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

H.B. NO. 954

A BILL FOR AN ACT

RELATING TO PRIOR AUTHORIZATION.

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

SECTION 1. The legislature finds that prior authorization is a process where a health care provider must get approval from a health insurance plan before providing certain medical services or prescriptions to a patient, ensuring that the treatment is deemed medically necessary and covered by the patient's health insurance plan. Prior authorization helps avoid unsafe or unnecessary treatments, lowers risk of harmful drug interactions, cuts out-of-pocket costs for patients, and confines health insurers' expenses to health care treatments deemed medically necessary. However, prior authorization in the State has become increasingly complex and opaque, causing delays in patient care, increasing administrative burdens, and eroding public trust in the health care system, as the process places cost saving ahead of optimal patient care.

The legislature further finds that lawmakers at the state and federal levels have similarly recognized the need for prior authorization reform. In 2023, nine states and Washington, D.C.

enacted measures to reform the prior authorization process in their jurisdictions. Further, in 2024, more than ninety bills have been introduced in legislatures across thirty states. New Jersey, Tennessee, and Washington D.C. have recently enacted comprehensive prior authorization reform laws, which will generally increase transparency and improve administrative efficiency around the prior authorization process and align clinical criteria used in making prior authorization determinations to nationally recognized standards.

The legislature believes that patient-physician relationship is paramount and should not be subject to third-party intrusion. Furthermore, prior authorization shall not ge permitted to hinder patient care or intrude on the practice of medicine. Therefore, prior authorization must be used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians, and other health care providers.

Accordingly, the purpose of this Act is to establish a comprehensive regulatory framework for the prior authorization process in the State.

SECTION 2. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"CHAPTER

ENSURING TRANSPARENCY IN PRIOR AUTHORIZATION ACT

§ -1 **Short title.** This chapter shall be known and may be cited as the Ensuring Transparency in Prior Authorization Act.

§ -2 **Definitions.** As used in this chapter:

"Adverse determination" means a decision by a utilization review entity to deny, reduce, or terminate a benefit coverage because the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are experimental or investigational. "Adverse determination" does not include a decision to deny, reduce, or terminate health care services that are not covered for reasons other than the health care services' medical necessity or experimental or investigational nature.

"Authorization" means a determination by a utilization review entity that a health care service has been reviewed and, based on the information provided, satisfies the utilization

review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

"Clinical criteria" means the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by the utilization review entity to determine the necessity and appropriateness of a health service.

"Emergency health care services" means health care services that are provided in an emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

(1) Placing the patient's health in serious jeopardy;

(2) Serious impairment to the patient's bodily function; or

(3) Serious dysfunction of any bodily organ or part of the patient.

"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 facility" has the same meaning as described in section 323D-2.

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

"Health care provider" means a health care professional or health care facility.

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

(1) A 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.

"Medically necessary health care services" means health care services that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

(1) In accordance with generally accepted standards of medical practice;

(2) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

"Medications for opioid use disorder" means medications commonly used in combination with counseling and behavioral therapies, including individual therapy, group counseling, family behavior therapy, motivational incentives, and other modalities, to provide a comprehensive approach to the treatment of opioid use disorder. "Medications for opioid use disorder" approved by the United States Food and Drug Administration include methadone; buprenorphine, whether used alone or in

combination with naloxone; and extended-release injectable naltrexone.

"NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs SCRIPT Standard Version 2017071, or the most recent standard adopted by the Department of Health and Human Services. "NCPDP SCRIPT Standard" includes subsequently released versions of the NCPDP SCRIPT Standard.

"Prior authorization" means a written or oral determination rendered by a utilization review entity before an enrollee receives a health care service confirming that the health care service is a covered benefit under the applicable plan and that a requirement of medical necessity or other requirements imposed by the utilization review entity as prerequisites for payment for the services have been satisfied.

"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 review and issues a prior authorization or adverse determination for one or more of the following entities:

(1) An employer with employees in the State who are covered under a health benefit plan or health insurance policy;

(2) An insurer that writes health insurance policies;

(3) A preferred provider organization or health maintenance organization; and

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

§ -3 **Prior authorization requirements and restrictions; disclosure and notice required.** (a) A utilization review

entity shall make any current prior authorization requirements and restrictions readily accessible on its website to enrollees, health care professionals, and the general public, including the written clinical criteria; provided that requirements shall be described in detail but also in easily understandable language.

