JOSH GREEN, M.D.
GOVERNOR

SYLVIA LUKE
LIEUTENANT GOVERNOR

STATE OF HAWAIʻI
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
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TESTIMONY BY DEREK MIZUNO
ADMINISTRATOR, HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
DEPARTMENT OF BUDGET AND FINANCE
STATE OF HAWAII
TO THE HOUSE COMMITTEE ON FINANCE
ON HOUSE BILL NO. 250 HD2

February 21, 2025
2:00p.m.
Conference Room 308 & Videoconference

WRITTEN ONLY

RELATING TO HEALTH

Chair Yamashita, Vice Chair Takenouchi, and Members of the Committee:

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) Board of Trustees has not taken a position on this bill. EUTF staff would like to provide comments.

The tight turnaround times and automatic approvals are estimated to add $20-$25 million annually ($10.6-$13.25 million for actives and $9.4-$11.75 million for retirees) in additional claims to the EUTF plans. This could increase the employers' unfunded liability by $428.6-$535.7 million.

Thank you for the opportunity to testify.

JOSH GREEN, M.D.
GOVERNOR OF HAWAI'I
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I

KENNETH S. FINK, M.D., M.G.A., M.P.H.
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KA LUNA HO'OKELE

STATE OF HAWAII
DEPARTMENT OF HEALTH
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Testimony in SUPPORT of HB250 HD1
RELATING TO HEALTH**.**

REP. KYLE T. YAMASHITA, CHAIR
HOUSE COMMITTEE ON FINANCE

Hearing Date: February 21, 2025 Room Number: 308

Department Testimony: The Department of Health (DOH) supports HB250 HD1 but prefers the original draft HB250 as more practical and achievable.

Feedback from the healthcare provider community is very strong and clear that the administrative burden from prior authorization of healthcare services is leading to provider burnout, delays in care, and diminished productivity that impacts direct patient care.

Although prior authorization is a legitimate cost control tool, the fact that 83% of requests are subsequently overturned by the health plan that originally denied the service, according to a national survey administered by the American Medical Association, compels further examination of this practice.

Making prior authorization statistics available will help consumers make more informed choices when choosing their health plan, and can contribute to creating community standards and practices that are more effective, return more value, and that are simpler to administer.

Thank you for the opportunity to testify.

‘Ahahui o nā Kauka

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February 19, 2025

COMMITTEE ON FINANCE
Rep. Kyle T. Yamashita, Chair Rep.
Jenna Takenouchi, Vice Chair

Rep. Tina Nakada Grandinetti Rep. Mike Lee Rep. Daniel Holt Rep. Tyson K. Miyake Rep. Ikaika Hussey Rep. Dee Morikawa Rep. Sue L. Keohokapu-Lee Loy Rep. Shirley Ann Templo Rep. Lisa Kitagawa Rep. David Alcos III Rep. Matthias Kusch Rep. Julie Reyes Oda Rep. Rachele F. Lamosao Rep. Gene Ward

Group Testimony in Support of
HB250HD2 RELATING TO HEALTH (Prior Authorization)

'Ahahui o nā Kauka is an organization of Native Hawaiian physicians dedicated to the health of the people of Hawai'i and Native Hawaiians in particular. Prior Authorization requirements levied by health insurers have become a rampant source of frustration for both physicians and patients by covertly undermining our professional authority, doctor-patient relationships, and trust in the entire health care system. In his 2024 ruling, Judge Robert Kim concluded these types of requirements are “unconscionable” with the case exposing many examples of the cruel effects wrought by these policies. Unfortunately, prior authorizations are so widely utilized by insurers that they have become standard care (or lack thereof) rather than rare aberrations. Furthermore, the variability, lack of transparency, and lack of accountability in navigating appeals to these policy decisions compound the problem.

In rural and disenfranchised communities, including many Native Hawaiians, the damage caused by prior authorization policies are magnified. As these communities attempt to navigate the many barriers to accessing care, these policies all too often result in patients giving up and accepting the negative outcomes of the lack of care. We have pleaded with insurance plans to amend these universally applied policies to allow us to use our professional discernment to provide appropriate and timely care to meet the needs of the individual patient, and we have pleaded with our patients to have faith that the insurers will eventually do the right thing and approve their care. Still, it is no surprise prior authorization policies drive many of our patients to conclude the healthcare system never did and never will care for them.

We strongly support increasing accountability and transparency for health insurers by requiring them to share prior authorization policy data with the State Health Planning and Development Agency.

Hawaii Association of Health Plans

February 21, 2025

To: Chair Yamashita, Vice Chair Takenouchi, and Members of the House Committee on Finance (FIN)
From: Hawaii Association of Health Plans Public Policy Committee
Date/Location: February 21, 2025; 2:00 pm/Conference Room 308 & Videoconference

Re: Testimony with comments on HB 250 HD2 – Relating to Health.

