JOSH GREEN, M.D.
GOVERNOR OF HAWAI'I
KE KIA'ĀINA O KA MOKU'ĀINA 'O HAWAI'I

KENNETH S. FINK, M.D., M.G.A., M.P.H.
DIRECTOR OF HEALTH
KA LUNA HO'OKELE

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
Honolulu, HI 96801-3378
doh.testimony@doh.hawaii.gov

Testimony in SUPPORT of HB250 HD1
RELATING TO HEALTH**.**

REP. SCOT Z. MATAYOSHI, CHAIR
HOUSE COMMITTEE ON CONSUMER PROTECTION & COMMERCE

Hearing Date: February 11, 2025 Room Number: 329

Department Testimony: Department Testimony: The Department of Health (DOH) supports HB250 HD1.

Feedback from the healthcare provider community is very strong and clear that the administrative burden from prior authorization of healthcare services is leading to provider burnout, delays in care, and diminished productivity that impacts direct patient care.

Although prior authorization is a legitimate cost control tool, the fact that 83% of requests are subsequently overturned by the health plan that originally denied the service, according to a national survey administered by the American Medical Association, compels further examination of this practice.

Making prior authorization statistics available will help consumers make more informed choices when choosing their health plan, and can contribute to creating community standards and practices that are more effective, return more value, and that are simpler to administer.

Lastly, the Department recommends against establishing a commission due to the advice and consent requirement, and proposes that a task force take its place.

Thank you for the opportunity to testify.

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
DEPARTMENT OF HEALTH - *KA ʻOIHANA OLAKINO*

JOSH GREEN, M.D.
GOVERNOR OF HAWAIʻI
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

KENNETH S. FINK, MD, MGA, MPH
DIRECTOR OF HEALTH
KA LUNA HOʻOKELE

JOHN C. (JACK) LEWIN, M.D.
ADMINISTRATOR

LATE

January 27, 2025

To: House Committee on Consumer Protection and Commerce
Representative Scot Matayoshi, Chair
Representative Cory Chun, Vice Chair, and
Honorable Members

From: Jack Lewin MD, Administrator, SHPDA, and Sr. Advisor to Governor Josh Green MD on Healthcare Innovation

Re: HB 250 HD1 -- RELATING TO HEALTH (Prior authorization)

Position: SUPPORT

Testimony:

HB 250 requires utilization review entities (health insurers) to submit data relating to the prior authorization of health care services to the State Health Planning and Development Agency, and establishes the Health Care Appropriateness and Necessity working group within the State Health Planning and Development Agency.

Prior authorization, first created by health insurers in the 1980s, was intended to identify and deny payment to doctors, hospitals and health care providers that was deemed not medically necessary or appropriate. The practice has become much more frequently applied to denial of medical claims over the years, and the process of attempting to appeal or reverse the denials has become a major source of frustration, and a time-consuming and expensive burden for physicians, hospitals, and other providers.

In addition, since the clinical standards, guidelines, or scientific bases for such denials varies from insurer to insurer, are generally not published or clearly defined, physicians and other providers are forced to navigate the increasing complexity of this process, and many providers do not have the time or resources to challenge the denials on behalf of their patients. Meanwhile, insurers

increasingly contract out their prior authorization determinations to other private companies that providers believe to be increasing denial rates with what appear to be perverse financial incentives to do so.

Patients and the members of the public have also recently become aware of and frustrated by prior authorization denials of care that physicians have prescribed for them or their family members, as was tragically apparent in the public response to the recent murder of an insurance executive in New York.

It is time to build trust back between the public, providers of care, and insurers by streamlining the prior authorization process. Accurate assessment of medical necessity can be a very difficult process given patient individuality, increasing complexity of medical diagnostics and therapeutics, and the common presence of patient co-morbidities (multiple medical conditions) associated with a medical claim. But we live in the information age, and SHPDA firmly believes that prior authorization can and will be streamlined and automated over time to the benefit of patients, physicians and providers, and insurers.

This bill proposes two methods to accomplish this improvement: first, mandatory reporting by insurers of all key parameters associated with prior authorization to achieve clearer understanding of and transparency around the PA process in Hawaii. And second, creation of a Health Care Appropriateness and Necessity Working Group (HCAN) working group of fifteen members, with equal representation of insurers, providers, and purchasers of insurance (the latter including consumers, employers, and government) to collaborate on achieving statewide agreement on the best and peer-reviewed standards, guidelines, and criteria available nationally for prior authorization determinations. If this can be achieved, PA can be largely automated and streamlined to the benefit of all. The PA determinations could be made before the patient leaves the clinician's office or immediately during hospital admission.

SHPDA is well equipped to staff and organize such a process, noting, however, that insurers and providers will need to bring their technical, scientific, clinical, and IT expertise to the process for it to succeed. But it is clearly doable if there is a collaborative will for it to happen. Hawaii would once again be the first state to take this challenge on and to automate the PA process if the HCAN succeeds.

SHPDA suggests adding language to the bill regarding a streamlined approach to the appointment of the 15 Health Care Appropriateness and Necessity Working Group members as follows:

The five members representing the insurance (utilization review entities) industry shall be appointed by the Hawaii Association of Health Plans (HAHP).

Of the five members representing the provider community, two shall be appointed by the Hawaii Medical Association (HMA), two shall be appointed by the Healthcare Association of Hawaii (HAH), and one by the Hawaii State Center for Nursing (HSCN) at the University of Hawaii.

Of the five members representing the consumer/employer community, two shall be appointed by the Employer-Union Health Benefits Trust Fund (EUTF), one shall be a consumer member appointed by the SHPDA State Health Coordinating Council, one shall be appointed by the Hawaii Primary Care Association (HPCA), and one shall be appointed by Papa Ola Lokahi.

In addition, the Director of Health, the Administrator of the DHS Med-QUEST Division, and the Insurance Commissioner shall each appoint an ex-officio advisor to the HCAN working group.

While actions on the recommendations of the working group by the health insurance (and utilization review entities) industry shall be voluntary, the HCAN working group shall report on the extent to which its recommendations have been adopted across the healthcare industry.

The Health Care Appropriateness and Necessity Working Group shall sunset after delivering a report of its progress and findings prior to the opening session of the 2017 Legislature.

Mahalo for the opportunity to testify.

- -- Jack Lewin MD, Administrator, SHPDA

Hawai'i Association of Professional Nurses (HAPN)

To: The Honorable Representative Scot Z. Matayoshi, Chair of the House Committee on Consumer Protection & Commerce

From: Hawai'i Association of Professional Nurses (HAPN)

Subject: HB250 HD1 – Relating to Health

Hearing: February 11, 2025, 2:00 p.m.

Aloha Representative Matayoshi, Chair; Representative Chun, Vice Chair; and Members of the Committee,

On behalf of the Hawai'i Association of Professional Nurses (HAPN), we strongly support HB250 HD1 **with amendments**, which seeks to bring greater transparency, efficiency, and accountability to the prior authorization process in Hawai'i.

Recommended Amendment: Inclusion of an APRN on the Working Group

While we strongly support HB250 HD1, we recommend an amendment to ensure that the Health Care Appropriateness and Necessity Working Group includes at least one APRN.

APRNs are independent healthcare providers in Hawai'i who diagnose, treat, and prescribe. They face the same prior authorization challenges as physicians and must be represented in discussions shaping policy reforms.

Ensuring APRN inclusion in the working group will provide a more comprehensive and equitable perspective on how prior authorization impacts all healthcare professionals and the patients they serve.

The Need for Prior Authorization Reform

Originally intended as a cost-control measure, prior authorization has evolved into a significant barrier to timely patient care, leading to delays, administrative burdens, and negative health outcomes. Healthcare providers, including advanced practice registered nurses (APRNs), spend substantial time navigating complex and often inconsistent prior authorization processes that interfere with the efficient delivery of necessary medical care.

Recent data highlights the urgent need for reform:

• 83% of prior authorization denials are later overturned, indicating many denials were unnecessary.

• 94% of healthcare providers report that prior authorization leads to delays in care, and nearly 1 in 5 providers state that these delays resulted in serious adverse events, including hospitalization and life-threatening conditions.

• The 2023 Physician Workforce Report from the University of Hawai'i John A. Burns School of Medicine identified prior authorization as the top administrative burden for healthcare providers in the state.

• APRNs, like physicians, experience these burdens, affecting their ability to provide timely and appropriate patient care.

Key Provisions of HB250 HD1

This bill takes necessary steps to address these concerns by:

1. Requiring transparency – Utilization review entities must report data on prior authorization decisions, providing valuable insight into approval rates, processing times, and the impact on patient care.

2. Establishing clear timelines – The bill sets deadlines for prior authorization approvals to reduce delays for both urgent and non-urgent services.

3. Creating the Health Care Appropriateness and Necessity Working Group – This group will evaluate and recommend improvements to expedite the prior authorization process.

Conclusion

HB250 HD1 is a critical step toward a more efficient, transparent, and patient-centered prior authorization system. By reducing unnecessary administrative burdens, we can improve patient access to timely care while supporting healthcare providers in delivering high-quality services.

We respectfully urge the committee to pass HB250 HD1 with our recommended amendment to include an APRN on the Health Care Appropriateness and Necessity Working Group.

Mahalo for the opportunity to provide testimony in strong support of this important bill. Please do not hesitate to contact us if additional information is needed.

Respectfully,

Dr. Jeremy Creekmore, APRN
HAPN President

HB-250-HD-1
Submitted on: 2/10/2025 9:11:10 AM
Testimony for CPC on 2/11/2025 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Robert Thomas Carlisle, MD, MPH	Hawaii Academy of Family Physicians (HAFP)	Support	Written Testimony Only

Comments:

HOUSE COMMITTEE ON HEALTH

Rep. Scot Z. Matayoshi, Chair

Rep. Cory M. Chun, Vice Chair

Date: February 10, 2025

From: Legislative Committee, Hawai‘i Academy of Family Physicians (HAFP)

Robert Carlisle, MD, MPH

RE: HB250; RELATING TO UTILIZATION REVIEW, PRIOR AUTHORIZATION, AND THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY (SHPDA)

Position: Support

Thank you for allowing testimony on HB250. The Hawai‘I Academy of Family Physicians endorses the need to mitigate the profound adverse impact of prior authorization burden leading to frustration of patients and physicians seeking appropriate health care. SECTION 1 of HB250 recites some of the statistics involved.

There are at least eight bills before the legislature this session, and all contain important elements to improve the burden of prior authorization affecting the people of Hawai‘i. We endorse HB250 with the following comments.

Section 2, 342D, page 5, section (b), page 5, line 19 states that any health care facility or health care professional who fails to submit the information requested pursuant to subsection (b)(2) within twenty-hour hours shall submit a new prior authorization request. An algorithm that leads to health care providers having to submit new prior authorization requests if information clarification is not provided within 24 hours for non-urgent requests may actually worsen the burden of prior authorization and be a step backwards in attempts to optimize the delivery of safe and smart health care.

We appreciate the changes from the original Appropriateness and Necessity Commission and look forward to ongoing refinement, here being labeled a working group.

In addition to the actions included in HB250, HAFP endorses the following considerations for prior authorization reform in Hawai‘i.