(b) A utilization review entity that intends to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction shall:

(1) Ensure that the new or amended requirement or restriction is not implemented until the utilization review entity's website has been updated to reflect the new or amended requirement or restriction; and

(2) Provide contracted health care providers of enrollees with written notice of the new or amended requirement or amendment no later than sixty days before the implementation of the requirement or restriction.

(c) Any entity requiring prior authorization of any health care service shall make statistics on prior authorization approvals and denials available to the public on their website in a readily accessible format; provided that the statistics shall include categories for:

(1) Physician specialty;

(2) Medication or diagnostic test or procedure;

(3) Indication offered;

(4) Reason for prior authorization denial;

(5) If a prior authorization was appealed;

(6) If a prior authorization was approved or denied on appeal; and

(7) The time between the submission and subsequent response for a prior authorization request.

§ -4 Prior authorization review; adverse determination personnel; qualifications; criteria. (a) A utilization review entity shall ensure that all adverse determinations are made by a physician who:

(1) Possesses a current and valid non-restricted license issued pursuant to chapter 453;

(2) Is of the same specialty as a physician who typically manages the medical condition or disease or provides the health care service subject to the review;

(3) Have experience treating patients with the medical condition or disease for which the health care service is being requested;

Provided that the physician shall make the adverse determination under the clinical direction of one of the utilization review entity's medical directors who is responsible for the provision of health care services provided to enrollees of the State; provided further that the medical director shall be a physician licensed in the State.

§ -5 **Adverse determination; notice and discussion required.** Any utilization review entity questioning the medical necessity of a health care service shall notify the enrollee's physician that medical necessity is being questioned. Before issuing an adverse determination, the enrollee's physician shall have the opportunity to discuss the medical necessity of the health care service on the telephone with the physician who will be responsible for determining authorization of the health care service under review.

§ -6 **Appeal review personnel; qualifications; criteria.** (a) A utilization review entity shall ensure that all appeals are reviewed by a physician who:

(1) Possesses a current and valid non-restricted license issued pursuant to chapter 453;

(2) Is, and has been, in active practice for at least five consecutive years in the same or similar specialty as a physician who typically manages the medical condition or disease;

(3) Is knowledgeable of, and has experience providing, the health care services under appeal;

(4) Is not employed by a utilization review entity or be under contract with the utilization review entity other than to participate in one or more of the utilization review entity's health care provider networks or to perform reviews of appeals, and otherwise does not have any financial interest in the outcome of the appeal; and

(5) Was not directly involved in making the adverse determination.

(b) The physician reviewing the appeal shall consider all know clinical aspects of the health care service under review, including but not limited to a review of all pertinent medical records provided to the utilization review entity by the enrollee's health care provider, any relevant records provided to the utilization review entity by a health care facility, and

any medical literature provided to the utilization review entity by the health care provider.

§ -7 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 provider;

(2) Request the health care provider for all additional information needed to render a decision; or

(3) Notify the health care provider 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 provider submits the additional information requested pursuant to paragraph (2).

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

(d) For the purposes of this subsection, "information needed to make a decision" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

§ -8 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 the health care provider for all additional information needed to render a decision; or

(3) Notify the health care provider 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 provider submits the additional information requested pursuant to paragraph (2).

(b) Any health care provider who fails to submit the information requested pursuant to subsection (a)(2) within twelve hours shall submit a new prior authorization request.

§ -9 Prior authorization for pre-hospital transportation and emergency health care services; prohibited. (a) No utilization review entity shall require prior authorization for pre-hospital transportation or the provision of emergency health care services.

(b) Following an emergency admission of an enrollee into a health care facility or provision of an emergency health care service to an enrollee, the enrollee or health care provider shall be given at least twenty-four hours, excluding holidays and weekends, to notify the utilization review entity of the admission or provision of the health care service.

(c) A utilization review entity shall cover emergency health care services necessary to screen and stabilize an enrollee; provided that if a health care provider certifies in writing to a utilization review entity within seventy-two hours of an enrollee's admission that the enrollee's condition required emergency health care services, the emergency health care services administered by the health care provider to the enrollee shall be presumed to have been medically necessary and may be rebutted only if the utilization review entity establishes by clear and convincing evidence that the emergency health care service was not medically necessary.

(d) No utilization review entity, when determining the medical necessity or appropriateness of an emergency health care service, shall:

(1) Consider whether the emergency health care service was provided by a participating or nonparticipating provider; or

(2) Impose greater restrictions on the coverage of emergency health care services provided by a nonparticipating provider than those that apply to the same services provided by a participating provider.

