HOUSE OF REPRESENTATIVES
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

H.B. NO. 250 H.D. 2 S.D. 2 C.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH.

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

SECTION 1. The legislature finds that prior authorization is a health plan cost-control process that requires physicians, health care professionals, and hospitals to obtain advance approval from a health plan before a specific service to a patient is qualified for payment or coverage. Each health plan has its own policies and procedures that health care providers are required to navigate to have services they prescribe for their patients approved for payment before being provided to the patient. Each health plan uses its own standards and methods, the individual judgment of an employed medical director, or advice from a contracted firm for determining the medical necessity of the services prescribed, which are not transparent or clear to the prescribing clinician or health care provider.

The legislature further finds that there is emerging consensus among health care providers that prior authorization increases administrative burdens and costs. In the 2023 physician workforce report published by the university of Hawaii

John A. Burns school of medicine, physicians voted prior authorization as their top concern regarding administrative burden. Furthermore, a physician survey conducted by the American Medical Association reported that ninety-five per cent of physicians attribute prior authorization to somewhat or significantly increased physician burnout, and that more than one in three physicians have staff who work exclusively on prior authorization. The survey also found that:

(1) Eighty-three per cent of prior authorization denials were subsequently overturned by health plans;

(2) Ninety-four per cent of respondents said that the prior authorization process always, often, or sometimes delays care;

(3) Nineteen per cent of respondents said prior authorization resulted in a serious adverse event leading to a patient being hospitalized;

(4) Thirteen per cent of respondents said prior authorization resulted in a serious adverse event leading to a life-threatening event or requiring intervention to prevent permanent impairment or damage; and

(5) Seven per cent of respondents said prior authorization resulted in a serious adverse event leading to a patient's disability, permanent body damage, congenital anomaly, birth defect, or death.

The legislature believes that reducing the burdens of prior authorization will assist health care providers, thereby ensuring the health and safety of their patients.

Accordingly, the purpose of this Act is to:

(1) Examine prior authorization practices in the State by requiring utilization review entities to report certain prior authorization data to the state health planning and development agency; and

(2) Establish the health care appropriateness and necessity working group to make recommendations to improve and expedite the prior authorization process.

SECTION 2. Chapter 323D, Hawaii Revised Statutes, is amended by adding two new sections to part II to be appropriately designated and to read as follows:

"**§323D- Prior authorization data; reporting.** (a) Utilization review entities doing business in the State shall submit data to the state agency relating to prior authorization

of health care services, in a format specified by the state agency. Reporting shall be annual for the preceding calendar year and shall be submitted no later than January 31 of the subsequent calendar year. The state agency shall post the format for reporting on its website no later than three months before the start of the reporting period.

(b) Protected health information as defined in title 45 Code of Federal Regulations section 160.103 shall not be submitted to the state agency unless:

(1) The individual to whom the information relates authorizes the disclosure; or

(2) Authorization is not required pursuant to title 45 Code of Federal Regulations section 164.512.

(c) The state agency shall compile the prior authorization data by provider of health insurance, health care setting, and line of business, and shall post a report of findings, including recommendations, on its website no later than March 1 of the year after the reporting period. If the state agency is unable to post the report of findings by March 1, the state agency shall notify the legislature in writing within ten days and

include an estimated date of posting, reasons for the delay, and if applicable, a corrective action plan.

§323D- Health care appropriateness and necessity working group; established. (a) There is established the health care appropriateness and necessity working group within the state agency. The working group shall:

(1) Determine by research and consensus:

(A) The most respected peer-reviewed national scientific standards;

(B) Clinical guidelines; and

(C) Appropriate use criteria published by federal agencies, academic institutions, and professional societies,

that correspond to each of the most frequent clinical treatments, procedures, medications, diagnostic images, laboratory and diagnostic tests, or types of medical equipment prescribed by licensed physicians and other health care providers in the State that trigger prior authorization determinations by the utilization review entities;

(2) Assess whether it is appropriate to require prior authorization for each considered clinical treatment, procedure, medication, diagnostic image, laboratory and diagnostic test, or type of medical equipment prescribed by licensed physicians and other health care providers;

