
A BILL FOR AN ACT

RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES.

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

1 SECTION 1. The legislature finds that prior authorization
2 is a health plan cost-control process that requires physicians
3 and other health care professionals to obtain advance approval
4 from a health plan before a specific service is delivered to a
5 patient to qualify for payment coverage. Each health plan has
6 its own policies and procedures that health care providers are
7 forced to navigate.

8 The legislature further finds that there is emerging
9 consensus among health care providers that prior authorization
10 increases administrative burdens. In the 2023 physician
11 workforce report published by the university of Hawaii John A.
12 Burns school of medicine, physicians voted prior authorization
13 their top concern regarding administrative burden. Furthermore,
14 a 2023 physician survey conducted by the American Medical
15 Association reported that ninety-five per cent of physicians
16 attribute prior authorization to somewhat or significantly
17 increased physician burnout, and that more than one-in-three



1 physicians have staff who work exclusively on prior
2 authorization.

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

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

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

12 (3) Thirteen per cent of respondents said prior
13 authorization resulted in a serious adverse event
14 leading to a life-threatening event or requiring
15 intervention to prevent permanent impairment or
16 damage; and

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



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

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

- 10 (1) Requiring utilization review entities to report data
- 11 relating to prior authorization of health care
- 12 services to the state health planning and development
- 13 agency; and
- 14 (2) Establish the health care appropriateness and
- 15 necessity working group to make recommendations to
- 16 improve and expedite the prior authorization process.

17 SECTION 2. Chapter 323D, Hawaii Revised Statutes, is
 18 amended by adding two new sections to part II to be
 19 appropriately designated and to read as follows:

20 "§323D- Prior authorization; reporting. (a) Any
 21 utilization review entity doing business in the State shall



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

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

- 11 (1) The individual to whom the information relates
12 authorizes the disclosure; or
- 13 (2) Authorization is not required pursuant to title 45
14 Code of Federal Regulations section 164.512.

15 (c) The state agency shall compile the data by provider of
16 health insurance, health care setting, and line of business, and
17 shall post a report of findings, including recommendations, on
18 its website no later than March 1 of the year after the
19 reporting period. If the state agency is unable to post the
20 report of findings by March 1, the state agency shall notify the
21 legislature in writing within ten days and include an estimated



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

3 §323D- Health care appropriateness and necessity

4 working group; established. (a) There is established the

5 health care appropriateness and necessity working group within

6 the state agency. The working group shall:

7 (1) Determine by research and consensus:

8 (A) The most respected peer-reviewed national
9 scientific standards;

10 (B) Clinical guidelines; and

11 (C) Appropriate use criteria published by federal
12 agencies, academic institutions, and professional
13 societies,

14 that correspond to each of the most frequent clinical

15 treatments, procedures, medications, diagnostic

16 images, laboratory and diagnostic tests, or types of

17 medical equipment prescribed by licensed physicians

18 and other health care providers in the State that

19 trigger prior authorization determinations by the

20 utilization review entities;



- 1 (2) Assess whether it is appropriate to require prior
2 authorization for each considered clinical treatment,
3 procedure, medication, diagnostic image, laboratory
4 and diagnostic test, or type of medical equipment
5 prescribed by licensed physicians and other health
6 care providers;

- 7 (3) Make recommendations on standards for third party
8 reviewers related to the specialty expertise of those
9 reviewing and for those discussing a patient's denial
10 with the patient's health care provider;

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

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

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

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



1 (2) Five members representing licensed health care
2 professionals, two of whom shall be selected by the
3 Hawaii Medical Association, two of whom shall be
4 selected by the Healthcare Association of Hawaii, and
5 one of whom shall be selected by the Hawaii state
6 center for nursing; and

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

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

20 (c) The working group shall submit a report of its
21 findings and recommendations regarding information under



1 subsection (a), including any proposed legislation, to the
2 legislature no later than twenty days prior to the convening of
3 the regular session of 2026 and each regular session thereafter.

4 (d) The recommendations of the working group shall be
5 advisory only and not mandatory for health care facilities,
6 health care professionals, insurers, and utilization review
7 entities. The state agency shall promote the recommendations
8 among health care facilities, health care professionals,
9 insurers, and utilization review entities and shall publish
10 annually in its report to the legislature the extent and impacts
11 of the use of its recommendations in the State.

12 (e) The state agency shall seek transparency and agreement
13 among health care facilities, health care professionals,
14 insurers, utilization review entities, and consumers related to
15 the most respected clinical, scientific, and efficacious
16 standards, guidelines, and appropriate use criteria
17 corresponding to medical treatments and services most commonly
18 triggering prior authorization determinations in order to reduce
19 uncertainty around common prior authorization processes, and
20 also foster automation of prior authorization for the benefit of
21 all. The state agency shall explore means of achieving



1 statewide health sector agreement on means of automating prior
2 authorization determinations in the near future that decrease
3 delays and disruptions of medically necessary patient care."

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

7 "Prior authorization" means the process by which a
8 utilization review entity determines the medical necessity or
9 medical appropriateness of otherwise covered health care
10 services before the rendering of the health care services.

11 "Prior authorization" includes any health insurer's or
12 utilization review entity's requirement that an enrollee or
13 health care provider notify the health insurer or utilization
14 review entity before providing health care services.

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

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



- 1 (2) Brand name drugs, diagnosis-related group codes,
2 durable medical equipment type, generic drug names,
3 procedure codes, or revenue codes;
- 4 (3) Diagnosis codes;
- 5 (4) Specialty of the health care provider requesting prior
6 authorization for a health care service;
- 7 (5) Health care setting, such as inpatient, outpatient,
8 observation, or other;
- 9 (6) Date of initial provider request for prior
10 authorization, date of health plan response, and the
11 status of the prior authorization request by date,
12 such as pending, approved, denied, appealed, or
13 overturned; and
- 14 (7) Any other data identified by the state agency.
- 15 "Utilization review entity" means an individual or entity
16 that performs prior authorization for one or more of the
17 following entities:
- 18 (1) An insurer that writes health insurance policies;
- 19 (2) An insurer governed by chapter 431, article 10A; a
20 mutual benefit society governed by chapter 432,
21 article 1; a fraternal benefit society governed by



1 chapter 432, article 2; or a health maintenance
2 organization governed by chapter 432D; or
3 (3) Any other individual or entity that provides, offers
4 to provide, or administers hospital, outpatient,
5 medical, prescription drug, or other health benefits
6 to a person treated by a health care provider the
7 State under a policy, plan, or contract."

8 SECTION 4. New statutory material is underscored.

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



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. (HD2)

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not legislation or evidence of legislative intent.*

