THE SENATE
THIRTY-THIRD LEGISLATURE, 2026
STATE OF HAWAII

S.B. NO. 2282

JAN 2 1 2026

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 health care insurance prior authorization for treatment processes in Hawaii pose significant challenges, which have been reported to delay treatment, negatively impact patient outcomes, and impose considerable administrative burdens on health care 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 health care 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 health care reform.

The purpose of this Act is to:

(1) Establish a list of medical conditions for which authorization by a health insurance company for health insurance coverage is not required before treatment;

(2) Require health insurers to align their procedures with comparable procedures established by medicare's guidelines for an insured to obtain authorization from a health insurance company before treatment; and

(3) Reduce administrative burdens, improve health care access, and ensure consistency across payers.

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

"**§431:10A-A Prior authorization; exemptions.** (a) No insurer shall deny payment on the basis that the insured or any representative of the insured failed to obtain prior authorization for any service, medication, or procedure to treat a condition that the prior authorization committee has determined under section 431:10A-B does not require prior authorization for coverage of treatment.

(b) For purposes of this section:

"Insurer" shall have the same meaning as in section 431:10A-C.

"Prior authorization" shall have the same meaning as in section 431:10A-C.

§431:10A-B Prior authorization committee. (a) There is established within the insurance division the prior authorization committee. The committee shall consist of seven voting members as follows:

(1) The commissioner or the commissioner's designee, who shall serve as the chairperson of the committee; and

(2) Six members appointed by the governor under section 26-34; provided that:

(A) Two members shall be appointed to represent insurers;

(B) Two members shall be appointed to represent insureds; and

(C) Two members shall be appointed to represent health care providers.

The director of health or the director of health's designee shall serve as an ex officio, nonvoting member.

(b) The members of the committee shall serve without pay but shall be entitled to reimbursement for necessary expenses while attending meetings and while in discharge of their duties.

(c) No later than October 1 of each year, the committee shall publish a report on the website of the department of commerce and consumer affairs and submit the same report to the legislature. The report shall contain:

(1) The list of conditions for which prior authorization under section 431:10A-A is not required for coverage of treatment; and

(2) Recommendations to the legislature regarding amendments to section 431:10A-A or 431:10A-C, if any.

Unless specified by the committee in the report, the list of conditions for which prior authorization under section 431:10A-A is not required for coverage of treatment shall become effective on January 1 of the following calendar year and shall remain effective until superseded by a subsequent report by the committee; provided that any condition on a superseded list shall remain effective for an insured who commences treatment of that condition before the list is superseded.

§431:10A-C Prior authorization; insurer process. (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 seven 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 violating 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. In codifying the new sections added by section 2 of this Act, the revisor of statutes shall substitute appropriate section numbers for the letters used in designating the new sections in this Act.

SECTION 4. New statutory material is underscored.

SECTION 5. This Act shall take effect upon its approval.

INTRODUCED BY: _____

S.B. NO. 2282

Report Title:
Health Insurance; Medical Insurance; Prior Authorization; Medicare

Description:
Establishes the Prior Authorization Committee to specify medical conditions for which prior authorization by the insurer for treatment is not required for health insurance coverage. Requires health plan insurers to align their prior authorization processes for other conditions with Medicare policies.

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