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 SB1449
RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES.

SENATOR JOY SAN BUENAVENTURA, CHAIR
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

Hearing Date: February 3, 2025 Room Number: 229

Department Testimony: Department Testimony: The Department of Health (DOH) strongly supports SB1449, which is part of the Governor's Administrative Package, to require utilization review entities to report data relating to prior authorization of health care services to the State Health Planning and Development Agency (SHPDA).

Prior authorization requirements impose significant administrative burdens on health care providers. A 2023 American Medical Association prior authorization physician survey revealed that most denials are subsequently overturned, raising doubts about the value of the process. While prior authorization may be a legitimate tool to control health care costs, there are concerns from health care providers that it negatively impacts patient health.

Thus, tasking SHPDA with collecting and publicly reporting prior authorization data can shed light on the impact of such practices in Hawaii.

Thank you for the opportunity to testify.

Hawaii Association of Health Plans

February 5, 2025

To: Chair San Buenaventura, Vice Chair Aquino, and Members of the Senate Committee on Health and Human Services (HHS)
From: Hawaii Association of Health Plans Public Policy Committee
Date/Location: February 5, 2025; 1:00 pm/Conference Room 255 & Videoconference

Re: Testimony with comments on SB 1449 – Relating to Prior Authorization of Health Care Services

The Hawaii Association of Health Plans (HAHP) appreciates the opportunity to offer comments on SB 1449. 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. 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 the opportunity to testify on SB 1449.

Sincerely,

HAHP Public Policy Committee
cc: HAHP Board Members

KAISER PERMANENTE®

Government Relations

Testimony of
Jonathan Ching
Government Relations Director

Before:
Senate Committee on Health and Human Services
The Honorable Joy A. San Buenaventura, Chair
The Honorable Henry J.C. Aquino, Vice Chair

February 5, 2025
1:00 p.m.
Via Videoconference
Conference Room 225

Re: SB 1449, Relating to Prior Authorization of Health Care Services.

Chair San Buenaventura, Vice Chair Aquino, and committee members, thank you for this opportunity to provide testimony on SB 1449, which requires utilization review entities in the State to submit to the State Health Planning and Development Agency data relating to prior authorization of health care services.

Kaiser Permanente Hawai‘i provides the following COMMENTS on HB 250 and requests an AMENDMENT.

Kaiser Permanente Hawai‘i is one of the nation’s largest not-for-profit health plans, serving 12.6 million members nationwide, and more than 271,000 members in Hawai‘i. In Hawai‘i, more than 4,200 dedicated employees and more than 650 Hawai‘i Permanente Medical Group physicians and advance practice providers work in our integrated health system to provide our members coordinated care and coverage. Kaiser Permanente Hawai’i has more than 20+ medical facilities, including our award-winning Moanalua Medical Center. We continue to provide high-quality coordinated care for our members and deliver on our commitment to improve the health of our members and the people living in the communities we serve.

Kaiser Permanente Hawai‘i strives to ensure that all care provided to our members and patients is safe, equitable, practitioner-led, high-quality, high-value, and supported by the best available evidence. In our integrated model, prior authorization is used very sparingly to ensure that care delivery comports with these standards.

P**rior authorization should not inhibit the timely delivery of clinically appropriate care.** We support meaningful transparency as a tool to hold health plans accountable for making timely, accurate, consistent, fair and equitable prior authorization decisions. We further support policies

711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Office: (808) 432-5210
Facsimile: (808) 432-5906
Email: jonathan.l.ching@kp.org

that promote the development and use of technology to streamline administrative processes and facilitate communication between health plans, providers and patients.

We suggest that the reporting requirements sought in Section 2 should align any state reporting requirements with the federal requirements in the 2024 Interoperability and Prior Authorization final rule.[1] This should help alleviate some administrative burden on all plans and allow more useful comparisons with federal data. We respectfully request Section 2 be amended as follows:

SECTION 2. Chapter [~~323D~~] 431, Hawaii Revised Statutes, is amended by adding two new sections to part II to be appropriately designated and to read as follows:

"**§323D- Prior authorization; reporting.** (a) Utilization review entities doing business in the State shall submit data to the state agency relating to prior authorization of health care services **required for compliance with federal law and the regulations of the Centers for Medicare and Medicaid Services, including those promulgated under 42 C.F.R. §§ 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c).,** in a format specified by the state agency. Reporting shall be annual for the preceding calendar year and shall be submitted no later than January 31 of the subsequent calendar year. The state agency shall post the reporting format on its website no later than three months prior to the start of the reporting period.

[1] *See* 89 Fed. Reg. 8758 (February 8, 2024).