- Access to transparent authorization requirements that are free of charge to patients and health care providers
- Authorizations of services are valid for one year or the duration of treatment course—whichever is longer
- Review of appeals for denied services will be executed with an insurer physician who typically manages the medical condition
- Prohibition on prior authorization requirements for medication use for opioid disorder; for buy-and-bill provision of services for family planning and reproductive health pharmaceuticals and supplies; and for the associated medical services
- Rollover of authorized services from one insurer to another for a designated period
- Exemption of physicians from prior authorization if their approval rate exceeds a set standard

Thank you for allowing Hawai‘i Academy of Family Physicians to testify on this.

‘Ahahui o nā Kauka

677 Ala Moana Blvd., Suite 1015
Honolulu HI 96813
Phone 808.548.0270
E-mail huikauka@gmail.com

February 10, 2025

COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Scot Z. Matayoshi, Chair Rep.
Cory M. Chun, Vice Chair Rep.
Greggor Ilagan Rep. Nicole E. Lowen Rep. Linda Ichiyama Rep. Lisa Marten Rep. Kim Coco Iwamoto Rep. Adrian K. Tam Rep. Sam Satoru Kong Rep. Elijah Pierick

Group Testimony in Support of
HB250HD1 RELATING TO HEALTH (Prior Authorization)

'Ahahui o nā Kauka is an organization of Native Hawaiian physicians dedicated to the health of the people of Hawai'i and Native Hawaiians in particular. Prior Authorization requirements levied by health insurers have become a rampant source of frustration for both physicians and patients by covertly undermining our professional authority, doctor-patient relationships, and trust in the entire health care system. In his 2024 ruling, Judge Robert Kim concluded these types of requirements are “unconscionable” with the case exposing many examples of the cruel effects wrought by these policies. Unfortunately, prior authorizations are so widely utilized by insurers that they have become standard care (or lack thereof) rather than rare aberrations. Furthermore, the variability, lack of transparency, and lack of accountability in navigating appeals to these policy decisions compound the problem.

In rural and disenfranchised communities, including many Native Hawaiians, the damage caused by prior authorization policies are magnified. As these communities attempt to navigate the many barriers to accessing care, these policies all too often result in patients giving up and accepting the negative outcomes of the lack of care. We have pleaded with insurance plans to amend these universally applied policies to allow us to use our professional discernment to provide appropriate and timely care to meet the needs of the individual patient, and we have pleaded with our patients to have faith that the insurers will eventually do the right thing and approve their care. Still, it is no surprise prior authorization policies drive many of our patients to conclude the healthcare system never did and never will care for them.

We strongly support increasing accountability and transparency for health insurers by requiring them to share prior authorization policy data with the State Health Planning and Development Agency.

Hawaii Medical Association
1360 South Beretania Street, Suite 200 • Honolulu, Hawaii 96814
Phone: 808.536.7702 • Fax: 808.528.2376 • hawaiimedicalassociation.org

HOUSE COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Representative Scot Z Matayoshi, Chair
Representative Cory M Chun, Vice Chair

Date: February 11, 2025
From: Hawaii Medical Association (HMA)
Jerald Garcia MD - Chair, HMA Public Policy Committee

Re: HB 250 HD1 RELATING TO HEALTH - Prior Authorization; Utilization Review Entities; Reporting; Health Care Appropriateness and Necessity Commission; State Health Planning and Development Agency
Position: Support with amendments

Time-consuming Prior Authorization (PA) processes delay patient care. Healthcare providers struggle to overcome PA barriers that impede the evaluation, diagnosis and treatment of their patients and divert valuable time and resources from direct patient care. This leads to lower rates of patient adherence to treatment, as well as harmful negative clinical outcomes.

This measure would require utilization review entities to submit data relating to the PA of health care services to the State Health Planning and Development Agency and establishes the Health Care Appropriateness and Necessity Commission within the State Health Planning and Development Agency.

The disclosure and reporting of the relevant payor utilization data of PA is imperative for meaningful analyses of challenges, and a body for oversight is necessary to address deficiencies as well as monitor progress. Given the complexities of PA and healthcare delivery, modifications and revisal will require ongoing assessment and review over time. HMA supports the intent of this measure. The work to eliminate PA barriers should also include specific provisions to reduce time delays and volumes of PA, improve transparency and ensure high quality review of care delivery for Hawaii patients, bridging PA policy gaps that may continue to exist otherwise.

HMA appreciates the proposed HLT changes of HB 250 to include the establishment of a Health Care Appropriateness and Necessity Working Group, rather than a commission; and to include laboratory and diagnostic tests to the list of services to be assessed by the Working Group.

With regard to the proposed establishment of timelines for the approval of prior authorization requests for non-urgent health care services (Chapter 323D, Hawaii Revised Statutes), HMA supports the following:
A prior authorization request submitted pursuant to subsection (a) shall be deemed approved forty-eight hours after the submission.

HMA respectfully recommends changes to subsection c as follows (new language is in red):

(c) **i) The utilization review entity should provide detailed transparent justification for questions on medical necessity, relevant plan provision, coverage criteria citation, narrative explanation; also provide covered alternative treatment; and detail additional info requirements, appeal options, actions needed to obtain coverage or additional information or selecting an alternative treatment option identified by the plan.**

ii) Any health care facility or health care professional who fails to submit the information requested pursuant to subsection (b)(2) within ~~twenty-four hours~~ **two weeks** shall submit a new prior authorization request.

HMA also respectfully requests these additions/amendments for consideration:

REDUCTION OF PA DELAY AND UNNECESSARY VOLUME (language is taken from HB 954)

Repeat prior authorization is prohibited for chronic unchanged conditions.

Retroactive or retrospective prior authorization denials are prohibited, unless:
(1) The health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from a utilization review entity;
(2) The health care service was no longer a covered benefit on the day it was provided;
(3) The health care provider was no longer contracted with the patients' health insurance plan on the date the care was provided;
(4) The health care provider failed to meet the utilization review entity's timely filing requirements;
(5) The utilization review entity is not liable for the claim; or
(6) The patient was no longer eligible for health care coverage on the day the health care was provided.

Length of prior authorization. A prior authorization shall be valid for a minimum of one year from the date the enrollee or the enrollee's health care provider receives the prior authorization and shall be effective regardless of any changes in dosage for a prescription drug prescribed by the health care provider.

Duration of prior authorization for treatment for chronic or long-term care conditions. If a utilization review entity requires a prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization shall remain valid for the duration of

the treatment and the utilization review entity shall not require the enrollee to obtain a new prior authorization again for the health care service.

Continuity of care for enrollees; prior authorization transfers.

(a) Upon receipt of information documenting a prior authorization from the enrollee or from the enrollee's health care provider, a utilization review entity shall honor a prior authorization granted to an enrollee from a previous utilization review entity for at least the initial ninety days of an enrollee's coverage under a new health plan.

(b) During the time period described in subsection (a), a utilization review entity may perform its own review to grant a prior authorization.

(c) If there is a change in coverage of, or approval criteria for, a previously authorized health care service, the change in coverage or approval criteria shall not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's plan year.

(d) A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same health insurance company.

Gold card or exemption program for providers

Prior authorization exemptions for health care providers.

(a) A utilization review entity shall not require a health care provider to complete a prior authorization request for a health care service for an enrollee to receive coverage; provided that in the most recent twelve-month period, the utilization review entity has approved or would have approved not less than eighty per cent of the prior authorization requests submitted by the health care provider for that health care service, including any approval granted after an appeal.

(b) A utilization review entity may evaluate whether a health care provider continues to qualify for exemptions as described in subsection (a) not more than once every twelve months. Nothing in this subsection shall be construed to require a utilization review entity to evaluate an existing exemption or prevent a utilization review entity from establishing a longer exemption period.

(c) A health care provider shall not be required to request for an exemption to qualify for an exemption pursuant to this section.

(d) A health care provider who is denied an exemption pursuant to this section may request evidence from the utilization review entity to support the utilization review entity's decision at any time, but not more than once per year per service. A health care provider may appeal a utilization review entity's decision to deny an exemption.

(e) A utilization review entity may revoke an exemption only at the end of the twelve-month period described in subsection (b) if the utilization review entity:

(1) Determines that the health care provider would not have met the eighty per cent approval criteria based on a retrospective review of the claims for the particular service for which the exemption applies for the previous three months, or for a longer period if needed to reach a minimum of ten claims for review;

(2) Provides the health care provider with the information the utilization review entity relied upon in making its determination to revoke the exemption; and

(3) Provides the health care provider a plain language explanation of how to appeal the decision.

(f) An exemption shall remain in effect until the thirtieth day after the date the utilization review entity notifies the health care provider of its determination to revoke the exemption or, if the health care provider appeals the determination, the fifth day after the revocation is upheld on appeal.

(g) A determination to revoke or deny an exemption shall be made by a health care provider licensed in the State of the same or similar specialty as the health care provider being considered for an exemption and have experience in providing the service for which the potential exemption applies.

(h) A utilization review entity shall provide a health care provider that receives an exemption a notice that includes:

(1) A statement that the health care provider qualifies for an exemption from preauthorization requirements;

(2) A list of services to which the exemptions apply; and

(3) A statement of the duration of the exemption.

(i) A utilization review entity shall not deny or reduce payment for a health care service exempted from a prior authorization requirement under this section, including a health care service performed or supervised by another health care provider when the health care provider who ordered the health care service received a prior authorization exemption, unless the rendering health care provider:

(1) Knowingly and materially misrepresented the health care service in request for payment submitted to the utilization review entity with the specific intent to deceive and obtain an unlawful payment from the utilization review entity; or

(2) Failed to substantially perform the health care service.

QUALITY (language is taken from HB 954)

Medically necessary; Clinical criteria – Utilization review entities must use appropriate criteria that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

(1) In accordance with generally accepted standards of medical practice;

(2) Clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider.

Prior authorization review; adverse determination personnel; qualifications; criteria. A utilization review entity shall ensure that all adverse determinations are made by a physician who:

(1) Possesses a current and valid non-restricted license issued pursuant to chapter 453;

(2) Is of the same specialty as a physician who typically manages the medical condition or disease or provides the health care service subject to the review;

(3) Have experience treating patients with the medical condition or disease for which the health care service is being requested.

TRANSPARENCY (language is taken from HB 954)

Prior Authorization Transparency - Prior authorization requirements and restrictions; disclosure and notice required.

(a) A utilization review entity shall make any current prior authorization requirements and restrictions readily accessible on its website to enrollees, health care professionals, and the general public, including the written clinical criteria; provided that requirements shall be described in detail but also in easily understandable language.

(b) A utilization review entity that intends to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction shall:

(1) Ensure that the new or amended requirement or restriction is not implemented until the utilization review entity's website has been updated to reflect the new or amended requirement or restriction; and

(2) Provide contracted health care providers of enrollees with written notice of the new or amended requirement or amendment no later than sixty days before the implementation of the requirement or restriction.

(c) Any entity requiring prior authorization of any health care service shall make statistics on prior authorization approvals and denials available to the public on their website in a readily accessible format; provided that the statistics shall include categories for:

(1) Physician specialty;
(2) Medication or diagnostic test or procedure;
(3) Indication offered;
(4) Reason for prior authorization denial;
(5) If a prior authorization was appealed;
(6) If a prior authorization was approved or denied on appeal; and
(7) The time between the submission and subsequent response for a prior authorization request.

