the denial of the claim, the following:

- 7 (1) A copy of the denial;
8 (2) A copy of the peer-to-peer review;
9 (3) A written request for review; and
10 (4) A written statement setting forth specific reasons for
11 the objections.

12 (h) The commissioner shall:

- 13 (1) Conduct a hearing in conformity with chapter 91 to
14 review the denial of prior authorization;
15 (2) Have all the powers to conduct a hearing as set forth
16 in section 92-16; and
17 (3) Affirm the denial or reject the denial and order the
18 provision of benefits as the facts may warrant, after
19 granting an opportunity for hearing to the insurer and
20 claimant.



1 (i) The commissioner may assess the cost of the hearing
2 upon either or both of the parties.

3 (j) Within thirty days of the conclusion of any hearing,
4 the commissioner shall enter an order, which shall be binding on
5 the insurer and any other person authorized or licensed by the
6 commissioner on the date specified, unless sooner withdrawn by
7 the commissioner or a stay of the order has been ordered by a
8 court of competent jurisdiction.

9 (k) The commissioner shall adopt rules pursuant to chapter
10 91 for purposes of administrating, executing, and enforcing this
11 section.

12 (l) Nothing in this section shall be construed to mandate
13 the coverage of a service that is not medically necessary.

14 (m) This section shall not apply to an employee pension or
15 welfare benefit plan that is covered by the Employee Retirement
16 Income Security Act of 1974, as amended.

17 (n) For the purposes of this section, "prior
18 authorization" means the process by which an insurer determines
19 if a request for treatment plan, prescription drug, or durable
20 medical equipment is covered by the insurer prior to the
21 provision of the treatment plan, prescription drug, or durable



1 medical equipment to the policyholder or any dependent of the
2 policyholder that is covered by the policy."

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

6 "§432:1- Prior authorization; procedures; alignment
7 with medicare guidelines. (a) Each individual or group
8 hospital or medical service plan contract issued or renewed in
9 the State after December 31, 2025, shall establish policies,
10 procedures, and criteria for approving or denying requests for
11 prior authorization that are equivalent to the guidelines for
12 prior authorization used by medicare plans.

13 (b) The policies, procedures, and criteria shall include
14 but not be limited to:

15 (1) Time frames for decision making for initial requests
16 and appeals, which shall be as follows:

17 (A) For urgent requests: Within twenty-four hours of
18 receipt of the request; and

19 (B) For non-urgent requests: Within three calendar
20 days of receipt of the request;



1 provided that if a mutual benefit society fails to
2 respond to a request for prior authorization within
3 the required time frame, the request shall be
4 automatically deemed approved;

5 (2) Approval criteria, which shall be based on nationally
6 recognized evidence-based guidelines and medicare's
7 standards of medical necessity; provided that plan
8 contracts that provide medicare advantage (medicare
9 part C) coverage shall not limit or require prior
10 authorization for tests that are allowed under
11 medicare guidelines;

12 (3) Required documentation, which shall be no more than
13 the level of documentation required by medicare; and

14 (4) Duration, which shall be for ninety days or the entire
15 course of treatment, whichever is longer.

16 (c) Each mutual benefit society shall prominently publish
17 the criteria for prior authorization and the process for
18 requesting prior authorization on the mutual benefit society's
19 website.

20 (d) Each mutual benefit society shall provide written
21 notice to its subscribers and members at least _____ weeks prior

1 to any changes of any criteria for prior authorization
2 established pursuant to subsection (b).

3 (e) No mutual benefit society shall retroactively deny
4 payment for any service, medication, or procedure that received
5 prior authorization except in cases of fraud, intentional
6 misrepresentation, or non-compliance with the terms of the plan
7 contract that were explicitly stated at the time the prior
8 authorization was requested and approved.

9 (f) Each mutual benefit society shall provide a peer-to-
10 peer review of a claim when requested by a health care provider
11 if the claim is denied within twenty-four hours of filing. Each
12 mutual benefit society shall allow the provision of basic
13 patient information by a health care provider's support staff
14 prior to a peer-to-peer review.

