THE SENATE
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

S.B. NO. 832

JAN 17 2025

A BILL FOR AN ACT

RELATING TO INSURER PRIOR AUTHORIZATION.

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

SECTION 1. The legislature finds that prior authorization processes in Hawaii pose significant challenges, which have been reported to delay treatment, negatively impact patient outcomes, and impose considerable administrative burdens on healthcare providers. Physicians and staff spend excessive time navigating these requirements, detracting from direct patient care. The legislature finds that studies and legislative actions have highlighted concerns over the timeliness and efficiency of healthcare delivery under these procedures.

The legislature further finds that streamlining prior authorization requirements to reduce delays and align with national best practices will enhance patient care, reduce administrative burdens, and ensure timely access to medical services, ultimately improving health outcomes and positioning Hawaii as a leader in healthcare reform.

The purpose of this Act is to require insurers operating within the State to minimize unnecessary authorizations and

align their prior authorization procedures with medicare's established guidelines. This Act also aims to reduce administrative burdens, improve healthcare access, and ensure consistency across payers.

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

"**§431:10A- Prior authorization.** (a) Insurers shall align their prior authorization processes with medicare policies for similar services, including requirements that:

(1) Urgent requests be decided within twenty-four hours of receipt; and

(2) Non-urgent requests be decided within three calendar days of receipt.

If an insurer fails to respond to a prior authorization request within the required timeframe, the request shall be deemed approved.

(b) Documentation required by insurers shall be equivalent or less burdensome than documentation required by medicare for comparable services.

(c) Insurers shall base decisions on nationally recognized evidence-based medical guidelines and medicare's standards of medical necessity.

(d) Prior authorizations shall remain valid for the duration of the treatment course or ninety days, whichever is longer.

(e) Insurers shall not retroactively deny payment for any service, medication, or procedure that received prior authorization except in cases of:

(1) Fraud;

(2) Intentional misrepresentation; or

(3) Non-compliance with the terms of the policy explicitly stated at the time of prior authorization.

(f) The commissioner shall:

(1) Conduct annual audits of insurers' prior authorization policies; and

(2) Investigate patient or provider complaints regarding noncompliance with this section.

(g) Insurers shall submit quarterly reports to the commissioner detailing the volume of prior authorization requests, approval and denial rates, and average response times.

The commissioner shall make the reports available to the public on the department's website.

(h) Insurers found in violation of this section shall be subject to:

(1) Suspension or revocation of state licensure for repeated or egregious non-compliance;

(2) Public disclosure of violations and penalties; and

(3) Implementation of corrective action plans to prevent future violations.

(i) Providers and patients may appeal denials directly to the commissioner, who shall issue a binding decision within thirty days of receiving the appeal.

(j) This section shall not apply to:

(1) Health plans regulated by federal law under the Employee Retirement Income Security Act; or

(2) Medicare Advantage plans or other federally administered programs.

(k) For purposes of this section:

"Insurer" means any entity offering health insurance plans subject to regulation under state law including:

(1) Health maintenance organizations;

(2) Preferred provider organizations;

(3) Exclusive provider organizations; and

(4) Indemnity insurers.

"Medicare" means the federal health insurance program under Title XVIII of the Social Security Act.

"Prior authorization" means a process used by insurers to determine coverage of a service, treatment, or medication before the service, treatment, or medication is provided to the patient."

SECTION 3. New statutory material is underscored.

SECTION 4. This Act shall take effect upon its approval.

INTRODUCED BY: (B/R)

S.B. NO. 832

Report Title:
Insurance; Prior Authorization; Medicare

Description:
Requires health plan insurers to align their prior authorization processes with Medicare policies.

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