711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Office: (808) 432-5210
Facsimile: (808) 432-5906
Email: jonathan.l.ching@kp.org

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

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

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

(c) The state agency shall compile the data by provider of health insurance, health care setting, and line of business, and shall post a report of findings, including recommendations, on its website no later than March 1 of the year after the reporting period. If the state agency is unable to post the report of findings by March 1, the state agency shall notify the legislature in writing within ten days and include an estimated date of posting, reasons for the delay, and if applicable, a corrective action plan.

(d) For purposes of this section:

(1) "Prior authorization" means the process by which a utilization review entity determines the medical necessity or medical appropriateness of otherwise covered health care services prior to the rendering of the health care services. Prior authorization includes any health insurer's or utilization review entity's requirement that an enrollee or health care provider notify the health insurer or utilization review entity prior to providing health care services.

[~~(2) "Prior authorization data" means data requested by the state agency that relates to the prior authorization of health care services. These data include, but are not limited to:~~

711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Office: (808) 432-5210
Facsimile: (808) 432-5906
Email: jonathan.l.ching@kp.org

~~(A) Patient demographics such as sex, age, residential ZIP code, and primary insurance plan;~~

~~(B) Procedure codes, revenue codes, diagnosis-related group codes, brand name drugs, generic drug names, or durable medical equipment type;~~

~~(C) Diagnosis codes;~~

~~(D) Specialty of the health care provider requesting prior authorization for a health care service;~~

~~(E) Setting, such as inpatient, outpatient, observation, or other;~~

~~(F) Date of initial provider request for prior authorization, date of health plan response, and the status of the prior authorization request by date, such as pending, approved, denied, appealed, or overturned, and;~~

~~(G) Any other data identified by the state agency.]~~

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

(A) An insurer that writes health insurance policies;

711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Office: (808) 432-5210
Facsimile: (808) 432-5906
Email: jonathan.l.ching@kp.org

(B) An accident and health or sickness insurance plan licensed pursuant to chapter 431, mutual benefit society or fraternal benefit society licensed pursuant to chapter 432, or health maintenance organization licensed pursuant to chapter 432D; or

(C) Any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health benefits to a person treated by a health care provider the State under a policy, plan, or contract."

Given the harmonization with federal regulations, the definition of "prior authorization data" is not necessary as it is defined in the Code of Federal Regulations (February 8, 2024).

Mahalo for the opportunity to testify on this important measure.

711 Kapiolani Boulevard
Honolulu, Hawaii 96813
Office: (808) 432-5210
Facsimile: (808) 432-5906
Email: jonathan.l.ching@kp.org

SB-1449
Submitted on: 2/3/2025 10:03:59 PM
Testimony for HHS on 2/5/2025 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Christina Marzo, MD, MPH	Testifying for Hawaii Academy of Family Physicians, Legislative Committee	Support	Written Testimony Only

Comments:

Thank you for allowing testimony on SB1449. In caring and advocating for the people and primary care physicians of Hawai‘i, HAFP 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 concisely 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 patients and physicians in Hawai‘i. We endorse SB1449 with the following comments.

In addition to the actions included in SB1449, HAFP endorses the following considerations for prior authorization reform in Hawai‘i.

· Readily accessible, easily identifiable prior authorization requirements on insurer websites free of charge to patients and health care providers

· Decision on urgent requests for medical care within 24 hours of submission

· Decision on nonurgent requests for medical care with 72 hours or 3 working days

· If insurers do not respond within the designated timeframes, then requests are reflexively approved

· 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 rates exceed a set standard

· Inclusion of primary care representation in any regulatory or advisory body on prior authorization

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

An Independent Licensee of the Blue Cross and Blue Shield Association

February 5, 2025

The Honorable Joy A. San Buenaventura, Chair
The Honorable Henry J.C. Aquino, Vice Chair
Senate Committee on Health and Human Services

Re: SB 1449 – RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES

Dear Chair San Buenaventura, Vice Chair Aquino, and Members of the Committee:

Hawaii Medical Service Association (HMSA) appreciates the opportunity to provide comments and suggestions to improve prior authorization reporting as stated in SB 1449, which will require utilization review entities in the State to submit to the State Health Planning and Development Agency data relating to prior authorization of health care services.

We support the intent of this measure and appreciate the legislature's recognition of 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. As a health organization partnering with over 7,500 providers across the state, we understand the challenges and are committed to working collaboratively to improve the prior authorization process and transparency of reporting while ensuring the highest quality of care for our members.

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 that aligning with these requirements (particularly for reporting) would be prudent and any additional statutory changes would be unnecessary and premature 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

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

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 approaching federal regulations.

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

1. Amending Section 2 to be applicable to 431:2, as the insurance division is the regulating body of health plans in the state.
2. In section 2 **Prior authorization; reporting** (parts a and b)
    i. to replace "utilization review entity" with "health plan".
3. Aligning reporting requirements as set out by CMS as found in 45 CFR §156.223 [2] as plans will need to start reporting this data in March of 2026.