15 (g) If, after a peer-to-peer review of the denial has been
16 requested and completed, a subscriber or member or health care
17 provider objects to the denial of a prior authorization by a
18 mutual benefit society and desires an administrative hearing,
19 the subscriber or member or health care provider shall file with
20 the commissioner, within sixty days after the date of the denial
21 of the claim, the following:



- 1 (1) A copy of the denial;
- 2 (2) A copy of the peer-to-peer review;
- 3 (3) A written request for review; and
- 4 (4) A written statement setting forth specific reasons for
5 the objections.

6 (h) The commissioner shall:

- 7 (1) Conduct a hearing in conformity with chapter 91 to
8 review the denial of prior authorization;
- 9 (2) Have all the powers to conduct a hearing as set forth
10 in section 92-16; and
- 11 (3) Affirm the denial or reject the denial and order the
12 provision of benefits as the facts may warrant, after
13 granting an opportunity for hearing to the mutual
14 benefit society and claimant.

15 (i) The commissioner may assess the cost of the hearing
16 upon either or both of the parties.

17 (j) Within thirty days of the conclusion of any hearing,
18 the commissioner shall enter an order, which shall be binding on
19 the mutual benefit society and any other person authorized or
20 licensed by the commissioner on the date specified, unless



1 sooner withdrawn by the commissioner or a stay of the order has
2 been ordered by a court of competent jurisdiction.

3 (k) The commissioner shall adopt rules pursuant to chapter
4 91 for purposes of administrating, executing, and enforcing this
5 section.

6 (l) Nothing in this section shall be construed to mandate
7 the coverage of a service that is not medically necessary.

8 (m) This section shall not apply to an employee pension or
9 welfare benefit plan that is covered by the Employee Retirement
10 Income Security Act of 1974, as amended.

11 (n) For the purposes of this section, "prior
12 authorization" means the process by which a mutual benefit
13 society determines if a request for treatment plan, prescription
14 drug, or durable medical equipment is covered by the mutual
15 benefit society prior to the provision of the treatment plan,
16 prescription drug, or durable medical equipment to the
17 subscriber or member or any dependent of the subscriber or
18 member that is covered by the plan contract."

19 SECTION 4. Chapter 432D, Hawaii Revised Statutes, is
20 amended by adding a new section to be appropriately designated
21 and to read as follows:



1 "§432D- Prior authorization; procedures; alignment with
2 medicare guidelines. (a) Each health maintenance organization
3 policy, contract, plan, or agreement issued or renewed in the
4 State after December 31, 2025, shall establish policies,
5 procedures, and criteria for approving or denying requests for
6 prior authorization that are equivalent to the guidelines for
7 prior authorization used by medicare plans.

8 (b) The policies, procedures, and criteria shall include
9 but not be limited to:

10 (1) Time frames for decision making for initial requests
11 and appeals, which shall be as follows:

12 (A) For urgent requests: Within twenty-four hours of
13 receipt of the request; and

14 (B) For non-urgent requests: Within three calendar
15 days of receipt of the request;

16 provided that if a health maintenance organization
17 fails to respond to a request for prior authorization
18 within the required time frame, the request shall be
19 automatically deemed approved;

20 (2) Approval criteria, which shall be based on nationally
21 recognized evidence-based guidelines and medicare's



1 standards of medical necessity; provided that
2 policies, contracts, plans, or agreements that provide
3 medicare advantage (medicare part C) coverage shall
4 not limit or require prior authorization for tests
5 that are allowed under medicare guidelines;

6 (3) Required documentation, which shall be no more than
7 the level of documentation required by medicare; and

8 (4) Duration, which shall be for ninety days or the entire
9 course of treatment, whichever is longer.

10 (c) Each health maintenance organization shall prominently
11 publish the criteria for prior authorization and the process for
12 requesting prior authorization on the health maintenance
13 organization's website.