(e) If an enrollee receives an emergency health care service that requires immediate post-evaluation or post-stabilization services, a utilization review entity shall make an authorization determination within sixty minutes of receiving a request; provided that if the authorization determination is not made within sixty minutes, the stabilization services shall be deemed approved.

§ -10 **Prior authorization for medications for opioid use disorder; prohibited.** No utilization review entity shall require prior authorization for the provision of medications for opioid use disorder.

§ -11 **Retrospective denial; health care provider payment; exceptions.** (a) A utilization review entity shall not revoke, limit, condition, or restrict a prior authorization if care is provided within forty-five business days from the date the health care provider received the prior authorization.

(b) A utilization review entity shall pay a health care provider at the contracted payment rate for a health care service provided by the health care provider per a prior authorization unless:

(1) The health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from a utilization review entity;

(2) The health care service was no longer a covered benefit on the day it was provided;

(3) The health care provider was no longer contracted with the patients' health insurance plan on the date the care was provided;

(4) The health care provider failed to meet the utilization review entity's timely filing requirements;

(5) The utilization review entity is not liable for the claim; or

(6) The patient was no longer eligible for health care coverage on the day the health care was provided.

§ -12 **Length of prior authorization.** A prior authorization shall be valid for a minimum of one year from the date the enrollee or the enrollee's health care provider receives the prior authorization and shall be effective

regardless of any changes in dosage for a prescription drug prescribed by the health care provider.

§ -13 **Duration of prior authorization for treatment for chronic or long-term care conditions.** If a utilization review entity requires a prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization shall remain valid for the duration of the treatment and the utilization review entity shall not require the enrollee to obtain a new prior authorization again for the health care service.

§ -14 **Continuity of care for enrollees; prior authorization transfers.** (a) Upon receipt of information documenting a prior authorization from the enrollee or from the enrollee's health care provider, a utilization review entity shall honor a prior authorization granted to an enrollee from a previous utilization review entity for at least the initial ninety days of an enrollee's coverage under a new health plan.

(b) During the time period described in subsection (a), a utilization review entity may perform its own review to grant a prior authorization.

(c) If there is a change in coverage of, or approval criteria for, a previously authorized health care service, the change in coverage or approval criteria shall not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's plan year.

(d) A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same health insurance company.

§ -15 Prior authorization exemptions for health care providers. (a) A utilization review entity shall not require a health care provider to complete a prior authorization request for a health care service for an enrollee to receive coverage; provided that in the most recent twelve-month period, the utilization review entity has approved or would have approved not less than eighty per cent of the prior authorization requests submitted by the health care provider for that health care service, including any approval granted after an appeal.

(b) A utilization review entity may evaluate whether a health care provider continues to qualify for exemptions as

described in subsection (a) not more than once every twelve months. Nothing in this subsection shall be construed to require a utilization review entity to evaluate an existing exemption or prevent a utilization review entity from establishing a longer exemption period.

(c) A health care provider shall not be required to request for an exemption to qualify for an exemption pursuant to this section.

(d) A health care provider who is denied an exemption pursuant to this section may request evidence from the utilization review entity to support the utilization review entity's decision at any time, but not more than once per year per service. A health care provider may appeal a utilization review entity's decision to deny an exemption.

(e) A utilization review entity may revoke an exemption only at the end of the twelve-month period described in subsection (b) if the utilization review entity:

(1) Determines that the health care provider would not have met the eighty per cent approval criteria based on a retrospective review of the claims for the particular service for which the exemption applies for

the previous three months, or for a longer period if needed to reach a minimum of ten claims for review;

(2) Provides the health care provider with the information the utilization review entity relied upon in making its determination to revoke the exemption; and

(3) Provides the health care provider a plain language explanation of how to appeal the decision.

(f) An exemption shall remain in effect until the thirtieth day after the date the utilization review entity notifies the health care provider of its determination to revoke the exemption or, if the health care provider appeals the determination, the fifth day after the revocation is upheld on appeal.

(g) A determination to revoke or deny an exemption shall be made by a health care provider licensed in the State of the same or similar specialty as the health care provider being considered for an exemption and have experience in providing the service for which the potential exemption applies.

(h) A utilization review entity shall provide a health care provider that receives an exemption a notice that includes:

(1) A statement that the health care provider qualifies for an exemption from preauthorization requirements;

(2) A list of services to which the exemptions apply; and

(3) A statement of the duration of the exemption.

