
A BILL FOR AN ACT

RELATING TO THE PATIENTS' BILL OF RIGHTS.

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

1 SECTION 1. The legislature finds that there is a growing
2 need to ensure Hawaii's residents receive appropriate and timely
3 health care. The legislature further finds that the existing
4 law protecting patient's rights does not address new and
5 emerging technologies, like the use of artificial intelligence
6 in health care decision making, or a patient's rights in cases
7 where their protected health information has been accessed when
8 a health insurer is the victim of a data breach.

9 Accordingly, the purpose of this Act is to update and
10 modernize the State's patients' bill of rights and
11 responsibilities act to increase access to care, reduce
12 administrative burdens, and address emerging technologies.

13 SECTION 2. This Act shall be known and may be cited as the
14 "Hawaii Patients' Bill of Rights of 2025"

15 SECTION 3. Chapter 432E, Hawaii Revised Statutes, is
16 amended by adding six new sections to be appropriately
17 designated and to read as follows:



1 **"S432E-** **Access to timely services.** (a) An enrollee
2 shall have the right to timely access and referrals to
3 specialist care.

4 (b) A managed care plan shall cover telehealth services
5 for covered benefits at a rate equal to that of an in-person
6 consultation between the patient and a health care provider.

7 **S432E-** **Prior authorization; decision-making; access;**
8 **reporting.** (a) A health carrier or its designated utilization
9 review organization shall make a determination on a prior
10 authorization request for an urgent health care service no later
11 than one business day after the request is submitted.

12 (b) A health carrier or its designated utilization review
13 organization shall make a determination on a prior authorization
14 request for a non-urgent health care service no later than three
15 business days after the request is submitted.

16 (c) If a health carrier or its designated utilization
17 review organization makes an adverse determination on a prior
18 authorization request, the health carrier shall furnish the
19 enrollee and the enrollee's provider with the following in
20 writing:





1 providing health care services in rural or medically underserved
2 areas of the State.

3 (f) Each health carrier shall submit a monthly report to
4 the insurance commissioner that contains the following
5 aggregated and de-identified information:

6 (1) The number of prior authorization requests received by
7 the health carrier or its designated utilization
8 review organization;

9 (2) The rate of approval and denial of prior authorization
10 requests;

11 (3) The median processing time for a prior authorization
12 request;

13 (4) The number of appeals of an adverse determination of a
14 prior authorization request and the rate at which the
15 adverse determination was overturned; and

16 (5) The number of prior authorization determinations that
17 were made using an automated decision support tool.

18 (g) No later than twenty days prior to the regular session
19 of 2028, and each regular session thereafter, the insurance
20 commissioner shall submit a report to the legislature on:



- 1 (1) The number of prior authorization requests and the
2 median processing time for a prior authorization
3 request, broken down by health carrier;
- 4 (2) The number of prior authorization denials made in the
5 preceding calendar year, broken down by health
6 carrier;
- 7 (3) The number of appeals of a prior authorization
8 determination and their outcomes, broken down by
9 health carrier; and
- 10 (4) The number of prior authorization determinations that
11 were made using an automated decision support tool,
12 broken down by health carrier.

13 **S432E- Automated decision support tool; oversight;**

14 **review; notice.** (a) A health carrier or utilization review
15 organization that uses an automated decision support tool for
16 the purpose of utilization review shall provide a written
17 disclosure on how the automated decision support tool is used in
18 the utilization review process in each policy, plan, contract,
19 or agreement issued by a health carrier in the State.

20 (b) A health carrier shall notify an enrollee and the
21 enrollee's provider in writing if the use of an automated



1 decision support tool materially contributed to an adverse
2 action, including a denial of a request for prior authorization.

3 (c) If an automated decision support tool materially
4 contributed to an adverse action, the health carrier shall not
5 issue the adverse action until the claim is independently
6 reviewed and approved by a board-certified clinician. When
7 conducting the independent review of the adverse action, the
8 board-certified clinician shall exercise independent medical
9 judgment and shall not rely solely on recommendations from any
10 other sources, including an automated decision support tool.

11 (d) No later than June 30, 2027, a health carrier shall
12 develop and make available for annual review by the insurance
13 commissioner the following information:

14 (1) The health carrier's governance policies for the use of
15 automated decision support tools;
16 (2) The health carrier or its designated utilization
17 review organization's process for validation and bias
18 testing of the automated decision support tool; and
19 (3) The health carrier's monitoring records of the
20 automated decision support tool.