Denials - Adverse determination; notice and discussion required. Any utilization review entity questioning the medical necessity of a health care service shall notify the enrollee's physician that medical necessity is being questioned. Before issuing an adverse determination, the enrollee's physician shall have the opportunity to discuss the medical necessity of the health care service on the telephone with the physician who will be responsible for determining authorization of the health care service under review. The utilization review entity should provide justification for denials, relevant plan provision, coverage criteria citation, narrative explanation; also provide covered alternative treatment; and detail appeal options, actions needed to obtain coverage or additional information or selecting an alternative treatment option identified by the plan.

OVERSIGHT (language is taken from HB 954)

Utilization review entities; annual report to insurance commissioner [and oversight Task Force]. (a) No later than March 1 of each year, each utilization review entity shall submit a report to the insurance commissioner on prior authorization requests for the previous calendar year using forms and in a manner prescribed by the insurance commissioner, which shall include:

(1) A list of all health care services that require prior authorization;
(2) The number and percentage of prior authorization requests that were approved;
(3) The number and percentage of prior authorization requests that were denied;
(4) The number and percentage of prior authorization requests that were initially denied and approved after appeal;
(5) The number and percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved;
(6) The average and median time that elapsed between the submission of a non-urgent prior authorization request and a determination by a utilization review entity;

(7) The average and median time that elapsed between the submission of an urgent prior authorization request and a determination by the utilization review entity;

(8) The average and median time that elapsed to process an appeal submitted by a health care professional initially denied by the utilization review entity for non-urgent prior authorizations; and

(9) The average and median time that elapsed to process an appeal submitted by a health care professional initially denied by the utilization review entity for urgent prior authorizations; provided that the information required by paragraphs (2) through (9) shall be individualized for each listed health care service for each health care service listed in paragraph (1).

(b) Each utilization review entity shall make the report required pursuant to subsection (a) available to the public through the utilization review entity's website in the format prescribed by the insurance commissioner.

With establishment of a Health Care Appropriateness and Necessity Working Group, HMA recommends the following composition of members:

-Director of Health, or the Director's designee

-The Insurance Commissioner, or the Insurance Commissioner's designee

-Administrator of the Med-QUEST Division of the Department of Human Services, or the Administrator's designee

-Representative from the Professional and Vocational Licensing Division of the Department of Commerce and Consumer Affairs

-Representative from the Hawaii Association of Health Plans

-Healthcare organizations (each with a representative):

Hawaii State Center for Nursing
Hawaii Medical Association (HMA)
Hawaii State Rural Health Association
Healthcare Association of Hawaii

The working group will regularly review PA policies and make recommendations for

Ongoing reduction of volume. This requires coordinated review of PA data, trends, population health characteristics and standards of care as well as utilization use and overuse.

- Identifying drugs and services for which PA is rarely denied, have high approval rates on appeal, are important to provide expeditiously
- Examine PA that disproportionately impacts marginalized patients

Review of validity, clinical criteria. Regular systematic review and updates for changes in population health characteristics, standards of care and scientific information that will allow for continued informed decisions on the safety and needs to apply PA or lift PA restrictions.

HMA strongly supports Prior Authorization policies and continued oversight that may reduce patient and provider burdens, improve patient access and facilitate the timely delivery of high quality and safe medical care.

Thank you for allowing the Hawaii Medical Association to testify in support of this measure with amendments.

REFERENCES AND QUICK LINKS

Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). CMS Interoperability and Prior Authorization Final Rule (CMS-0057-Fhttps://www.cms.gov/files/document/cms-0057-f.pdf

American Medical Association. Issue Brief: Federal Changes to Prior Authorization Rules and their Impact on State Legislative Efforts. https://cdn.ymaws.com/hawaiimedicalassociation.org/resource/resmgr/advocacy/prior_auth_issue_brief_on_fe.pdf

American Medical Association. 2023 AMA Prior Authorization (PA) Physician Survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf Accessed Jan 28 2025.

American Association of Family Physicians (AAFP). Prior Authorization. https://www.aafp.org/family-physician/practice-and-career/administrative-simplification/prior-authorization.html Accessed Jan 28 2025.

HB-250-HD-1
Submitted on: 2/10/2025 11:57:10 AM
Testimony for CPC on 2/11/2025 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Jerald Garcia, M.D.	Hawaii Medical Association	Support	Remotely Via Zoom

Comments:

Please refer to the testimony of the Hawaii Medical Association

An Independent Licensee of the Blue Cross and Blue Shield Association

February 11, 2025

The Honorable Scot Z. Matayoshi, Chair
The Honorable Cory M. Chun, Vice Chair
House Committee on Consumer Protection & Commerce

Re: HB250- RELATING TO HEALTH

Dear Chair Matayoshi, Vice Chair Chun, and members of the committee;

Hawaii Medical Service Association (HMSA) **opposes** the current version of HB 250 HD1, which 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 timelines for the approval of prior authorization requests for urgent and non-urgent health care services, and establishes the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency.

We thank the legislature for recognizing the importance of prior authorization (PA). It is one of many important components that help to keep health care premiums affordable and will continue to help ensure the long-term sustainability of Hawaii's overall healthcare system. We are committed to working with all stakeholders to improve the prior authorization process while also ensuring the highest quality of care for our members. While we understand the challenges provider face and support the intent of PA reform, we **do not support the changes inserted in the HD1** (page 4, line 14 to page 7, line 2) to establish unrealistic timelines for the approval of PA requests, especially in light of new 2026 PA requirements that will already significantly improve the timeframes.

We also want to note that PA is in place to mitigate misuse, ensure quality care for members, and ultimately contribute to affordability of premiums for employers and individuals. Unrealistic timelines would clog the system and could lead to negative outcomes for provider, patients, and have a significant impact on increasing member premiums. We estimate that EUTF and QUEST, which make up a large percentage of our membership would be impacted by upwards of $25 million.

2026 Prior Authorization Improvement Requirements
We want to note for the committee that there are already pending new requirements for prior authorization on the near horizon that will address many of concerns raised about PA. Beginning in 2026, new CMS requirements[1] will streamline and reduce the burden associated with PA processes by including shortening the timeframe for PA decisions, promoting greater transparency for medical necessity criteria, strengthening PA reporting, and improving the adoption of electronic PA processes and the electronic exchange of health care information. With the new 2026 requirements quickly approaching, we believe this measure is not necessary at this

[1] https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

time and it would be premature to put any new PA requirements in statute as health plans are already working towards alignment with these new regulations.

HMSA Prior Authorization
HMSA currently meets, and typically exceeds, Centers for Medicare & Medicaid Services and National Committee for Quality Assurance timeliness requirements for PA. PA does not apply to emergency care or care that members receive when hospitalized. Of our 17 million claims processed last year, only 204,000 (1%) required PA. Of these 81,600 (40%) did not require submission. 163,200 (80%) of the PA submissions we receive are via fax machine despite the availability of an online option increasing errors and requiring additional time for review and communication. Large numbers of claims are also incomplete or have incorrect documentation and require multiple back and forth communications forcing longer timeframes for decisions. We want to thank Hawaii Medical Association (HMA) for their leadership and partnership as we continue to work with our provider partners to make progress in these areas. HMSA is committed to forward progress and we have already participated in and convened conversations around solutioning around administrative burden, eliminated PA requirements for certain procedures, expanded our Fast Pass Program for qualifying providers, and are moving towards a fully integrated and digitized PA process to further improve accuracy, efficiency, and turnaround time and minimize errors and administrative burden. We are certainly open to continuing the conversations around PA improvement, again, noting above that this measure may be premature given the aforementioned approaching federal regulations.

We also want to note that there is a Senate version of this bill, SB1449, which we feel more clearly captures the intent of PA improvements including reporting.

With that in mind, and should the committee still choose to move this measure forward, we ask the committee to consider the following critical amendments:

1. **Amending Section 2:**
    a. **To replace all references to ~~chapter 323D~~ with chapter 431:2** as the Insurance Commission is the appropriate oversight body for health plans in Hawaii.

    b. **(Page 4, line 1-13) Amend Prior authorization; reporting** (parts a and b)
        i. to replace all instances of "~~utilization review entity~~" with "health plan".
        ii. to replace all instance of "~~state agency~~" with "insurance commissioner".

    c. **Amend page 4, line 6-8** to include prior authorization reporting of aggregate data instead of individual reports to ensure no breach of antitrust laws:
        i. The ~~state agency~~ insurance commissioner shall post ~~each report~~ the aggregate data on its

website no later than three months before the start of the subsequent reporting period.

d. **Delete page 4, line 14 to page 7, line 2** since this is unnecessary as shortened timeframes will already be required beginning in 2026 by new CMS regulations.

e. **(Page 7 line 3 to Page 10 line 20) Replace the Health care appropriateness and necessity workgroup, established** section with:

§431:2- Prior authorization working group; established.

(a) There is established the prior authorization working group to consider the issues of administrative burden in the health care delivery system convened by the insurance commissioner. The working group shall assess and evaluate the prior authorization process, identify inefficiencies and pain points for stakeholders, and make recommendations to improve speed, transparency, and overall efficiency. The working group shall consider:

(1) Evaluation of current prior authorization practices;

(2) Alignment with current and pending prior authorization regulations;

(2) Potential for digitization and technology;

(3) Compliance and risk review;

(4) Incorporation of electronic health records to maximize efficiency in the prior authorization process;

(5) Best practices of other states that have adopted policies to streamline prior authorization processes.

The working group shall submit a report of its findings and recommendations to the legislature no later than June 31, 2026.

(b) The working group established pursuant to this Act shall be convened by the Insurance Commissioner. The working group shall include:

An Independent Licensee of the Blue Cross and Blue Shield Association

(1) The state Insurance Commissioner, or Commissioner's designee;

(2) The director of the department of health, or the director's designee;

(3) The administrator of the State Medicaid agency, or designee;

(4) The administrator of the State Health Planning and Development Agency, or designee;

(5) A representative from the Hawaii Medical Association;

(6) A representative from the Hawaii Association of Health Plans;

(7) A representative from the Healthcare Association of Hawaii; and

(8) A representative of the consumer or patient advocacy community.

(c) The working group shall cease to exist on July 1, 2026.

Thank you for the opportunity to testify on this very important measure.

Sincerely,

Dawn Kurisu
Assistant Vice President
Community and Government Relations

Hawaii Association of Health Plans

February 11, 2025

To: Chair Matayoshi, Vice Chair Chun, and Members of the House Committee on Consumer Protection and Commerce (CPC)
From: Hawaii Association of Health Plans Public Policy Committee
Date/Location: February 11, 2025; 2:00 pm/Conference Room 329 & Videoconference

Re: Testimony with comments on HB 250 HD1 – Relating to Health.

The Hawaii Association of Health Plans (HAHP) appreciates the opportunity to offer comments and to share our concerns regarding HB 250 HD1. HAHP is a statewide partnership that unifies Hawaii's health plans to improve the health of Hawaii's communities together. A majority of Hawaii residents receive their health coverage through a plan associated with one of our organizations.

HAHP appreciates the efforts of lawmakers to address prior authorization improvements and want to emphasize that we believe prior authorization continues to be a critical process that is constantly evolving and is critical to ensuring quality patient care. We recognize the importance of addressing concerns of providers and are committed to continuing to work with stakeholders to improve the issue, however, we are concerned that the addition of new statutory requirements and timeframes that do not align with current best practices or regulations could pose unintended negative consequences to a process we are already working diligently to improve.