The Hawaii Association of Health Plans (HAHP) appreciates the opportunity to offer comments and to share our concerns regarding HB 250 HD2. HAHP is a statewide partnership that unifies Hawaii's health plans to improve the health of Hawaii's communities together. A majority of Hawaii residents receive their health coverage through a plan associated with one of our organizations.

HAHP appreciates the efforts of lawmakers to improve prior authorization processes and emphasizes that prior authorization remains a critical, evolving mechanism essential for ensuring quality patient care. We recognize the importance of addressing providers' concerns and are committed to collaborating with stakeholders to enhance this process. However, we have specific concerns about the current legislation:

- The new statutory requirements mandated by this bill do not align with current best practices and could unintentionally disrupt a process we are diligently working to improve.
- The creation of state timelines and approval deadlines that conflict with CMS requirements set to take effect on January 1, 2026, are problematic and could clog the system, creating unnecessary delays in care.

Additionally, we are concerned that the proposed changes could have significant financial implications, potentially increasing healthcare costs and resulting in higher premiums for individuals and employer groups.

HAHP acknowledges the complexity of this issue and agrees that it warrants the formation of a working group to develop solutions that benefit all parties involved. Given our extensive experience with this matter, we respectfully request to be included in this working group to ensure that Hawaii's health plans can collaborate with lawmakers and stakeholders to ensure high-quality, affordable healthcare for our state.

Thank you for your consideration and the opportunity to testify on HB 250 HD2.

Sincerely,

HAHP Public Policy Committee
cc: HAHP Board Members

Hawaii Medical Association
1360 South Beretania Street, Suite 200 • Honolulu, Hawaii 96814
Phone: 808.536.7702 • Fax: 808.528.2376 • hawaiimedicalassociation.org

HOUSE COMMITTEE ON FINANCE
Representative Kyle T Yamashita, Chair
Representative Jenna Takenouchi, Vice Chair

Date: February 21, 2025
From: Hawaii Medical Association (HMA)
Jerald Garcia MD - Chair, HMA Public Policy Committee

Re: HB 250 HD2 RELATING TO HEALTH - Prior Authorization; Utilization Review Entities; Reporting; Health Care Appropriateness and Necessity Commission; State Health Planning and Development Agency
Position: Support with amendments

Time-consuming Prior Authorization (PA) processes delay patient care. Healthcare providers struggle to overcome PA barriers that impede the evaluation, diagnosis and treatment of their patients and divert valuable time and resources from direct patient care. This leads to lower rates of patient adherence to treatment, as well as harmful negative clinical outcomes.

This measure would require utilization review entities to submit data relating to the PA of health care services to the State Health Planning and Development Agency and establishes the Health Care Appropriateness and Necessity Commission within the State Health Planning and Development Agency.

The disclosure and reporting of the relevant payor utilization data of PA is imperative for meaningful analyses of challenges, and a body for oversight is necessary to address deficiencies as well as monitor progress. Given the complexities of PA and healthcare delivery, modifications and revisal will require ongoing assessment and review over time. HMA supports the intent of this measure. The work to eliminate PA barriers should also include specific provisions to reduce time delays and volumes of PA, improve transparency and ensure high quality review of care delivery for Hawaii patients, bridging PA policy gaps that may continue to exist otherwise.

HMA appreciates the proposed HLT changes of HB 250 to include the establishment of a Health Care Appropriateness and Necessity Working Group, rather than a commission; and to include laboratory and diagnostic tests to the list of services to be assessed by the Working Group. HMA also appreciates the proposed changes of CPC to extend the deadline, from twenty-four hours to fourteen days, by which a health care facility or health care professional is required to submit requested additional information for prior authorization.
(contd)

HMA also respectfully requests these additions/amendments for consideration:

REDUCTION OF PA DELAY AND UNNECESSARY VOLUME (language is taken from HB 954)

Repeat prior authorization is prohibited for chronic unchanged conditions.

Retroactive or retrospective prior authorization denials are prohibited, 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.

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.

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.

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.

Gold card or exemption program for providers
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.

QUALITY (language is taken from HB 954)

Medically necessary; Clinical criteria – Utilization review entities must use appropriate criteria 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.

Prior authorization review; adverse determination personnel; qualifications; criteria. 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.

TRANSPARENCY (language is taken from HB 954)

Prior Authorization Transparency - 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.

Denials - 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. The utilization review entity should provide justification for denials, relevant plan provision, coverage criteria citation, narrative explanation; also provide covered alternative treatment; and detail appeal options, actions needed to obtain coverage or additional information or selecting an alternative treatment option identified by the plan.