1 (e) For the purposes of this section, an automated
2 decision support tool shall be deemed to have materially
3 contributed to an adverse action if the health carrier or its
4 designated utilization review organization relied primarily on
5 the automated decision support tool in its utilization review.

6 **§432E- Data protection and handling; offshoring;**

7 **security breaches; notice.** (a) No later than June 30, 2027, a
8 health carrier shall develop and implement safeguards for
9 protected health information that meet or exceed the privacy
10 requirements under the federal Health Insurance Portability and
11 Accountability Act of 1996, P.L. 104-191, and its related
12 regulations under title 45 Code of Federal Regulations parts 160
13 and 164.

14 (b) No later than June 30, 2027, each health carrier
15 shall, in a form and manner as prescribed the insurance
16 commissioner, submit an attestation for each offshoring contract
17 for services related to protected health information to the
18 insurance commissioner that:

19 (1) The protected health information shall not be shared
20 with any person, entity, or organization other than



1 the one with whom the health carrier enters into a
2 contract; and

3 (2) The offshoring contract contains measures for the
4 handling of protected health information that fully
5 complies with the Health Insurance Portability and
6 Accountability Act of 1996, P.L. 104-191, and all
7 other applicable federal and state privacy laws,
8 rules, and regulations.

9 (c) If a health carrier or its designated utilization
10 review organization knows or suspects that it is the victim of a
11 data breach, the health carrier shall notify the insurance
12 commissioner and all enrollees in the health carrier's managed
13 care plans of the suspected or known data breach and provide a
14 copy of the health carrier's corrective action plans within
15 seventy-two hours of the time the health carrier or its
16 designated utilization review organization is made aware of the
17 known or suspected data breach.

18 **§432E- Network adequacy; reports.** A health carrier
19 shall submit reports on a quarterly basis to the insurance
20 commissioner on the health carrier's network adequacy. Each
21 quarterly report shall include:



- 1 (1) Provider ratios broken down by island or region;
- 2 (2) Wait times;
- 3 (3) Telehealth utilization; and
- 4 (4) Referral outcomes.

5 **§432E- Provider protections; provider assistance.** (a)

6 No health carrier shall retaliate against a health care provider
7 who files a complaint against the health carrier with the
8 insurance commissioner, assists an enrollee with filing a
9 complaint with the health carrier pursuant to section 432E-5, or
10 requests an external review of a health carrier's adverse action
11 pursuant to section 432E-33.

12 (b) The insurance commissioner and the department of
13 commerce and consumer affairs shall provide guidance and
14 technical assistance to small and rural practices on navigating
15 health carrier administrative requirements, the appeals and
16 complaints process under section 432E-5, the external review
17 process under section 432E-33, and compliance with this
18 chapter."

19 SECTION 4. Section 432E-1, Hawaii Revised Statutes, is
20 amended by adding five new definitions to be appropriately
21 inserted and to read as follows:



1 ""Artificial intelligence"" means an engineered or machine-
2 based system that varies in its level of autonomy and that can,
3 for explicit or implicit objectives, infer from inputs how to
4 generate outputs, including content, decisions, predictions, and
5 recommendations, that can influence physical or virtual
6 environments.

7 "Automated decision support tool" means any artificial
8 intelligence, algorithmic, software-based, statistical, or data-
9 driven tool, model, or process that autonomously or semi-
10 autonomously generates, recommends, or adjudicates coverage
11 determinations or prior authorization decisions without
12 contemporaneous decision-making by a physician licensed under
13 chapter 453 or advanced practice registered nurse licensed under
14 chapter 457.

15 "Offshoring contract" means the contracting of services by
16 a health carrier for claims processing, call center staffing,
17 technical support, or other administrative services to be
18 rendered, in whole or in part, by another party located outside
19 of the United States or its territories.

20 "Prior authorization" has the same meaning as defined in
21 section 323D-2.



1 "Urgent health care service" means a health care service
2 which, without an expedited prior authorization, could, in the
3 opinion of a physician with knowledge of the enrollee's medical
4 condition:

5 (1) Seriously jeopardize the life or health of the
6 enrollee or the ability of the enrollee to regain
7 maximum function; or
8 (2) Subject the enrollee to severe pain that cannot be
9 adequately managed without the care or treatment that
10 is the subject of the utilization review.

11 "Urgent health care service" includes mental and behavioral
12 health care services."