HAHP believes this is a nuanced and complicated issue, with multiple bills in both houses this session. We would be willing to participate in further conversations with lawmakers and stakeholders.

Thank you for your consideration and the opportunity to testify on HB 250 HD1.

Sincerely,

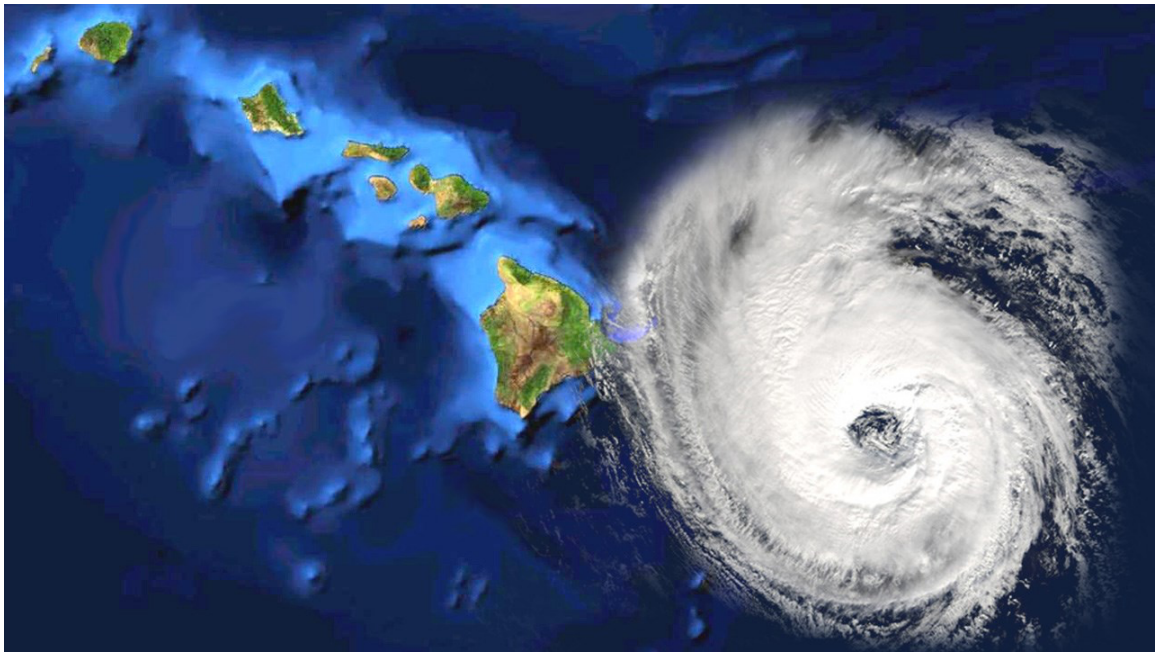
HAHP Public Policy Committee
cc: HAHP Board Members

LATE

Perfect Storms
The Hawaii Physician Shortage Crisis
6th Edition. 2025

You could be a meteorologist all your life and never see something like this. It would be a disaster of epic proportions……the perfect storm."

The Perfect Storm: Sebastian Junger



"The physician shortage that we have long feared—and warned was on the horizon—is already here. It's an urgent crisis … hitting every corner of this country—urban and rural—with the most direct impacting hitting families with high needs and limited means.

Imagine walking into an emergency room in your moment of crisis—in desperate need of a physician's care—and finding no one there to take care of you."

Doctor Jesse M. Ehrenfeld, MD, MPH
President of the American Medical Association
10/25/23 National Address

John Lauris Wade MD
Hawaii Provider Shortage Crisis Task Force

The Perfect Storm

"The Annual Report to the Legislature on Findings from the HI Physician Workforce Assessment Project" is prepared annually by the HI/Pacific Basin Area Health Education Center, John A. Burns School of Medicine at the University of Hawai'i.

The most recent report released in December 2024 demonstrates:
A 41% shortage of physicians on Maui.
A 40 % shortage of physicians on the Big Island.
A 21% shortage of physicians statewide.

We do not have enough Doctors.

In 2024, the Healthcare Association of Hawai'i counted 34,181 total non-physician healthcare positions in the state. 4,669 or 14% were unfilled. Neighbor Island job openings were uniformly higher than on Oahu. In 2022, there were 3873 unfilled healthcare positions. In 2020 there were 2200. The number of unfilled healthcare positions more than doubled in four years.

We do not have enough Healthcare Workers.

Data published by the Association of American Medical Colleges indicate the United States will see shortages of nearly 122,000 physicians by 2032. Healthcare Worker shortages are also increasing. The major driver is a growing and aging population. Doctors and healthcare workers are also aging and retiring. One third of currently active doctors will be older than 65 within the next decade.

HI Physician and Healthcare Worker Shortages must be assessed within a context of a dwindling national supply of such workers. Understandably, the Physician Shortage has received the most attention from government, patients, and media. That said, the Physician Shortage is only a proxy for a hollowed out Hawaii Healthcare System.

The Physician Workforce Shortage

In 2024, there were 12,000 physicians licensed in Hawai'i. Of these, 3772 currently provide patient care to people of the State. Some of these physicians work part time. As such, the cadre of physicians provide a full time equivalent (FTE) of 3075 doctors.

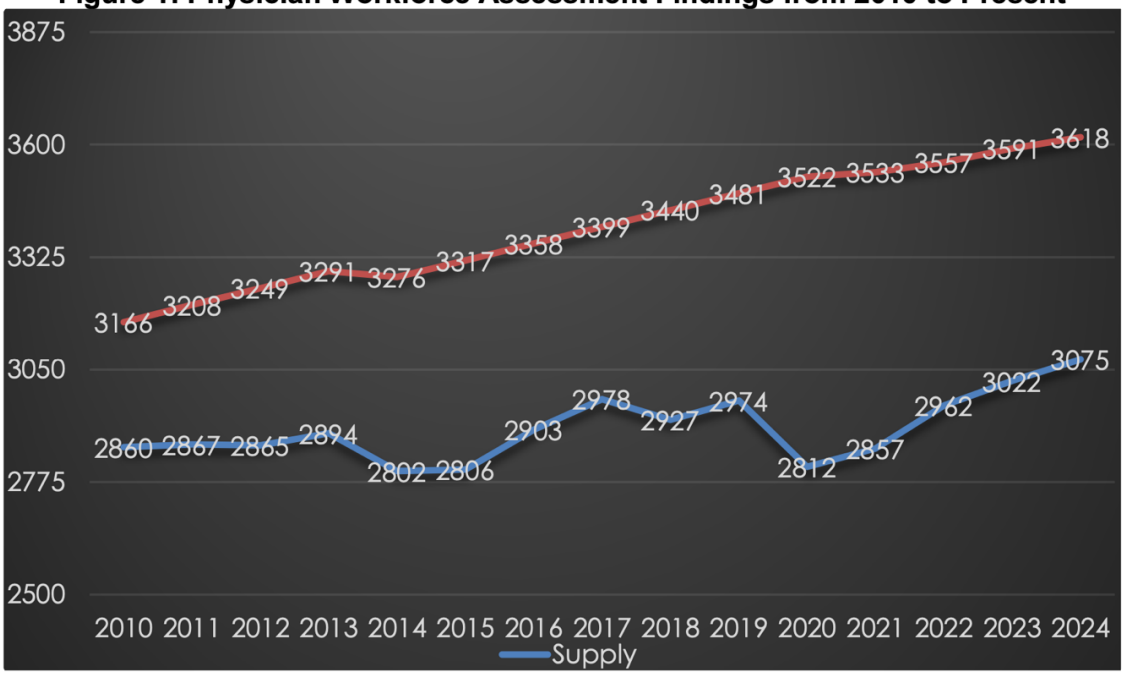
For 15 years, the HI Physician Workforce Assessment Project has studied the ongoing Physician Workforce Shortage.

Measured by FTE, the following graph demonstrates the shortage over time.

The red line measures total physician full time equivalents needed (Demand).
The blue line measures total physician full time equivalents in practice (Supply).

Supply and demand are not adjusted for specialty coverage needs on neighbor islands

Figure 1: Physician Workforce Assessment Findings from 2010 to Present



Takeaways

1. Unadjusted statewide demand for Physicians is up 14.3% since 2010.
2. Unadjusted statewide supply is up 7.5% in the same period.
3. Demand has outstripping supply for at least 15 years.
4. Supply versus Demand "Gap" has increased from 306 to 543.
5. Supply versus Demand "Gap" has increased 77% over 15 years.

Hawaii's unique geographic exacerbates physician shortages. Hawaii is an Island State. As such, an adequate supply of Specialist Physicians on Oahu does not address the dearth of such specialists on Neighbor Islands. Neighbor Islands need their own basic set of specialists to provide basic medical care to their residents.

As such, the Workforce Assessment Project made adjustments to its model to account for the need for basic array of specialty physicians on each Neighbor Island. The following table shows Physician Shortages adjusted for such needs.

Table 2: Physician Shortage by County (Prior year numbers in parentheses)

	Hawai'i County	Honolulu County	Kaua'i County	Maui County	Statewide
Shortage	**201 (206)**	**328 (318)**	**43 (52)**	**174 (181)**	**768 (757)**
Percent	**40% (41%)**	**13% (13)**	**24% (30)**	**41% (43)**	**21% (21)**

The 2024 unadjusted shortage of physicians is 543. The 2024 adjusted shortage of physicians, allowing for the needs of Neighbor Islands, 768.

Readers with a good memory might recall that the Big Island Physician Shortage measured 53% in 2020. It currently measures 40%. The statewide shortage was 29% in 2020. It currently measures 21%.

This "improvement" is an illusion. The mathematical methodology or formula to assess need was changed. The total number of physicians practicing in Hawaii changed very little.

Hawaii's total number of FTE Physicians in pre-pandemic 2019 was 2974. That number is now 3075. We have gained very little ground.

Unadjusted Physician Demand is currently 3719 full time equivalent doctors. Supply is 3075. That is an unadjusted shortage of 543 doctors.

When adjusting for Island Geography, the estimated unmet need increases to 768.

Hawai'i needs to attract and retain 768 physicians

Healthcare access for our most vulnerable patients is at stake.

Hawaii's Healthcare Future

Hawaii residents deserve excellent healthcare. Excellence is driven by attention to quality, cost, and access.

Despite significant and increasing shortages of Physicians and Healthcare Workers, Hawaii has continued to deliver excellent healthcare.

In 2023 the United Health Foundation ranked Hawaii the 6th healthiest state in the nation. In 2022, Hawaii ranked 4th. In 2020, Hawaii ranked 3rd. The ranking includes measures of healthy behavior, quality of health care when delivered, health policy, the presence of disease, and measures of deaths from illness.

While still excellent, Hawaii's rank among the healthiest states shows some fraying, falling three spots in three years. Physician and healthcare worker shortages threaten this ranking, particularly when serving economically vulnerable patients.

Attracting and retaining Physicians and Healthcare Workers must be a priority. That said, there are considerable challenges.

Physician and Healthcare Workers Decide

Many factors are involved when choosing a state in which to work and practice medicine. A short list might include school system, local health care, the local economy, state fiscal stability, infrastructure, job opportunity quality, crime, recreational opportunities, and environment.