We are happy to provide the committee with a proposed draft that incorporates the requested amendments. Thank you for the opportunity to testify on this measure.

Sincerely,

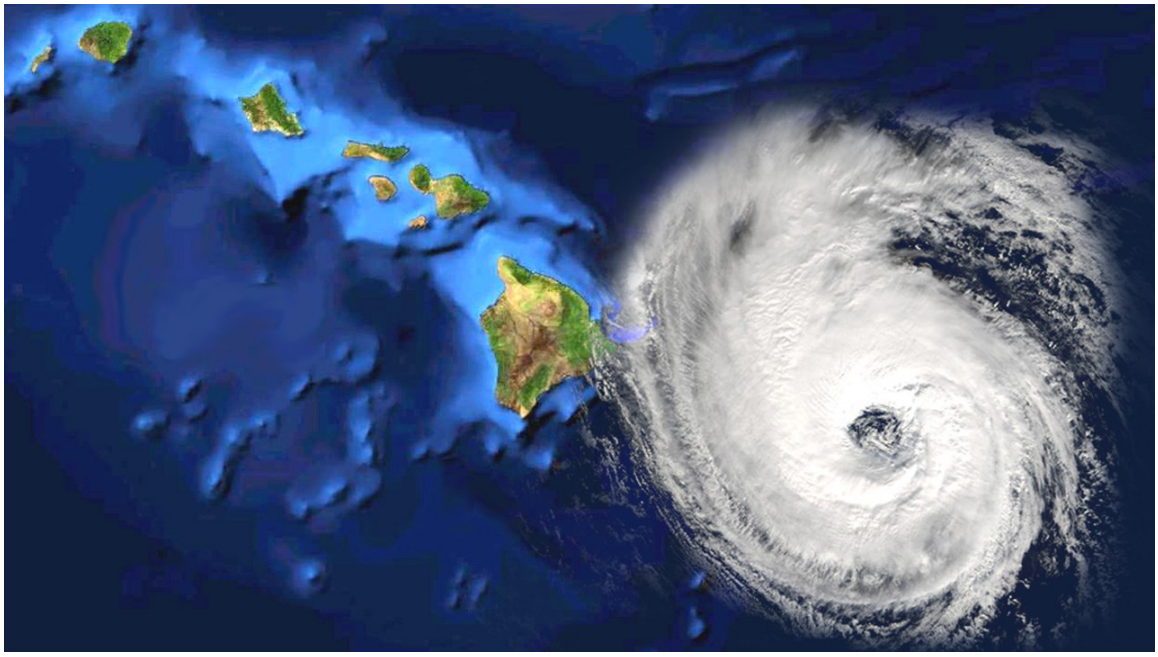
Dawn Kurisu
Assistant Vice President
Community and Government Relations

[2] https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-C/section-156.223

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.

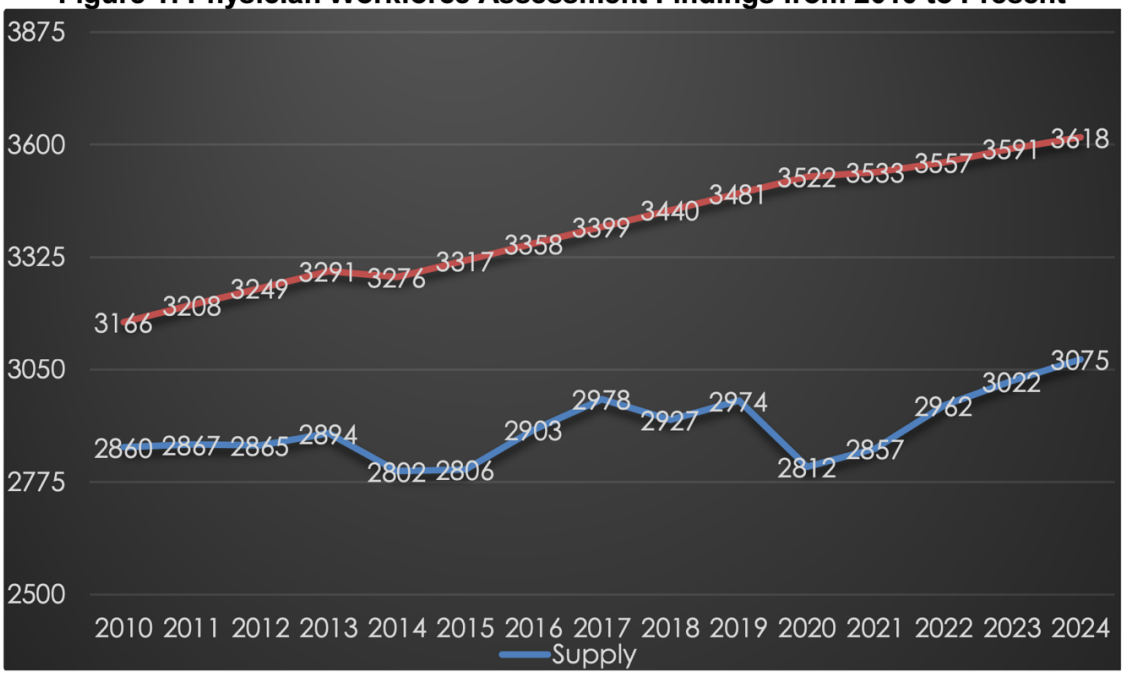
For 15 years, the HI Physician Workforce Assessment Project has studied the ongoing Physician Workforce Shortage.