OVERSIGHT (language is taken from HB 954)

Utilization review entities; annual report to insurance commissioner [and oversight Task Force]. (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.

With establishment of a Health Care Appropriateness and Necessity Working Group, HMA recommends the following composition of members:

-Director of Health, or the Director's designee

-The Insurance Commissioner, or the Insurance Commissioner's designee

-Administrator of the Med-QUEST Division of the Department of Human Services, or the Administrator's designee

-Representative from the Professional and Vocational Licensing Division of the Department of Commerce and Consumer Affairs

-Representative from the Hawaii Association of Health Plans

-Healthcare organizations (each with a representative):
Hawaii State Center for Nursing
Hawaii Medical Association (HMA)
Hawaii State Rural Health Association
Healthcare Association of Hawaii

The working group will regularly review PA policies and make recommendations for
Ongoing reduction of volume. This requires coordinated review of PA data, trends, population health characteristics and standards of care as well as utilization use and overuse.
- Identifying drugs and services for which PA is rarely denied, have high approval rates on appeal, are important to provide expeditiously
- Examine PA that disproportionately impacts marginalized patients

Review of validity, clinical criteria. Regular systematic review and updates for changes in population health characteristics, standards of care and scientific information that will allow for continued informed decisions on the safety and needs to apply PA or lift PA restrictions.

HMA strongly supports Prior Authorization policies and continued oversight that may reduce patient and provider burdens, improve patient access and facilitate the timely delivery of high quality and safe medical care.

Thank you for allowing the Hawaii Medical Association to testify in support of this measure with amendments.

REFERENCES AND QUICK LINKS

Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). CMS Interoperability and Prior Authorization Final Rule (CMS-0057-
Fhttps://www.cms.gov/files/document/cms-0057-f.pdf

American Medical Association. Issue Brief: Federal Changes to Prior Authorization Rules and their Impact on State Legislative Efforts. https://cdn.ymaws.com/hawaiimedicalassociation.org/resource/resmgr/advocacy/prior_auth_issue_brief_on_fe.pdf

American Medical Association. 2023 AMA Prior Authorization (PA) Physician Survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf Accessed Jan 28 2025.

American Association of Family Physicians (AAFP). Prior Authorization. https://www.aafp.org/family-physician/practice-and-career/administrative-simplification/prior-authorization.html Accessed Jan 28 2025.

American College of Obstetricians and Gynecologists District VIII, Hawai'i (Guam & American Samoa) Section

TO: Committee on Finance
Rep. Kyle T. Yamashita, Chair
Rep. Jenna Takenouchi, Vice Chair

DATE: Friday, Feb 21, 2025
PLACE: Hawaii State Capitol, Conference Room 308

FROM: Hawai'i Section, ACOG
Dr. Angel Willey, MD, FACOG, Chair
Dr. Tiffinie R. Mercado, MD, FACOG, Vice-Chair
Dr. Ricardo A. Molero Bravo, MD, FACOG, Legislative Chair

Re: HB250 HD2 Relating to Health. Prior Authorization; Utilization Review Entities; Reporting;
Health Care Appropriateness and Necessity Commission; State Health Planning and Development Agency
Position: SUPPORT

On behalf of the Hawai'i Section of the American College of Obstetricians and Gynecologists (ACOG), we write in support of HB250 HD2, which seeks to reform prior authorization processes, reduce administrative burdens on healthcare providers, and improve patient access to timely medical care.

As physicians dedicated to providing high-quality obstetric and gynecologic care, we witness firsthand the negative impact that delays in prior authorization have on our patients. The current process imposes unnecessary administrative hurdles, leading to delayed treatments, increased provider burnout, and adverse patient outcomes. National and state-level data confirm that prior authorization is a top concern for physicians, often resulting in denied or delayed access to medically necessary care.

The administrative barriers created by inconsistent and often opaque prior authorization criteria particularly impact maternal health and reproductive care, where timely access to services can be crucial. A delay in diagnostic testing, medications, or procedures could jeopardize the health of pregnant individuals and those experiencing gynecologic conditions, leading to avoidable complications and higher healthcare costs.

By passing HB250 HD2, the Legislature has the opportunity to reduce delays in patient care, support physicians in delivering evidence-based treatments, and ensure that healthcare decisions are made by medical professionals rather than insurance companies.

We respectfully urge you to pass HB250 HD2 and protect the ability of Hawai'i's healthcare providers to deliver timely, patient-centered care.

Additionally, we support Hawaii Medical Association proposed amendments.