Medscape 2024 ranks HI in the 4th best state to Practice Medicine when lifestyle measures are heavily weighted. "The healthiest state in the US, according to Forbes, Hawaii ranked number one in the nation for residents' low disease risk and healthy lifestyle habits. With its beautiful beaches and unique culture, the Aloha State also had a low physician burnout rate and middling malpractice insurance premiums compared with other states. Hawaii does, however, sport a high cost of living, high taxes, and uncompetitive salaries."

Wallet Hub 2024 ranks HI the 50th worst State to Practice Medicine, 51st if you include the District of Columbia. Wallet Hub weighs economic issues heavily. What use are beautiful beaches and a unique culture if you cannot afford to live there.

World Population Review 2024 shows what you must accept when living in Hawaii.

- HI Cost of Living 193% higher than the National Average
- HI Housing Costs 315% higher than the National Average.
- HI Utility Bills 164% higher than the National Average.
- HI Grocery Bills 153% higher than the National Average.
- HI Transportation Costs 134% higher than the National Average

Hawai'i has the highest cost of living in the nation

Combining the highest cost of living in the nation with the nation's worst annual wages adjusted for cost living is a near insurmountable obstacle to the rebuilding of the Hawai'I Healthcare Work Force.

Storm Front 1:
Inadequate Federal Payments for Medical Services

Powerful Central Pacific Hurricanes begin as small tropical depressions within the Gulf of Tehuantepec. Similarly, the Hawaii Medicare Crisis begins as a barely noticed feature of the Physician Medicare Payment Formula: GPCI.

Medicare's Primacy

Physician practice revenue has three sources: Medicare and Tricare, Medicaid, and private third party Health Insurers. Medicare payments are based on a formula set by Federal Government. Hawaii Medicaid payments are par with Medicare. Private Health Care Insurers base payment schedules on Medicare. Discussions of Medical Practice revenue streams should largely center on the Medicare Program.

Medicare Payments

Payments are adjusted for geographic differences in market condition and business costs. These geographic adjustments intend to ensure provider payments reflect local costs of rendering care, so Medicare does not overpay in certain areas or underpay in others. The adjustment mechanism is called a GPCI or Geographic Price Cost Indices.

On a simple level Medicare calculates a physician payment as follows.

Payment = (Work RVU * Work GPCI) * Conversion Factor (CF).

Physician compensation largely depends on what task was performed (Work RVU) and where (Work GPCI). This is then converted into dollars by (CF). Small additional payments are added for practice expense and malpractice costs.

Payments are not designed to account for variations in cost of living. CMS does not adjust payments to address workforce shortages or other policy goals. CMS takes the position that preserving access to care and other policy goals must be achieved explicitly through legislation.

Medicare uses a Geographic Practice Cost Index (GPCI) to address cost differences across between different geographic locations.

GPCI: Geographic Price Cost Indices

The Actuarial Research Corporation recalculates Work GPCI every three years. The most recent GPCI update was for the Calendar Year and published in the 2023 Medicare Physician Fee Schedule. The next proposed update is expected for Calendar Year 2026. The 2023 GPCI for physician work is currently 1.0.

Work GPCI attempts to capture relative costs of physician labor in a defined geographic area. It does so by comparing non-physician labor in the area to national labor markets using Bureau of Labor and Statistics Data. In other words, GPCI is essentially a ratio of the

compensation of seven occupation groups in HI relative to the compensation of the same seven groups in the national labor market. As such, HI physician compensation is pegged to market forces experienced by an array of professionals in Hawaii.

The following table shows Hawaii and National Market compensation for the seven occupational groups used to calculate GPCI. This is 2019 Data from the US Bureau of Labor and Statistics.

Occupation Group	HI	NatMarket	HI Delta
Architecture and Engineering	$82,600	$88,800	-7.0%
Computer, Math, Life, Physical Science	$81,790	$93,760	-12.8%
Legal	$86690	$109,630	-21%
Education, Training, Library	$54770	$57,710	-5.1%
RN	$104060	$77460	+34.3%
Pharmacists	$129360	$125,510	+3.1%
Art, Design, Entertainment, Sports, Media	$57580	$61960	-8.1%

Note 5 of 7 occupational groups used to calculate GPCI make less or substantially less than cohorts outside Hawaii. Actuarial Research Company calculates HI GPCI at 1.000. This is only slightly better than the legal minimum of 1.0.

This imbalance and its effect on GPCI has been examined at length by the Economic Research Organization at the University of Hawai'i (UHERO). "

"Hawai'i's endowment of natural amenities pushes up the cost of housing and doing business, but reduces wages that are required to attract higher-income workers when they are willing to forego higher wages in order to access and enjoy the amenities of living in Hawai'i. This compresses the wage distribution with higher wages for low-wage jobs and lower wages for high-wage jobs."

HI Physician Medicare rates are low because comparison professional incomes are low.

Medicare GPCI and its Effect on Payments

Medicare pays for physicians' services under Section 1848 of the Social Security Act. The Act requires payments be based on a national uniform Relative Value Unit system. The basic concept and methodology of current Medicare healthcare payments, known as the Resource-Based Relative Value Scale (RBRVS), were enacted in the Omnibus Budget Reconciliation Act of 1989 (OBRA) and implemented by CMS in 1992.

As previously noted, Hawaii GPCI is 1.000 and nationally, GPCI ranges between 1.0 and 1.02 in 62 of the 112 United States CMS designated geographic areas. In some geographic areas, GPCI is substantially higher.

The following illustrates how GPCI affects a payment for a $100.00 medical service.

State	GPCI	Payment
Ohio	1.0	$100.00
Hawaii	1.000	$100.00
California:	1.026-1.089	$102.60-108.8
Alaska:	1.50	$150.00

Hawaii Medicare payments are beyond unfair and inflict unmitigated harm on the State of Hawaii and its residents. Hawaii Healthcare Providers are paid as if they practice in a low cost State.

US Congressman Ed Case (D-HI)

"Medicare policy has long failed to account for the unique costs of providing medical services in Hawai'i" and "will likely lead directly to an accelerating shortage of health care providers across our state, especially in rural areas like the Neighbor Islands and more vulnerable communities."

Congressman Case's statement is supported by Data comparing the costs of living and doing business. World Population Review has published 2024 Cost of Living Index State by State. Hawaii is the highest cost state in the nation in which to live and work, far exceeding California and Alaska.

Hawaii and Comparison States Cost of Living

Hawaii	193
California	142
Alaska	124
The United States Cost Index	100
Ohio	94

The Hawaii Cost of Living is more than double Ohio, 92% higher than the US, 56% higher than Alaska, and 36% higher than California. Again, there is a disconnect between Hawaii Medicare Payments and reality. The lack of a Medicare Formula answer to these disparities place Hawaii's most vulnerable communities at risk.

What Cost Change?

By statute, changes to GPCI that do not explicitly receive additional funding must be budget neutral within Medicare. In practice, budget neutrality means that total Medicare Expenditure is unaffected by GPCI adjustments. Any adjustment upward for one payment location must be paid for by downward adjustments for other areas. This requirement can create tensions between providers in high-cost versus low-cost areas. However, there is no net cost to the Federal Government or Taxpayer. Medicare dollars are simply and fairly redistributed.

Alaska: A Brief History of Alaska Medicare

Did you notice the Alaska GPCI of 1.5? It is an outlier. Alaska faces an array of healthcare delivery challenges resulting in high-cost health care cost. Alaska has a small population (731,500) and is geographically isolated from the rest of the United States. The population is widely distributed including remote areas not connected by roads. There are a limited number of medical service providers. There is limited competition among providers, especially specialty physicians due to a limited number of specialists in more remote areas. There is fragmentation and duplication of services driven by geography.

These challenges were exacerbated by, and in turn drove, Alaska's high health care costs in the face of an inadequate Medicare reimbursement system. By 2008, Medicare beneficiaries were experiencing significant challenges to obtaining access to services.

In 2008, the Federal Government responded to Alaska's issues and passed the Medicare Improvements for Patient and Providers Act of 2008 (MIPPA or HR 6331). The Act repealed two statutorily mandated physician payment cuts totaling near 15%. The Act also set the Alaska Work GPCI to 1.5. This did not change with passage of the Patient Protection and Affordability Act in 2010.

Hawaii: Facing Similar Medicare Challenges

While a comparison to Alaska has limitations, Hawaii experiences healthcare delivery challenges very similar to Alaska.

Hawaii faces an array of healthcare delivery challenges resulting in high health care costs. Hawaii has a small population (1,430,880) and is geographically isolated from larger markets by the Pacific Ocean. The Jones Act, and its limitation on shipping, exacerbates isolation. Within state, population is widely distributed on multiple islands dependent on air travel. There are a limited number of medical service providers. There is limited competition among providers, especially specialty physicians due to a limited number of specialists on Neighbor Islands. There is fragmentation and duplication of services driven by Maritime Geography.

These challenges exacerbate, and in turn drive, Hawaii's high health care costs, in the face of an inadequate Medicare reimbursement system. Hawaii currently has the lowest percentage of Physicians accepting Medicare in the Nation. Similar challenges and patient access issues encountered by Alaska years ago were addressed by raising the Physician Work GPCI to 1.5.

2021 United States per beneficiary annual Medicare spending was $11,080.
2021 Alaska per beneficiary Medicare spending was $9939, 17th lowest in the Nation.
2021 Hawai'i per beneficiary Medicare spending was $7472, the lowest in the Nation.

Raising the Alaska GPCI has not resulted in significant Medicare overutilization or excessive program cost.

A Simple Medicare Solution

Payments for Physician Services within Medicare are made under authority and within the guidance of Section 1848 of the Compilation of the Social Security Laws.

In 2009, the Medicare Improvements for Patients and Providers Act or MIPPA, (HR 6631 Section 134) set the work geographic index for Alaska to 1.5, if the index would otherwise be less than 1.5 and no expiration was set for this modification.

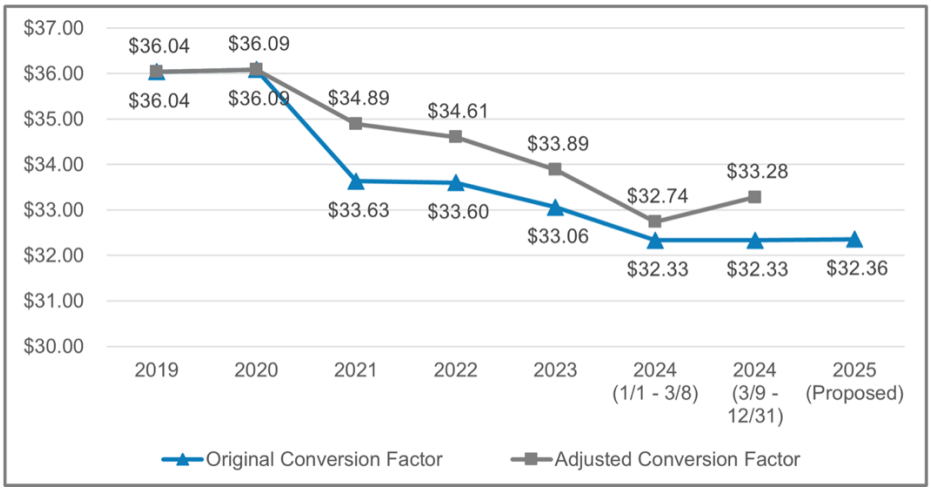
The HI Medicare issue could be addressed by requesting an amendment to the Social Security Act adding Hawaii to Section 42 U.S.C. 1395w–4(e)(1)(G)) which reads….