13 SECTION 5. Section 432E-1.4, Hawaii Revised Statutes, is
14 amended to read as follows:

15 **"\$432E-1.4 Medical necessity.** (a) For contractual
16 purposes, a health intervention shall be covered if it is an
17 otherwise covered category of service, not specifically
18 excluded, recommended by the treating licensed health care
19 provider, and determined by the health plan's medical director
20 to be medically necessary as defined in subsection (b). A
21 health intervention may be medically indicated and not qualify



1 as a covered benefit or meet the definition of medical
2 necessity. A managed care plan may choose to cover health
3 interventions that do not meet the definition of medical
4 necessity.

5 (b) A health intervention is medically necessary if it is
6 recommended by the treating physician or treating licensed
7 health care provider, is approved by the health plan's medical
8 director or physician designee, and is:

9 (1) For the purpose of treating a medical condition;
10 (2) The most appropriate delivery or level of service,
11 considering potential benefits and harms to the
12 patient;

13 (3) Known to be effective in improving health outcomes;
14 provided that:

15 (A) Effectiveness is determined first by scientific
16 evidence;
17 (B) If no scientific evidence exists, then by
18 professional standards of care; and
19 (C) If no professional standards of care exist or if
20 they exist but are outdated or contradictory,
21 then by expert opinion; and



6 (c) When the treating licensed health care provider and
7 the health plan's medical director or physician designee do not
8 agree on whether a health intervention is medically necessary, a
9 reviewing body, whether internal to the plan or external, shall
10 give consideration to, but shall not be bound by, the
11 recommendations of the treating licensed health care provider
12 and the health plan's medical director or physician designee.

13 (d) A managed care plan shall not retroactively deny any
14 medically necessary health intervention provided to an enrollee
15 during emergency services.

16 [del] (e) For the purposes of this section:

17 "Cost-effective" means a health intervention where the

18 benefits and harms relative to the costs represent an

19 economically efficient use of resources for patients with the

20 medical condition being treated through the health intervention;

21 provided that the characteristics of the individual patient



1 shall be determinative when applying this criterion to an
2 individual case.

3 "Effective" means a health intervention that may reasonably
4 be expected to produce the intended results and to have expected
5 benefits that outweigh potential harmful effects.

6 "Health intervention" means an item or service delivered or
7 undertaken primarily to treat a medical condition or to maintain
8 or restore functional ability. A health intervention is defined
9 not only by the intervention itself, but also by the medical
10 condition and patient indications for which it is being applied.

11 New interventions for which clinical trials have not been
12 conducted and effectiveness has not been scientifically
13 established shall be evaluated on the basis of professional
14 standards of care or expert opinion. For existing
15 interventions, scientific evidence shall be considered first
16 and, to the greatest extent possible, shall be the basis for
17 determinations of medical necessity. If no scientific evidence
18 is available, professional standards of care shall be
19 considered. If professional standards of care do not exist or
20 are outdated or contradictory, decisions about existing
21 interventions shall be based on expert opinion. Giving priority



1 to scientific evidence shall not mean that coverage of existing
2 interventions shall be denied in the absence of conclusive
3 scientific evidence. Existing interventions may meet the
4 definition of medical necessity in the absence of scientific
5 evidence if there is a strong conviction of effectiveness and
6 benefit expressed through up-to-date and consistent professional
7 standards of care, or in the absence of such standards,
8 convincing expert opinion.

9 "Health outcomes" mean outcomes that affect health status
10 as measured by the length or quality of a patient's life,
11 primarily as perceived by the patient.

12 "Medical condition" means a disease, illness, injury,
13 genetic or congenital defect, pregnancy, or a biological or
14 psychological condition that lies outside the range of normal,
15 age-appropriate human variation.

16 "Physician designee" means a physician or other health care
17 practitioner designated to assist in the decision-making process
18 who has training and credentials at least equal to the treating
19 licensed health care provider.

20 "Scientific evidence" means controlled clinical trials that
21 either directly or indirectly demonstrate the effect of the



1 intervention on health outcomes. If controlled clinical trials
2 are not available, observational studies that demonstrate a
3 causal relationship between the intervention and the health
4 outcomes may be used. Partially controlled observational
5 studies and uncontrolled clinical series may be suggestive, but
6 do not by themselves demonstrate a causal relationship unless
7 the magnitude of the effect observed exceeds anything that could
8 be explained either by the natural history of the medical
9 condition or potential experimental biases. Scientific evidence
10 may be found in the following and similar sources:

11 (1) Peer-reviewed scientific studies published in or
12 accepted for publication by medical journals that meet
13 nationally recognized requirements for scientific
14 manuscripts and that submit most of their published
15 articles for review by experts who are not part of the
16 editorial staff;