14 (d) Each health maintenance organization shall provide
15 written notice to its enrollees and subscribers at
16 least weeks prior to any changes of any criteria for prior
17 authorization established pursuant to subsection (b).

18 (e) No health maintenance organization shall retroactively
19 deny payment for any service, medication, or procedure that
20 received prior authorization except in cases of fraud,
21 intentional misrepresentation, or non-compliance with the terms



1 of the policy, contract, plan, or agreement that were explicitly
2 stated at the time the prior authorization was requested and
3 approved.

4 (f) Each health maintenance organization shall provide a
5 peer-to-peer review of a claim when requested by a health care
6 provider if the claim is denied within twenty-four hours of
7 filing. Each health maintenance organization shall allow the
8 provision of basic patient information by a health care
9 provider's support staff prior to a peer-to-peer review.

10 (g) If, after a peer-to-peer review of the denial has been
11 requested and completed, an enrollee or a subscriber or a health
12 care provider objects to the denial of a prior authorization by
13 a health maintenance organization and desires an administrative
14 hearing, the enrollee or subscriber or health care provider
15 shall file with the commissioner, within sixty days after the
16 date of the denial of the claim, the following:

- 17 (1) A copy of the denial;
18 (2) A copy of the peer-to-peer review;
19 (3) A written request for review; and
20 (4) A written statement setting forth specific reasons for
21 the objections.



1 (h) The commissioner shall:

2 (1) Conduct a hearing in conformity with chapter 91 to
3 review the denial of prior authorization;

4 (2) Have all the powers to conduct a hearing as set forth
5 in section 92-16; and

6 (3) Affirm the denial or reject the denial and order the
7 provision of benefits as the facts may warrant, after
8 granting an opportunity for hearing to the health
9 maintenance organization and claimant.

10 (i) The commissioner may assess the cost of the hearing
11 upon either or both of the parties.

12 (j) Within thirty days of the conclusion of any hearing,
13 the commissioner shall enter an order, which shall be binding on
14 the health maintenance organization and any other person
15 authorized or licensed by the commissioner on the date
16 specified, unless sooner withdrawn by the commissioner or a stay
17 of the order has been ordered by a court of competent
18 jurisdiction.

19 (k) The commissioner shall adopt rules pursuant to chapter
20 91 for purposes of administering, executing, and enforcing this
21 section.



1 (l) Nothing in this section shall be construed to mandate
2 the coverage of a service that is not medically necessary.

3 (m) This section shall not apply to an employee pension or
4 welfare benefit plan that is covered by the Employee Retirement
5 Income Security Act of 1974, as amended.

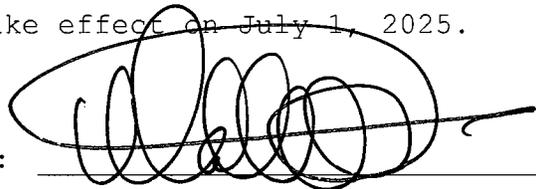
6 (n) For the purposes of this section, "prior
7 authorization" means the process by which a health maintenance
8 organization determines if a request for treatment plan,
9 prescription drug, or durable medical equipment is covered by
10 the health maintenance organization prior to the provision of
11 the treatment plan, prescription drug, or durable medical
12 equipment to the enrollee or subscriber or any dependent of the
13 enrollee or subscriber that is covered by the policy, contract,
14 plan, or agreement."

15 SECTION 5. New statutory material is underscored.

16 SECTION 6. This Act shall take effect on July 1, 2025.

17

INTRODUCED BY:



JAN 21 2025



H.B. NO. 857

Report Title:

Health Insurance; Prior Authorization; Health Insurers; Mutual Benefit Societies; Health Maintenance Organizations; Medicare

Description:

Requires all accident and health or sickness insurers, mutual benefit societies, and health maintenance organizations operating in the State to adopt policies, procedures, and criteria for approving or denying requests for prior authorization that are the equivalent to the guidelines for prior authorization established by Medicare.

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