For purposes of payment for services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, after calculating the practice expense, malpractice, and work geographic indices in clauses (i), (ii), and (iii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.67 if such index would otherwise be less than 1.67. For purposes of payment for services furnished in the State described in the preceding sentence on or after January 1, 2009, after calculating the work geographic index in subparagraph (A)(iii), the Secretary shall increase the work geographic index to 1.5 if such index would otherwise be less than 1.5.

Medicare Cuts and Inflation

The Centers for Medicare and Medicaid Services has published the Calendar Year (CY) 2025 Medicare Physician Fee Schedule (MPFS). The rule includes a conversion factor (CF) of $32.35. This is a 2.83% reduction compared to the 2024 CF of $33.29. This is the 5th consecutive year of decreases and a 7.8% decrease from 2020. According to the American Medicare Association, provider payments declined 29% from 2001 to 2024.

Congressional Legislation could provide short-term relief from the payment cut. **The Medicare Patient Access and Practice Stabilization Act** averts the 2.83% cut and provides a payment update of 4.73%. This bill has yet to pass as of publication.



Meanwhile, cumulative inflation since 2019 is 22.7%. Physicians and Independent Providers fall into the only group not automatically getting an annual payment increase based on inflation.

Storm Front Two:
Hawaii General Excise Tax on Medical Services

In 1931 Hawaii established a traditional retail sales tax. This effort failed because the retail base was very small during the Great Depression. The sales tax was repealed and replaced by a tax on business. Tax was imposed on all transactions including services. The initial tax rate was set at 1.5%.

Currently, Hawaii levies a 4% General Excise Tax on business for the sale of goods and services. Counties levy an additional tax up to .5%. The GET currently generates more than half of Hawaii State tax revenue. A business may choose to visibly pass on the GET and any applicable county surcharge to its customers but is not required to do so. The tax is on the business, not the customer.

Hawaii General Excise Tax is levied on the gross receipts of all businesses including private medical practices. At present, Hawaii continues to tax every Medicare, Medicaid, Tricare, and Insurance dollar and remains the only state in the nation that taxes gross receipt private practice medical service revenue in this way. The Hawaii Provider Shortage Task Force and countless allies worked tirelessly for years to end the general excise taxation of healthcare services

At the conclusion of the 2024 legislative session, Governor Josh Green signed Senate Bill 1035 into law. This legislation will provide relief to the healthcare system in Hawai‘i by specifically exempting hospitals, infirmaries, medical clinics, health care facilities, pharmacies and medical and dental providers from the GET on goods or services that are reimbursed through Medicaid, Medicare or TRICARE.

Unfortunately, the bill will not take effect until January 1, 2026. For the remainder of 2025, many Hawaii Physicians will continue to pay more in combined General Excise Tax and Hawaii State Income Tax than Federal Income Tax.

Moving forward, the General Excise Tax will continue to be applied to services paid for by private insurance. This violates the Equal Protection Clause of the 14th Amendment to the United States Constitution. The clause provides “nor shall any State…deny to any person within its jurisdiction the equal protection of laws.” Individuals in similar situations must be treated equally. The GET on medical care should end.

Storm Front Three
A Payor Monopsony

The Blue Cross Blue Shield Association (BSBSA) is a national association of 33 independent, community-based and locally operated BCBS companies. The Association owns and manages BCBS trademarks and in more than 170 countries. The Association grants licenses to independent companies to use the trademark in exclusive geographic areas. BSBSA manages communications between its members as well as the operating policies required to be a licensee of the trademarks. This allows BCBSA to offer nationwide insurance coverage through its network and claims program even though licensees operate only within their designated service area.

While United Health Group is commonly viewed as having the largest healthcare insurance largest market share in the United States at 16.23%, the national footprint of BCBS companies is arguably larger. The biggest BCBS licensees Elevance Health (7.1%), Health Care Services Corporation (3.5%), Guidewell Florida Blue (1.9%), Highmark Group (1.3%), BCBS Michigan (1.2%), BCBS New Jersey (1.1%), BCBS North Carolina (.8%), Carefirst (.7%), BCBS Massachusetts (.6%), and BCBS Tennessee (.6%), together comprise 18.8% of the national market. All told, the Blues provide health insurance to more than 115 million beneficiaries in the United States.

HMSA functions as part of the largest health care delivery corporation in the US.

Hawaii Medical Service Association (HMSA) is a "nonprofit" health insurer.. HMSA is an independent licensee of the Blue Cross Blue Shield Association. As of December 31, 2023, HMSA had 792,055 beneficiaries, or 55% of the entire state population. This figure includes members in its commercial plan, Medicare Advantage plan, and Medicaid plan. Kaiser Permanente's second place share was about 19%.

Looking further, HMSA dominance of the Large Group Health Private Insurance Market is even greater. According to the Kaiser Family Foundation, the 2021 Hawaii Large Group total market measured 613,587 lives, divided as follows.

HMSA	405,213	66%
Kaiser	146,239	24%
University Health	36,694	6%
Other	25,067	4%

That said, it can be argued that Kaiser Permanente is a walled garden. Premiums are paid, physicians and staff practice, and facilities operate within a closed ecosystem. As such, the real competition for beneficiary premium is between HMSA, University Heatlh, and "Other."

Excluding Kaiser Permanente from the figures above lends a truer picture of HMSA's market position in the Large Group Health Insurance Market.

Total Market Non-Kaiser	466,794	
HMSA	405,213	87%
University Health	36,694	8%
Other	25,067	5%

HMSA Functions as a Monopsony.

A monopsony is a market condition in which a single or dominant buyer of a market good or service substantially controls the price of said good or service. HMSA is a monopsony.

HMSA is a Barrier to Care

HMSA imposes a preauthorization process on medical providers. Prior authorization is the practice of making a coverage determination prior to agreeing to pay for a service. Insurers assert prior authorization reduces waste, eliminating unnecessary services, lowering costs, and preventing fraud. Health service providers contend prior authorization requirements are onerous and that decisions by unlicensed insurer staff interfere with the providers' ability to adequately treat patients.

The scale of the HMSA preauthorization barrier is unknown. Insurers are not required by law to reveal Preauthorization Denial Rates. What is certain is that providers and their staff spend countless hours fighting for their patients access to care and this effort saps the financial strength of providers across the state.

HMSA Refuses to Pay for Care Provided

When patients receive healthcare, they seldom ask if their insurer will pay.

How often an insurance company refuses to pay for care already rendered is a closely guarded secret. That said, CMS has shed some light on the issue.

CMS "is committed to increase transparency in the Health Insurance Exchanges. Health plan information including benefits, copayments, premiums, and geographic coverage is publicly available on Healthcare.gov. CMS also publishes downloadable public use files (PUFs) so that researchers and other stakeholders can more easily access Exchange data."

As such, CMS publishes data about patients who have purchased Individual Marketplace Medical Qualified Health Plans on Healthcare.gov and does so annually. This data includes information on denial rates for individual plans offered in the Marketplace. This includes HMSA data. This data is provided by HMSA itself, in accordance with requirements of the Accountable Care Act. This data allows one to calculate an HMSA "In Network" Claims Denial Rate for Hawai'i residents who have purchased an Individual Marketplace Medical Qualified Health Pan on Healthcare.gov.

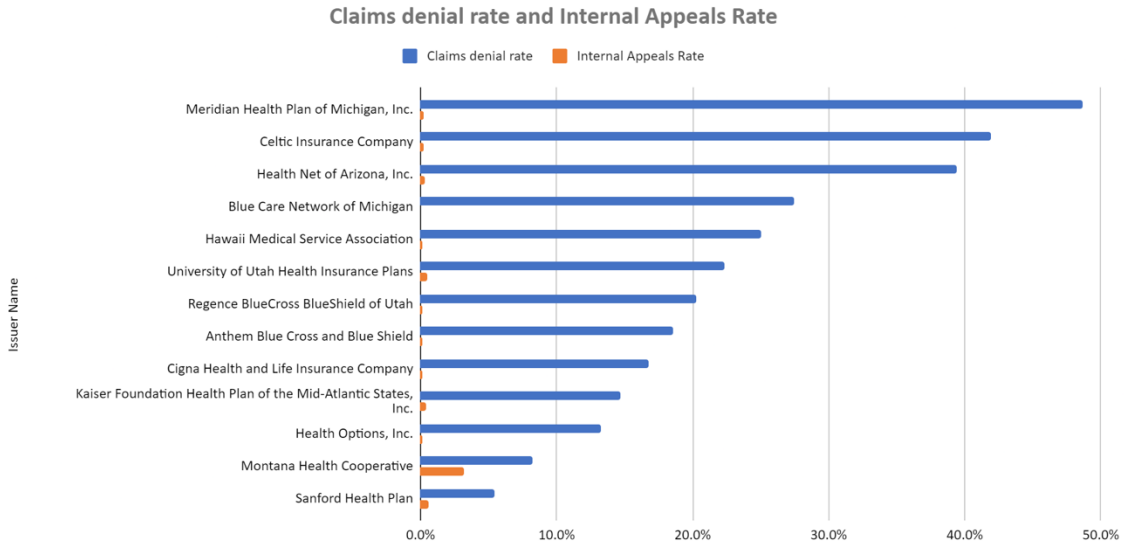
Over the last six years, the HMSA Claim Denial Rate for patients who have purchased their insurance on the HealthCare.gov and obtained care In Network is a stunning 25.1%.

The following data is from the CMS Transparency in Coverage Public Use Files.

HMSA In Network Claims Denials for Private Insurance Purchased on Healthcare.Gov

	Claims Received	Claims Denied	Percentage	
2024	637079	147,935	23.2%	
2023	471082	117703	25.0%	
2022	344408	86148	25.0%	
2021	550061	121993	22.2%	
2020	409325	93146	22.8%	
2019	483584	161163	33.3%	
Six Year Total	2895539	728088	**25.1%**	

As such, according to KFF, HMSA has earned its place among Insurance companies with some of the highest HealthCare.Gov Denial Rates in the Country.



The ramifications of this Claims Made Denial Rate are also stunning.

On a national basis, US Health care insurers adjudicate an average of 10 medical claims per enrollee per year.

HMSA had 792,055 beneficiaries as of 12/31/2023. With near 790,000 members

and an average number of claims per member, HMSA is estimated to adjudicate 7.9 million claim per year. Unfortunately all-encompassing insurer denial rates, a critical measure of how reliably they pay for patient care as a whole, remain secret to the public.

It is safely said that Insurance companies routinely reject authorizations for recommended care and claims for delivered care, inflicting untold damage to patient health, patient finances, and healthcare provider finances.

Average administrative costs to providers to fight delays in care (authorizations) and pursue Claim Denials (payments) for Medicare Advantage, Managed Medicaid, and Commercial Insurance is $45.44. The average administrative cost for providers to pursue delays and denials per claim for Federal Medicare and unmanaged Medicaid is $3.39. As such, the administrative cost of dealing with insurance companies is 13.4X higher than with government. The dollar cost to Healthcare Providers is hard to estimate. Authorization and claims denials are seldom pursued.

