HOUSE OF REPRESENTATIVES
THIRTY-SECOND LEGISLATURE, 2024
STATE OF HAWAII

H.C.R. NO. 182

HOUSE CONCURRENT RESOLUTION

REQUESTING THE AUDITOR TO ASSESS THE CHALLENGES TO THE TIMELY DELIVERY OF HEALTH CARE SERVICES IN THE STATE DUE TO PRIOR AUTHORIZATION REQUIREMENTS AND INCLUDE AN ANALYSIS OF PRIOR AUTHORIZATION REFORM, WITH INPUT OF DATA AND FEEDBACK FROM ALL STAKEHOLDERS, INCLUDING PATIENT ADVOCATES, PROVIDERS, FACILITIES, AND PAYERS.

WHEREAS, patients face continued challenges in accessing health care due to the burdens of prior authorization requirements, which serves as an upfront bottleneck to the delivery of many commonly indicated diagnostic tests and medical treatments; and

WHEREAS, prior authorization further compounds the increased costs and administrative demands on providers and staff, which are made worse by the health care workforce shortages in the State; and

WHEREAS, recent changes to the Centers for Medicare and Medicaid Services (CMS) rules on prior authorization are a step in the right direction, but it is necessary to address the prior authorization inconsistencies and concerns for all payers so that Hawaii residents can receive the timely medical care that they need; and

WHEREAS, time-consuming prior authorization processes encumber family physicians, divert valuable resources from direct patient care, and delay the start or continuation of necessary treatment, leading to lower rates of patient adherence to treatment and negative clinical outcomes; and

WHEREAS, administrative complexity in the United States health care system has been identified as a source of enormous

spending and should be further examined for cost-saving opportunities; and

WHEREAS, although payers use prior authorization and claims processes to reduce medical costs and design custom benefit designs to achieve a specific premium price, the misapplication of prior authorization often leads to inappropriate and dangerous delays in diagnosis and treatment and may result in abandoned care; and

WHEREAS, the misapplication of prior authorization increases the already substantial barriers to health care for patients in rural and underserved areas; and

WHEREAS, recent CMS rules have mandated changes to reform prior authorization that, taken together, will reduce overall payer and provider burden and improve patient access in federal programs; however, these changes do not apply to private insurers; and

WHEREAS, Hawaii health care private payers still require prior authorization for common inpatient, residential treatment center, and partial hospitalization admissions that are not directly from an emergency department, as well as for commonly indicated diagnostic testing and treatment of urgent cases for mental health, surgery, gynecology, and oncology; and

WHEREAS, the timeline is substantially variable and inconsistent for private payers in terms of prior authorization turnaround, and this complexity leads to confusion, additional paperwork, cost for staff, and contributes to significant provider team burnout; and

WHEREAS, an analysis by the Auditor is necessary to facilitate collaboration on prior authorization reform, with input of data and feedback from all stakeholders including patient advocates, providers, facilities, and payers; now, therefore,

BE IT RESOLVED by the House of Representatives of the Thirty-second Legislature of the State of Hawaii, Regular Session of 2024, the Senate concurring, that the Auditor is

requested to assess the challenges to the timely delivery of health care services in the State due to prior authorization requirements and include an analysis of prior authorization reform, with input of data and feedback from all stakeholders, including patient advocates, providers, facilities, and payers; and

BE IT FURTHER RESOLVED that the assessment and analysis is requested to evaluate the following:

(1) A determination of a reasonable and appropriate prior authorization response time, including whether a response time of twenty-four hours for urgent care and forty-eight hours for non-urgent care is feasible;

(2) Whether adverse determinations should only be conducted by a physician licensed in the State and of the same specialty that typically manages the patient's condition;

(3) The manner in which retroactive denials may be avoided if care is preauthorized;

(4) Whether it is feasible for a prior authorization to be valid for at least one year, regardless of dosage changes;

(5) For patients with chronic conditions, whether the prior authorization may be valid for the length of the treatment;

(6) Whether private insurers may publicly release prior authorization data by drug and service as it relates to approvals, denials, appeals, wait times, and other categories;

(7) Whether it is reasonable and appropriate for a new health plan to honor the patient's prior authorization for a transition prior of time; i.e., at least ninety days;

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(8) The factors that would allow for the reduction of total volume of prior authorization requests, such as exemptions or gold-carding programs; and

(9) A comparison of the State's prior authorization policies with other states' prior authorization policies; and

BE IT FURTHER RESOLVED that the Auditor is requested to submit a report of its findings and recommendations, including any proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2025; and

BE IT FURTHER RESOLVED that a certified copy of this Concurrent Resolution be transmitted to the Auditor.

OFFERED BY: _____

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