Thank you for your time and consideration

An Independent Licensee of the Blue Cross and Blue Shield Association

February 21, 2025

The Honorable Kyle T. Yamashita, Chair
The Honorable Jenna Takenouchi, Vice Chair
House Committee on Finance

Re: HB250 HD2 - RELATING TO HEALTH

Dear Chair Yamashita, Vice Chair Takenouchi, and members of the committee,

Hawaii Medical Service Association (HMSA) **opposes** the current version of HB 250 HD2, which 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 timelines for the approval of prior authorization requests for urgent and non-urgent health care services, and establishes the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency.

We thank the legislature for recognizing the importance of prior authorization (PA). It is one of many important components that keep health care premiums affordable and continue to ensure the long-term sustainability of Hawaii's overall healthcare system. We are committed to working with all stakeholders to improve the prior authorization process while also ensuring the highest quality of care for our members.

Prior authorization is in place to mitigate misuse, ensure quality care for members, and ultimately contribute to the affordability of premiums for employers and individuals. Specifically, if this legislation were to pass in its current form, we estimate that the total financial impact would be upwards of $180 million, with $22 million and $85 million impacting EUTF and QUEST, respectively.

2026 Prior Authorization Improvement Requirements
We want to note for the committee that there are already pending new requirements for prior authorization on the near horizon that will address the concerns that have been raised. Beginning in 2026, new CMS requirements[1] will streamline and reduce the burden associated with PA processes by:

- shortening the timeframe for PA decisions,
- promoting greater transparency for medical necessity criteria,
- strengthening PA reporting, and
- improving both the adoption of electronic PA processes and the electronic exchange of health care information.

With the new 2026 requirements quickly approaching, we believe this measure is unnecessary and that it would be premature to put any new PA requirements in statute, as health plans are already working towards alignment with these new regulations.

[1] https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

Currently, there is a Senate version of this bill, SB1449, which we feel more clearly captures the intent of PA improvements, including reporting.

With that in mind, and should the committee still choose to move this measure forward, we ask you to consider the following critical amendments:

1. **Amending Section 2:**
   a. **To replace all references to ~~chapter 323D~~ with chapter 431:2** as the Insurance Commissioner is the appropriate oversight body for health plans in Hawaii.

   b. **(Page 4, line 1-13) Amend Prior authorization; reporting** (parts a and b)
      i. to replace all instances of "~~utilization review entity~~" with "health plan".
      ii. to replace all instance of "~~state agency~~" with "insurance commissioner".

   c. **Amend page 4, line 6-8** to include prior authorization reporting of aggregate data instead of individual reports to ensure no breach of antitrust laws:
      i. The ~~state agency~~ insurance commissioner shall post ~~each report~~ the aggregate data on its website no later than three months before the start of the subsequent reporting period.

   d. **(Page 7 line 3 to Page 10 line 20) Replace the Health care appropriateness and necessity workgroup, established** section with:

§431:2- Prior authorization working group; established.

(a) There is established the prior authorization working group to consider the issues of administrative burden in the health care delivery system convened by the insurance commissioner. The working group shall assess and evaluate the prior authorization process, identify inefficiencies and pain points for stakeholders, and make recommendations to improve speed, transparency, and overall efficiency. The working group shall consider:

(1) Evaluation of current prior authorization practices;

(2) Alignment with current and pending prior authorization regulations;

(2) Potential for digitization and technology;

(3) Compliance and risk review;

(4) Incorporation of electronic health records to maximize efficiency in the prior authorization process;

(5) Best practices of other states that have adopted policies to streamline prior authorization processes.

The working group shall submit a report of its findings and recommendations to the legislature no later than June 31, 2026.

(b) The working group established pursuant to this Act shall be convened by the Insurance Commissioner. The working group shall include:

(1) The state Insurance Commissioner, or Commissioner's designee;

(2) The director of the department of health, or the director's designee;

(3) The administrator of the State Medicaid agency, or designee;

(4) The administrator of the State Health Planning and Development Agency, or designee;

(5) A representative from the Hawaii Medical Association;

(6) A representative from the Hawaii Association of Health Plans;

(7) A representative from the Healthcare Association of Hawaii; and

(8) A representative of the consumer or patient advocacy community.

(c) The working group shall cease to exist on July 1, 2026.

An Independent Licensee of the Blue Cross and Blue Shield Association

Thank you for the opportunity to testify on this very important measure.

Sincerely,

Dawn Kurisu
Assistant Vice President
Community and Government Relations

HB-250-HD-2
Submitted on: 2/20/2025 2:57:14 PM
Testimony for FIN on 2/21/2025 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Jerald Garcia, M.D.	Hawaii Medical Association	Support	Remotely Via Zoom

Comments:

Please see Hawaii Medical Association Testimony.