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

H.B. NO. 857

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

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

SECTION 1. The purpose of this Act is to require 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.

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- Prior authorization; procedures; alignment with medicare guidelines.** (a) Each individual or group policy of accident and health or sickness insurance issued or renewed in the State after December 31, 2025, shall establish policies, procedures, and criteria for approving or denying requests for prior authorization that are equivalent to the guidelines for prior authorization used by medicare plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) A copy of the denial;

(2) A copy of the peer-to-peer review;

(3) A written request for review; and

(4) A written statement setting forth specific reasons for the objections.

(h) The commissioner shall:

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

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

(3) Affirm the denial or reject the denial and order the provision of benefits as the facts may warrant, after granting an opportunity for hearing to the insurer and claimant.

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

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

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

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

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

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

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

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- Prior authorization; procedures; alignment with medicare guidelines.** (a) Each individual or group hospital or medical service plan contract issued or renewed in the State after December 31, 2025, shall establish policies, procedures, and criteria for approving or denying requests for prior authorization that are equivalent to the guidelines for prior authorization used by medicare plans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) A copy of the denial;

(2) A copy of the peer-to-peer review;

(3) A written request for review; and

(4) A written statement setting forth specific reasons for the objections.

(h) The commissioner shall:

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

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

(3) Affirm the denial or reject the denial and order the provision of benefits as the facts may warrant, after granting an opportunity for hearing to the mutual benefit society and claimant.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) A copy of the denial;

(2) A copy of the peer-to-peer review;

(3) A written request for review; and

(4) A written statement setting forth specific reasons for the objections.

(h) The commissioner shall:

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

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

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

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

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

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

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

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

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

SECTION 5. New statutory material is underscored.

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

INTRODUCED BY: _____

JAN 2 1 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.