HMSA Practices Medicine Without a License

The prior authorization process centers on a health plan issuer's assessment of "medical necessity." When a doctor prescribes a health service or medication, the doctor is finding that the procedure or drug is needed to treat the patient and meets accepted standards of care A physician is authorized by law to make such determinations as a part of the physician's license to practice medicine and their duty to the patient.

When HMSA reviews a requested service for medical necessity, they are engaged in the determination of whether a procedure or drug will be part of a treatment plan. From a patient's perspective, when HMSA denies an expensive treatment plan, it is no different than an attending physician declining to sign an intern's order.

HMSA employees making prior authorization decisions are not licensed physicians. When physicians are involved, they are often reviewing treatment plans outside their areas of expertise. HMSA and other insurers essentially establish treatment protocols based on cost rather than optimal patient outcomes. Treatments are delayed and/or less effective

HMSA denies it is practicing medicine. When HMSA write a policy, the insurance pool assumes the risk a patient will become sick or injured. HMSA then states that if a service or treatment is medically unnecessary, they will not pay. This foists the risk back on the patient. These decisions can be appealed but HMSA controls the process. After all appeals are exhausted, the doctor can appeal to an external, third-party. This process is lengthy and administratively expensive. As noted in the graph above, the successful appeal rate is miniscule.

HMSA holds that a plan's decision to not cover the cost does not prohibit the health

care provider from providing the procedure and therefore, HMSA is not practicing medicine. HMSA says the decision is simply to not pay for the procedure and devoid of any role in decision making. This is laughable.

Providing care without a preauthorization puts either the patient or the health care provider at financial risk, since medical services and treatments can be expensive. As such, the preauthorization process serves as a near insurmountable barrier to care for many of the state's most economically vulnerable patients.

HMSA is a Financial Investment Company

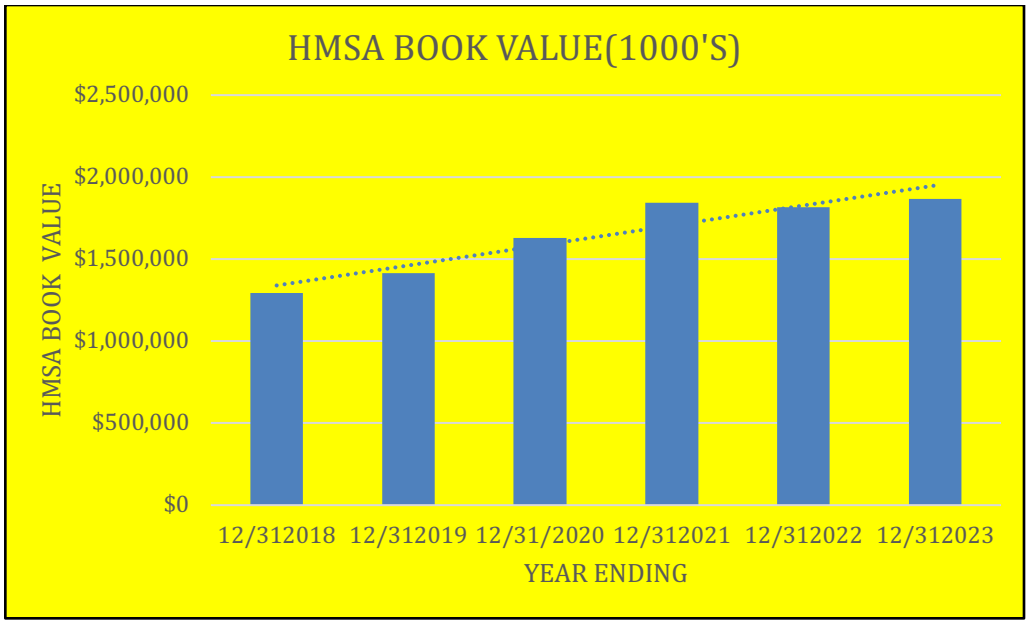
An investment company is a financial institution principally engaged in holding, managing, and investing securities. Think Blackrock, Vanguard, Fidelity.
Insurance companies are essentially investment vehicles driven by the principal of float. No one explains this better than Warren Buffett.

2010 Letter to Shareholders.
Insurers receive premiums upfront and pay claims later. This collect-now, pay-later model leaves us holding large sums - money we call "float" - that will eventually go to others. Meanwhile, we invest this float for Berkshire's benefit.

If premiums exceed the total of expenses and eventual losses, we register an underwriting profit that adds to the investment income produced from the float. This combination allows us to enjoy the use of free money -- and, better yet, get paid for holding it.

When HMSA denies a service, they retain insurance premium. When HMSA delays a payment, they hold premium longer. Both actions increase the value of float. In HMSA's Financial Report, total float is listed as "Member Premiums." In 2023, this was $4.136 Billion. HMSA in the act of delaying payments for claims is also listed. Listed as "Estimated Member Claims Outstanding." this totals $474 Million.

Float is invested in financial instruments, and over time, "not for profit" HMSA has accumulated great wealth. On Financial Reports, HMSA calls this wealth "Resources Available for the Protection of Members." The financial world calls this Book Value.



HMSA has accumulated "Resources Available for the Protection of Members." (ie. Bonds, Mutual Funds, ETF's, Real Estate) totaling $1,865,838,000 as of December 31, 2023.

The growth is impressive. Calculated five-year annual growth rate is 8.7%.

If HMSA Book Value continues to grow at a 5% annual rate and HMSA continues to earn a relatively modest underwriting profit (listed as Net Income of $7,452,000 in 2023), HMSA book value will exceed $3.1 Billion by the end of 2033.

HMSA Weakens HI Healthcare

While Hawaii has in the past enjoyed a reputation for low cost insurance, this is no longer the case. The Kaiser Family Foundation has determined that as of 2025, the Average Benchmark HI Premium for a 40 year old male was $493 per month. The national benchmark is $497. That said, Hawaii is a high cost state with healthcare delivery challenges similar to Alaska. The Average Benchmark AK Premium is $1045 per month.

Hawaii's relatively average Benchmark Premium remains low due to constraints of the Affordable Care Act and its Medical Loss Ratio (MLR) provision. This provision limits the amount of premium revenue that insurers are allowed to keep for administration, marketing, and profits.

In the individual and small group markets, insurers must spend at least 80% of their premium income on health care claims and quality improvement efforts, leaving the remaining 20% for administration, marketing expenses, and profit. The MLR threshold is higher for large group insurers, which must spend at least 85% of their

premium income on health care claims and quality improvement efforts. In fairness, it must be stated that HMSA's overall MLR as listed on the 2023 HMSA Financial Report is a commendable 93.5%.

That said, a Medical Loss Ratio loophole allows insurer parent companies to shift profits to subsidiaries like extended care and pharmacy benefits management companies in order to boost overall earnings while raising its MLR percentage. Unfortunately, HMSA accounting is opaque as to whether its MLR reflects reality.

Insurers that fail to meet the applicable MLR threshold requirements are required to pay back excess profits or margins in the form of rebates to individuals and employers that purchased coverage. This excess premium is not typically used to increase provider reimbursements. The system serves to keep premiums lower.

Meanwhile, HMSA simply presents Provider Contracts to hospitals, clinics, and individual healthcare professionals. These contracts include terms and conditions that define how healthcare professionals serve the beneficiaries covered by HMSA's insurance plan. These cover the scope of services and covered benefits, reimbursement rates and payment processes, quality measures and performance standards, and compliance requirements.

Now typically, negotiation of terms is the groundwork for a mutually beneficial partnership between an insurance company and a provider. But with 55% of the total market and 87% of the private insurance market, HMSA is a monopsony. A monopsony is a market condition in which a single or dominant buyer of a market good or service substantially controls the price of said good or service. HMSA exercises this power in its contracting.

Providers who do not accept HMSA insurance cannot survive in Hawaii.

In fact, HMSA negotiation and contractual behavior has been so egregious that in a recent court judgement, "contract terms and conditions" that HMSA "imposes on doctors and patients" were found "unconscionable and unenforceable." Judge Kim found that HMSA contracts were typically "contracts of adhesion" meaning "they were drafted wholly by the more powerful party and that the other party is unable to negotiate." Ongoing litigation is headed to the Hawaii Supreme Court.

Ideally, Provider Contracts should Patients. Insurers, and Medical Practices to thrive.

HMSA Practices Result in an Inadequate Healthcare System

The Affordable Care Act (ACA) requires health plans in the Marketplace to meet network adequacy standards.

Network adequacy refers to a health plan's ability to provide access to in-network physicians and hospitals to meet enrollee's health care needs. Inadequate networks

create obstacles for patients seeking new or continued care and limit their choice of physicians and facilities.

Requirements in place ensure enrollees have access to enough in-network providers to meet health care needs. It ensures that enrollees have access to needed care without unreasonable delays.

State agencies and the Department of Health and Human Services and Labor oversee private health plans while Federal and State policymakers establish network adequacy standards.

Despite these requirements, the use of narrow networks is increasingly common. Narrow networks restrict access to care. Plan administrators are more frequently using the threat of network termination to control utilization and provider behavior. Providers who present higher than expected claims are subject to audits and scrutiny and can be terminated before the audit process is complete.

HMSA and smaller insurers have a duty to address the ongoing Provider Shortage. Yet the Hawai'i Provider Shortage Crisis continues to grow.

Provider Contract Authorization Processes should be reformed or abolished altogether.

Provider Contracts should raise payment rates commensurate with the costs of practicing in a High Cost State.

Storm Shelter

Hawaii Provider Shortage Crisis Task Force Successes

Hawaii Medicare
Health Professions Shortage Area Designation:

HPSAs are geographic areas, or populations within geographic areas, that lack sufficient health care providers to meet the health care needs of the area or population. The Centers for Medicare & Medicaid Services (CMS) provides a 10 percent bonus payment when Medicare-covered services are rendered to beneficiaries in a geographic HPSA. The bonus is paid quarterly and is based on the amount paid for professional services.

Hawaii County became a Primary Care Type Geographic HPSA effective 9/5/2019. Lisa Rantz, President of the Hawaii Rural Health Association and Executive Director of the Hilo Medical Center Foundation, led this effort with collaborative input from

the Hawaii Physician Shortage Crisis Task Force. Should Hawaii solve its Physician Shortage Crisis, these payments will end and will no longer be needed.

Hawaii General Excise Tax
Medicaid, Medicare, and Tricare Exemption

At the conclusion of the 2024 legislative session, Governor Josh Green signed Senate Bill 1035 into law. This legislation will provide relief to the healthcare system in Hawai‘i by specifically exempting hospitals, infirmaries, medical clinics, health care facilities, pharmacies and medical and dental providers from the GET on goods or services that are reimbursed through Medicaid, Medicare or TRICARE.

Unfortunately, the bill will not take effect until January 1, 2026. For the remainder of 2025, many Hawaii Physicians will continue to pay more in combined General Excise Tax and Hawaii State Income Tax than Federal Income Tax.

Storm Report Summary:

There is a severe shortage of Healthcare Providers in Hawaii. The Shortage is greatest on the Neighbor Islands.

The Medicare Physician Fee Schedule fails to address the unique economic challenges of practicing medicine in Hawaii. The Hawaii Congressional Delegation must propose legislation amending the Social Security Act.

The HI General Excise Tax levied on medical service providers has had an outsized and negative effect on Medical Provider Income. The State of Hawaii should complete its elimination of GET on healthcare.