(i) A utilization review entity shall not deny or reduce payment for a health care service exempted from a prior authorization requirement under this section, including a health care service performed or supervised by another health care provider when the health care provider who ordered the health care service received a prior authorization exemption, unless the rendering health care provider:

(1) Knowingly and materially misrepresented the health care service in request for payment submitted to the utilization review entity with the specific intent to deceive and obtain an unlawful payment from the utilization review entity; or

(2) Failed to substantially perform the health care service.

§ -16 Electronic standards for prior authorization. (a) No later than January 1, 2026, an insurer shall accept and respond to prior authorization requests under the pharmacy

benefit plan through a secure electronic transmission using the NCPDP SCRIPT Standard electronic prior authorization transactions; provided that facsimile, propriety payer portals, electronic forms, or any other technology not directly integrated with a physician's electronic health record or electronic prescribing system shall not be considered a secure electronic transmission.

(b) For the purposes of this section, "insurer" has the same meaning as defined in section 431:10A-402.

§ -17 Utilization review entities; annual report to insurance commissioner. (a) No later than March 1 of each year, each utilization review entity shall submit a report to the insurance commissioner on prior authorization requests for the previous calendar year using forms and in a manner prescribed by the insurance commissioner, which shall include:

(1) A list of all health care services that require prior authorization;

(2) The number and percentage of prior authorization requests that were approved;

(3) The number and percentage of prior authorization requests that were denied;

(4) The number and percentage of prior authorization requests that were initially denied and approved after appeal;

(5) The number and percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved;

(6) The average and median time that elapsed between the submission of a non-urgent prior authorization request and a determination by a utilization review entity;

(7) The average and median time that elapsed between the submission of an urgent prior authorization request and a determination by the utilization review entity;

(8) The average and median time that elapsed to process an appeal submitted by a health care professional initially denied by the utilization review entity for non-urgent prior authorizations; and

(9) The average and median time that elapsed to process an appeal submitted by a health care professional initially denied by the utilization review entity for urgent prior authorizations;

provided that the information required by paragraphs (2) through (9) shall be individualized for each listed health care service for each health care service listed in paragraph (1).

(b) Each utilization review entity shall make the report required pursuant to subsection (a) available to the public through the utilization review entity's website in the format prescribed by the insurance commissioner.

§ -18 **Insurance commissioner; annual report.** No later than May 1 of each year, the insurance commissioner shall submit a report to the legislature that includes a summary of the reports received pursuant to section -18 that year, including all data received from each utilization review entity, and recommendations for the removal of prior authorization requirements imposed by utilization review entities on health care services that are regularly approved for prior authorization. For the purposes of this section, a health care service with a prior authorization approval rate of eighty per cent or higher shall be considered regularly approved.

§ -19 **Rules.** No later than January 1, 2026, the insurance commissioner shall adopt rules in accordance with chapter 91 necessary to carry out the purposes of this chapter.

§ -20 **Non-compliance; automatic approval.** Any failure of an utilization review entity to comply with the provisions of this chapter or any rule adopted thereunder shall result in the health care services subject to the utilization review entity's review being deemed automatically approved.

§ -21 **Severability.** If any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the invalidity does not affect other provisions or applications of the chapter that can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable."

SECTION 3. This Act shall take effect upon its approval.

INTRODUCED BY: _____

JAN 21 2025

H.B. NO. 954

Report Title:
Insurance Commissioner; Ensuring Transparency in Prior Authorization Act; Prior Authorization; Utilization Review Entity; Adverse Determination; Health Care Services; Reports

Description:
Establishes a comprehensive regulatory framework for prior authorization process in the State, including disclosure and notice requirements for utilization review entities regarding their prior authorization requirements and restrictions; qualifications and criteria for prior authorization review and appeals personnel; prior authorization process for non-urgent and urgent health care services, including the time frame by which utilization review entities must render a decision; adverse determination and appeal processes; prohibition of prior authorization for emergency health care services and medication for opioid use disorder; payments to health care providers; length and duration of prior authorizations; and exemptions for certain health care providers. Requires health insurers to utilize NCPDP SCRIPT Standard electronic prior authorization transactions by 1/1/2026. Requires utilization review entities to submit annual reports to the Insurance Commissioner each year. Requires the Insurance Commissioner to submit annual reports to the Legislature. Requires the Insurance Commissioner to adopt rules by 1/1/2026.

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