

JAN 17 2025

A BILL FOR AN ACT

RELATING TO INSURER PRIOR AUTHORIZATION.

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

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

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

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



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

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

8 **"§431:10A- Prior authorization.** (a) Insurers shall
9 align their prior authorization processes with medicare policies
10 for similar services, including requirements that:

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

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

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

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



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

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

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

10 (1) Fraud;

11 (2) Intentional misrepresentation; or

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

14 (f) The commissioner shall:

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

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

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



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

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

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

7 (2) Public disclosure of violations and penalties; and

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

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

13 (j) This section shall not apply to:

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

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

18 (k) For purposes of this section:

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

21 (1) Health maintenance organizations;



1 (2) Preferred provider organizations;

2 (3) Exclusive provider organizations; and

3 (4) Indemnity insurers.

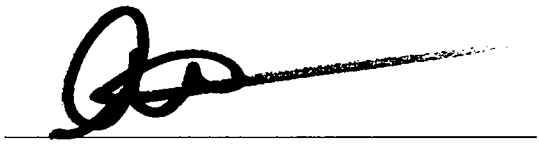
4 "Medicare" means the federal health insurance program under
5 Title XVIII of the Social Security Act.

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

10 SECTION 3. New statutory material is underscored.

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

12

INTRODUCED BY: 



S.B. NO. 1134

Report Title:

Insurance; Prior Authorization; Medicare

Description:

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

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