The combination of Medicare Payment Reform, elimination of the General Excise Tax on Physician and APRN Medical Services, and prior authorization reform is the single best path toward building a robust Hawaii Healthcare System.

HMSA and smaller Insurers share responsibility for the Hawaii Provider Shortage Crisis. This should be addressed via regulatory action, prior authorization reform, and both clarification and expansion of the Patient Bill of Rights.

“There are risks and costs to action. But they are far less than the long range risks of comfortable inaction.”

Weathering The Storm:
Reforms to Survive and Thrive

Hawai'i needs an array of changes to best take care of its people. Many of these reforms are discussed herein, many are not, and some have yet to be imagined. No one doubts that a multi-pronged strategy is the best path toward building a robust Hawaii Healthcare System.

An Ideal Healthcare System would provide high-quality, accessible, and affordable care to everyone in Hawai'i. It would be patient-centered, innovative, and collaborative. As such, the current Physician Shortage of 768 is a significant vulnerability. It is also a significant opportunity.

The 2018 American Medical Association study on the National Economic Impact of Physicians shows that every physician in the United States:

- Generates $3,166,901 in aggregate economic input
- Creates 17 new high paying jobs
- Generates $1,417,958 in wages and income.
- Generates over $126,129 in state and local tax revenue.

Using this AMA data, 768 missing physicians in Hawaii would:

- Generate over $2,432,000,000 in aggregate economic output
- Create 13056 new high paying jobs
- Generate over $1,080,002,000 in wages and income.
- Generate over $96,867,000 in state and local tax revenue.

Reforms designed to attract and retain Physicians and Healthcare Providers will create a virtuous economic cycle where improved access lowers overall cost and ultimately works toward a patient centered Healthy Hawai'i. This in turn will create the resources to make further investments in the wellbeing of the State.

As an example, the US Department of Commerce, Bureau of Economic Analysis has released figures that peg HI Physician Wages and Proprietor Gross Income at $1.1 Billion dollars. At a GET rate of 4.5%, Hawaii collects about $50 million dollars in revenue from Physician Proprietors. Yet in the long term, Hawaii will gather an additional $96 million dollars in annual aggregate tax income. Hawai'i can then deploy the $46 million dollar boost as it sees fit.

Meanwhile, Hawai'i will stimulate its economy to the tune of $2.4 Billion dollars and create more than 13,000 high paying jobs.

Perfect Storm Summary:

- There is a severe shortage of Healthcare Providers in Hawaii.
- Federal Medicare and Medicaid Payments for medical services are inadequate.
- The Hawaii Congressional Delegation must propose legislation amending the Social Security Act Hawai'i GPCI to 1.5.
- The State of Hawaii should complete its elimination of the General Excise Tax levied on medical services.
- HMSA is a Payor Monopsony. Its authorization process is a Barrier to Care. HMSA practices medicine without a license by refusing care. HMSA has systematically weakened the healthcare system with behaviors the courts have described as "unconscionable and unenforceable."
- A combination of Medicare Payment Reform, complete elimination of the General Excise Tax on Physician and Provider Medical Services, and prior authorization reform is the single best path toward building a robust Hawaii Healthcare System.

Pono

Pono is beautiful word with great depth and meaning.

It is commonly translated as "to do what is right" or "righteousness". Yet it also encompasses meanings that lend importance to self-esteem, self-care, resilience, and living healthy. It also refers to living in a way that respects local culture and the beauty of everyday life. Living Pono, one is in balance with self, others, and the community.

The Hawai'i Provider Shortage Crisis Task Force looks forward to the day when Pono is the essence of Hawai'i Healthcare.

Mahalo for your consideration and all your hard work.

John Lauris Wade MD
Hawaii Provider Shortage Crisis Task Force

HB-250-HD-1
Submitted on: 2/10/2025 7:26:07 PM
Testimony for CPC on 2/11/2025 2:00:00 PM

LATE

Submitted By	Organization	Testifier Position	Testify
Esther Smith, MD	Mohala Health LLC	Support	Remotely Via Zoom

Comments:

Testimony in Support of HB250

To: Members of the House Committee, Hawaii State Legislature
From: Mohala Health
Date: 2/10/2025
Subject: Urgent Support for HB250 – A Call for Immediate Action

Dear Chair Gregg Takayama, Vice Chair Sue L. Keohokapu-Lee Loy, and Members of the Committee,

Thank you for the opportunity to submit testimony in strong support of HB250, a crucial bill aimed at reforming the broken prior authorization system in Hawaii. While prior authorization was originally intended to prevent unnecessary costs, it has become a bureaucratic nightmare that denies and delays critical care. The tragic experience of Jonathan Opey, a resident of Hawaii living with multiple sclerosis, illustrates the devastating human cost of these administrative barriers.

Jonathan's Story: A System That Fails Patients

Jonathan Opey relies on forearm crutches for mobility. Last year, he fell and broke his arm, an injury that made daily life nearly impossible. This injury could have been prevented had United Healthcare approved his request for a motorized wheelchair, a request that has been repeatedly denied despite meeting all medical criteria. Following his accident, his need for the chair became even more urgent, yet the request remains in bureaucratic limbo. The delays have not only prolonged his suffering but have also deepened his social isolation. A motorized wheelchair would allow him to access the post office, the grocery store, and engage with his community—basic activities that most of us take for granted.

Jonathan's case is not unique. Every day, patients across Hawaii are caught in similar battles with insurance companies, fighting for the care and equipment they need to maintain their health and independence. Providers spend countless hours filling out redundant paperwork instead of focusing on patient care. These barriers are not just frustrating; they are life-altering.

HB250: A Necessary Step Forward

HB250 takes a critical step toward holding insurance companies accountable for the impact of prior authorization delays. By requiring insurers to report data on prior authorization denials and delays, and by establishing a commission to evaluate and recommend reforms, this bill brings much-needed transparency and oversight to a system that has long operated in the shadows.

However, transparency alone is not enough. We need real, enforceable policies that eliminate unnecessary prior authorizations for routine care, mandate faster approval timelines, and ensure that patients who are stable on long-term medications are not forced to switch treatments arbitrarily.

A Call for Immediate Action

The Legislature cannot afford to delay action on this issue. Every day that passes means more patients suffering needlessly, more injuries that could have been prevented, and more physicians overwhelmed by administrative burdens. The time for incremental change has passed—we need comprehensive reform now.

I urge you to pass HB250 and strengthen it with additional measures that eliminate excessive prior authorization requirements and hold insurers accountable. Patients like Jonathan Opey should not have to fight for years to receive medically necessary care. We must ensure that no one else in Hawaii is forced to endure unnecessary suffering because of an inefficient and unjust system.

Thank you for your time and consideration. I strongly urge you to act now in support of HB250 and take meaningful steps to fix Hawaii's broken prior authorization system.

Sincerely,
Esther Yu Smith, MD
COO Mohala Health

American College of Obstetricians and Gynecologists District VIII, Hawai'i (Guam & American Samoa) Section

TO: House Committee on Consumer Protection & Commerce
Rep. Scot Z. Matayoshi, Chair
Rep. Cory M. Chun, Vice Chair

LATE

DATE: Tuesday, Feb 11, 2025
PLACE: Hawaii State Capitol, Conference Room 329

FROM: Hawai'i Section, ACOG
Dr. Angel Willey, MD, FACOG, Chair
Dr. Tiffinie R. Mercado, MD, FACOG, Vice-Chair
Dr. Ricardo A. Molero Bravo, MD, FACOG, Legislative Chair

Re: HB250 Relating to Health. Prior Authorization; Utilization Review Entities; Reporting; Health Care Appropriateness and Necessity Commission; State Health Planning and Development Agency
Position: SUPPORT

On behalf of the Hawai'i Section of the American College of Obstetricians and Gynecologists (ACOG), I write in support of HB250, which seeks to reform prior authorization processes, reduce administrative burdens on healthcare providers, and improve patient access to timely medical care.

As physicians dedicated to providing high-quality obstetric and gynecologic care, we witness firsthand the negative impact that delays in prior authorization have on our patients. The current process imposes unnecessary administrative hurdles, leading to delayed treatments, increased provider burnout, and adverse patient outcomes. National and state-level data confirm that prior authorization is a top concern for physicians, often resulting in denied or delayed access to medically necessary care.

The administrative barriers created by inconsistent and often opaque prior authorization criteria particularly impact maternal health and reproductive care, where timely access to services can be crucial. A delay in diagnostic testing, medications, or procedures could jeopardize the health of pregnant individuals and those experiencing gynecologic conditions, leading to avoidable complications and higher healthcare costs.

By passing HB250, the Legislature has the opportunity to reduce delays in patient care, support physicians in delivering evidence-based treatments, and ensure that healthcare decisions are made by medical professionals rather than insurance companies.

We respectfully urge you to pass HB250 and protect the ability of Hawai'i's healthcare providers to deliver timely, patient-centered care.

Additionally, we support Hawaii Medical Association proposed amendments.

Thank you for your time and consideration

Big Island DOCS
East Hawaii IPA

LATE

February 11, 2025

To: House Committee on Health
Representative Gregg Takayama, Chair
Representative Sue Keohokapu-Lee Loy, Vice Chair, and Honorable Members

From: East Hawaii Independent Physicians Association (dba Big Island Docs)

Subject: Testimony in Strong Support of HB250 – Relating to Health (Prior Authorization)

Dear House Representatives,

We appreciate the opportunity to submit testimony in strong support of HB250, which will require utilization review entities to submit data relating to the prior authorization of health care services to the State Health Planning and Development Agency.

Big Island Docs represents 50 independent private practice providers on Hawai'i Island, delivering care to over 50,000 patients. As healthcare providers in Hawai'i, we are deeply aware of the growing challenges our patients face in accessing timely care, especially in rural and underserved communities. HB250 will help address these issues by ensuring that prior authorization processes are transparent, efficient, and consistent, thereby reducing delays and improving overall patient access to necessary care.

On behalf of our membership, we strongly urge the Committee to support and pass HB250. This bill will significantly improve the healthcare system for our patients and ensure more timely and equitable care for all.

Thank you for your time and consideration.

Mahalo,

Lynda Dolan, MD
President

Brenda Camacho, MD
VP & Treasurer

Craig Shikuma, MD
Medical Director, BIHC

Erin Kalua, MD
Secretary

www.bigislanddocs.com

Mailing Address: 670 Ponahawai St., Suite 117 | Hilo, HI 96720
Phone: (808) 797-3113 | Fax: (808) 935-4472

LATE

HB-250-HD-1
Submitted on: 2/10/2025 7:15:27 PM
Testimony for CPC on 2/11/2025 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Jonathan José Opey	Individual	Support	Remotely Via Zoom

Comments:

Refer to written testimony of Dr Smith,

I will just do oral testimony

LATE

HB-250-HD-1
Submitted on: 2/10/2025 8:05:25 PM
Testimony for CPC on 2/11/2025 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Avery Olson	Individual	Support	Written Testimony Only

Comments:

Hi all,

My name is Dr. Avery Olson, and I am a obstetrician gynecologist praciticing in Hawaii. Prior authorization is a barrier to care for many in Hawaii, often delaying crucial services days to weeks (sometimes even months!) Please consider supporting this bill for the health of our population, families, and community.

Please support HB250!

-Dr. Avery