(3) Make recommendations on standards for third party reviewers related to the specialty expertise of those reviewing and for those discussing a patient's denial with the patient's health care provider;

(4) Recommend appropriate time frames within which urgent and standard requests shall be decided;

(5) Monitor anticipated federal developments related to prior authorization for health care services and consider these developments when making its recommendations;

(6) Assess industry progress toward, and readiness to implement, any recommendations; and

(7) Make recommendations on treatments for common chronic or long-term conditions for which prior authorization

may remain valid for the duration of the treatment in the appropriate clinical setting.

(b) The administrator of the state agency shall invite the following to be members of the working group:

(1) Five members representing the insurance industry, to be selected by the Hawaii Association of Health Plans;

(2) Five members representing licensed health care professionals, two of whom shall be selected by the Hawaii Medical Association, two of whom shall be selected by the Healthcare Association of Hawaii, and one of whom shall be selected by the center for nursing; and

(3) Five members representing consumers of health care or employers, two of whom shall be selected by the board of trustees of the Hawaii employer-union health benefits trust fund, one of whom shall be a consumer selected by the statewide health coordinating council, one of whom shall be selected by the Hawaii Primary Care Association, and one of whom shall be selected by Papa Ola Lokahi.

The members of the working group shall elect a chairperson and vice chairperson from amongst themselves. The director of health, insurance commissioner, and administrator of the med-QUEST division of the department of human services shall each appoint an ex-officio advisor for the working group.

(c) The working group shall submit a report of its findings and recommendations regarding information under subsection (a), including any proposed legislation, to the legislature no later than twenty days prior to the convening of the regular session of 2026 and each regular session thereafter.

(d) The recommendations of the working group shall be advisory only and not mandatory for health care facilities, health care professionals, insurers, and utilization review entities. The state agency shall promote the recommendations among health care facilities, health care professionals, insurers, and utilization review entities and shall publish annually in its report to the legislature the extent and impacts of its use in the State.

(e) The state agency shall seek transparency and agreement among health care facilities, health care professionals, insurers, utilization review entities, and consumers related to

the most respected clinical, scientific, and efficacious standards, guidelines, and appropriate use criteria corresponding to medical treatments and services most commonly triggering prior authorization determinations to reduce uncertainty around common prior authorization processes, and also foster automation of prior authorization to the benefit of all. The state agency shall explore means of achieving statewide health sector agreement on means of automating prior authorization determinations that decrease delays and disruptions of medically necessary patient care in the near future."

SECTION 3. Section 323D-2, Hawaii Revised Statutes, is amended by adding four new definitions to be appropriately inserted and to read as follows:

""Health care professional" has the same meaning as defined in section 431:26-101.

"Prior authorization" means the process by which a utilization review entity determines the medical necessity or medical appropriateness of otherwise covered health care services before the health care services are rendered. "Prior authorization" includes any health insurer's or utilization

review entity's requirement that an insured or a health care facility or health care professional notify the insurer or utilization review entity before providing health care services to determine eligibility for payment or coverage.

"Prior authorization data" means data required for compliance with federal law and the regulations of the federal Centers for Medicare and Medicaid Services, including those promulgated under title 42 Code of Federal Regulations sections 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c).

"Utilization review entity" means an individual or entity that performs prior authorization for one or more of the following entities:

(1) An insurer governed by chapter 431, article 10A; a mutual benefit society governed by chapter 432, article 1; a fraternal benefit society governed by chapter 432, article 2; or a health maintenance organization governed by chapter 432D; or

(2) Any other individual that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health benefits to an individual treated by a health care facility or health

care professional in the State under a policy, contract, plan, or agreement."

SECTION 4. New statutory material is underscored.

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

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Report Title:
SHPDA; Prior Authorization; Data; Utilization Review Entities; Reporting; Health Care Appropriateness and Necessity Working Group; Reports

Description:
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 the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency and requires the working group to submit annual reports to the Legislature. (CD1)

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