17 (2) Peer-reviewed literature, biomedical compendia, and
18 other medical literature that meet the criteria of the
19 National Institutes of Health's National Library of
20 Medicine for indexing in Index Medicus, Excerpta



1 Medicus (EMBASE), Medline, and MEDLARS database Health
2 Services Technology Assessment Research (HSTAR);
3 (3) Medical journals recognized by the Secretary of Health
4 and Human Services under section 1861(t)(2) of the
5 Social Security Act, as amended;
6 (4) Standard reference compendia including the American
7 Hospital Formulary Service-Drug Information, American
8 Medical Association Drug Evaluation, American Dental
9 Association Accepted Dental Therapeutics, and United
10 States Pharmacopoeia-Drug Information;
11 (5) Findings, studies, or research conducted by or under
12 the auspices of federal agencies and nationally
13 recognized federal research institutes including but
14 not limited to the Federal Agency for Health Care
15 Policy and Research, National Institutes of Health,
16 National Cancer Institute, National Academy of
17 Sciences, Centers for Medicare and Medicaid Services,
18 Congressional Office of Technology Assessment, and any
19 national board recognized by the National Institutes
20 of Health for the purpose of evaluating the medical
21 value of health services; and



1 (6) Peer-reviewed abstracts accepted for presentation at
2 major medical association meetings.

3 "Treat" means to prevent, diagnose, detect, provide medical
4 care, or palliate.

5 "Treating licensed health care provider" means a licensed
6 health care provider who has personally evaluated the patient."

7 SECTION 6. Section 432E-7, Hawaii Revised Statutes, is
8 amended to read as follows:

9 "§432E-7 **Information to enrollees.** (a) The managed care
10 plan shall provide in plain language to its enrollees upon
11 enrollment and thereafter upon request the following
12 information:

13 (1) A list of participating providers which shall be
14 updated on a ~~regular~~ quarterly basis indicating, at
15 a minimum, their specialty and whether the provider is
16 accepting new patients;

17 (2) A complete description of benefits, exclusions,
18 services, and copayments;

19 (3) A statement on enrollee's rights, responsibilities,
20 and obligations:

(4) An explanation of the referral process, if any;



1 (5) Where services or benefits may be obtained;

2 (6) Information on complaints and appeals procedures [~~and~~
3 and], including a step-by-step explanation of the
4 appeal and external review process; and

5 (7) The telephone number of the insurance division.

6 This information shall be provided to prospective enrollees upon
7 request."

8 SECTION 7. Section 432E-8, Hawaii Revised Statutes, is
9 amended to read as follows:

10 "[§]S432E-8[§] **Enforcement.** (a) All remedies, penalties,
11 and proceedings in articles 2 and 13 of chapter 431 made
12 applicable hereby to managed care plans shall be invoked and
13 enforced solely and exclusively by the commissioner.

14 (b) In addition to any remedy, penalty, or proceeding
15 invoked pursuant to subsection (a), the commissioner may:
16 (1) Audit, investigate, or impose penalties on a health
17 carrier;
18 (2) Require a health carrier to provide restitution;
19 (3) Revoke a managed care plan's accreditation; or
20 (4) Pursue injunctive relief against a health carrier for
21 a violation of this chapter.



1 (c) The commissioner shall prepare and make public an
2 annual report of any enforcement actions taken against a health
3 carrier or managed care plan pursuant to this section."

4 SECTION 8. If any provision of this Act, or the
5 application thereof to any person or circumstance, is held
6 invalid, the invalidity does not affect other provisions or
7 applications of the Act that can be given effect without the
8 invalid provision or application, and to this end the provisions
9 of this Act are severable.

10 SECTION 9. Statutory material to be repealed is bracketed
11 and stricken. New statutory material is underscored.

12 SECTION 10. This Act shall take effect on July 1, 2026.

13

INTRODUCED BY: 



S.B. NO. 3027

Report Title:

Patients' Bill of Rights and Responsibilities; Prior Authorization; Artificial Intelligence; Automated Decision Support Tools; Utilization Review; Protected Health Information; Data Protection; Offshoring; Reporting Requirements; Insurance Commissioner

Description:

Establishes patient rights with respect to timely access to specialists and referrals and prior authorization determination timelines. Establishes certain requirements for health carriers for prior authorization determinations. Establishes certain requirements for the use of automated decision support tools for claims determinations and utilization review. Requires health carriers to establish certain safeguards for protected health information. Establishes certain reporting requirements for network adequacy. Establishes certain provider protections. Expands the Insurance Commissioner's enforcement authority.

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