THE SENATE
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

S.B. NO. 1449 S.D. 1 H.D. 1

A BILL FOR AN ACT

RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES.

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 and other health care professionals to obtain advance approval from a health plan before a specific service is delivered to a patient to qualify for payment coverage. Each health plan has its own policies and procedures that health care providers are forced to navigate.

The legislature further finds that there is emerging consensus among health care providers that prior authorization increases administrative burdens. In the 2023 physician workforce report published by the university of Hawaii John A. Burns school of medicine, physicians voted prior authorization their top concern regarding administrative burden. Furthermore, a 2023 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

physicians have staff who work exclusively on prior authorization.

Other findings from the American Medical Association prior authorization physician survey questioning the value and impact to patient care are that:

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

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

(3) 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

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

Yet despite the time and resources dedicated to the prior authorization process, and the risk to patient safety, an analysis by the Kaiser Family Foundation, "Use of Prior Authorization in Medicare Advantage Exceeded 46 Million Requests in 2022," published in August 2024, reveals that the vast majority of appeals, or eighty-three per cent, resulted in overturning the initial prior authorization denial.

Accordingly, the purpose of this Act is to examine prior authorization practices in the State by:

(1) Requiring utilization review entities to report data relating to prior authorization of health care services to the state health planning and development agency; and

(2) 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 two new sections to part II to be appropriately designated and to read as follows:

"**§323D- Prior authorization; reporting.** (a) Any utilization review entity doing business in the State shall

submit data to the state agency relating to prior authorization of health care services, in a format specified by the state agency. Reporting shall be annual for the preceding calendar year and shall be submitted no later than January 31 of the subsequent calendar year. The state agency shall post the reporting format on its website no later than three months before the start of the reporting period.

(b) Protected health information as defined in title 45 Code of Federal Regulations section 160.103 shall not be submitted to the state agency unless:

(1) The individual to whom the information relates authorizes the disclosure; or

(2) Authorization is not required pursuant to title 45 Code of Federal Regulations section 164.512.

(c) The state agency shall compile the data 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 year after the reporting period. If the state agency is unable to post the report of findings by March 1, the state agency shall notify the legislature in writing within ten days and include an estimated

date of posting, reasons for the delay, and if applicable, a corrective action plan.

§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 the patient's health care provider;

(4) Recommend appropriate time frames within which urgent and standard requests shall be decided; and

(5) Make recommendations on treatments for common chronic or long-term conditions for which prior authorization may remain valid for the duration of the treatment in the appropriate clinical setting.

(b) The administrator shall invite the following individuals to be members of the working group:

(1) Five members representing the insurance industry, to be selected by the Hawaii Association of Health Plans;

(2) Five members representing licensed health care professionals, two of whom shall be selected by the

Hawaii Medical Association, two of whom shall be selected by the Healthcare Association of Hawaii, and one of whom shall be selected by the Hawaii state center for nursing; and

(3) Five members representing consumers of health care or employers, two of whom shall be selected by the board of trustees of the employer-union health benefits trust fund, one of whom shall be a consumer selected by the statewide health coordinating council, one of whom shall be selected by the Hawaii Primary Care Association, and one of whom shall be selected by Papa Ola Lokahi.

The members of the working group shall elect a chairperson and vice chairperson from amongst themselves. The director of health, insurance commissioner, and administrator of the med-QUEST division of the department of human services shall each appoint an ex-officio advisor for the working group.

(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 the use of its recommendations 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 for 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 that decrease delays and disruptions of medically necessary patient care."

SECTION 3. Section 323D-2, Hawaii Revised Statutes, is amended by adding three 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 prior to the rendering of the health care services. "Prior authorization" includes any health insurer's or utilization review entity's requirement that an enrollee or health care provider notify the health insurer or utilization review entity prior to providing health care services.

"Prior authorization data" means data requested by the state agency that relates to the prior authorization of health care services. "Prior authorization data" includes but is not limited to:

(1) Patient demographics such as sex, age, residential ZIP code, and primary insurance plan;

(2) Procedure codes, revenue codes, diagnosis-related group codes, brand name drugs, generic drug names, or durable medical equipment type;

(3) Diagnosis codes;

(4) Specialty of the health care provider requesting prior authorization for a health care service;

(5) Health care setting, such as inpatient, outpatient, observation, or other;

(6) Date of initial provider request for prior authorization, date of health plan response, and the status of the prior authorization request by date, such as pending, approved, denied, appealed, or overturned; and

(7) Any other data identified by the state agency.

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

(1) An insurer that writes health insurance policies;

(2) 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

(3) 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 provider the State under a policy, plan, or contract."

SECTION 4. New statutory material is underscored.

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

S.B. NO. 1449 S.D. 1 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 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.