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.

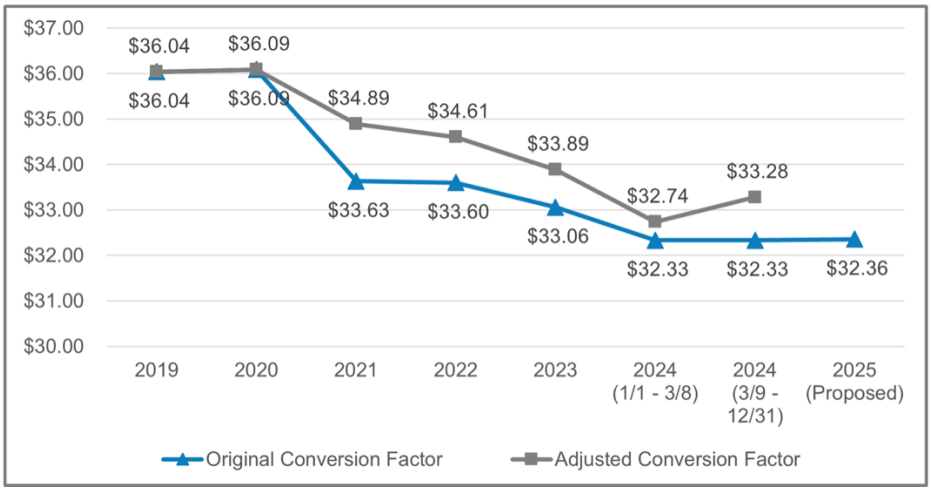
The HI Medicare issue could be addressed by requesting an amendment to the Social Security Act adding Hawaii to Section 42 U.S.C. 1395w–4(e)(1)(G)) which reads….

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.

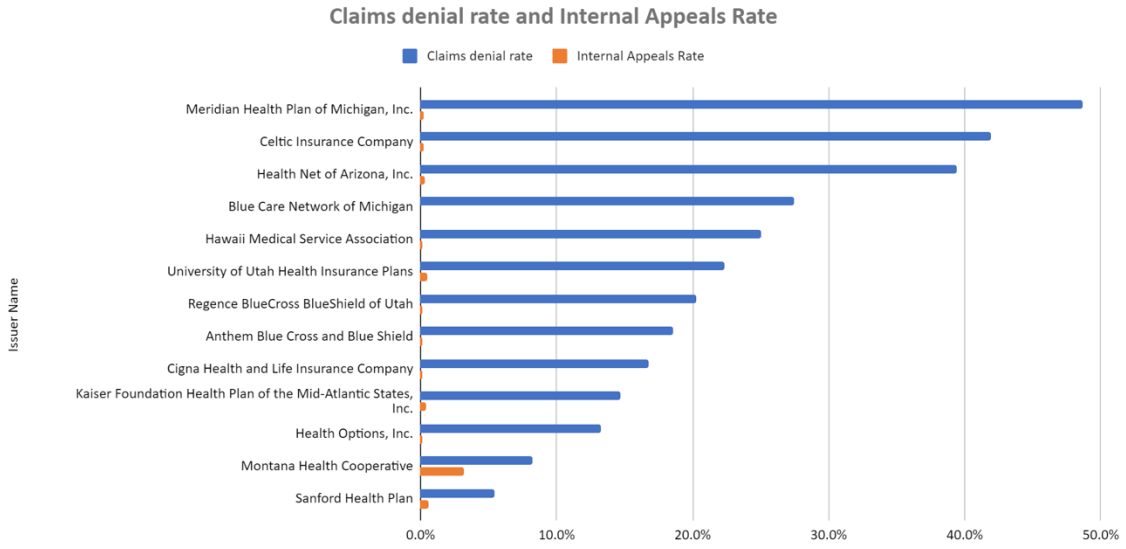
Over the last six years, the HMSA Claim Denial Rate for patients who have purchased their insurance on the HealthCare.gov and obtained care In Network is a stunning 25.1%.

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

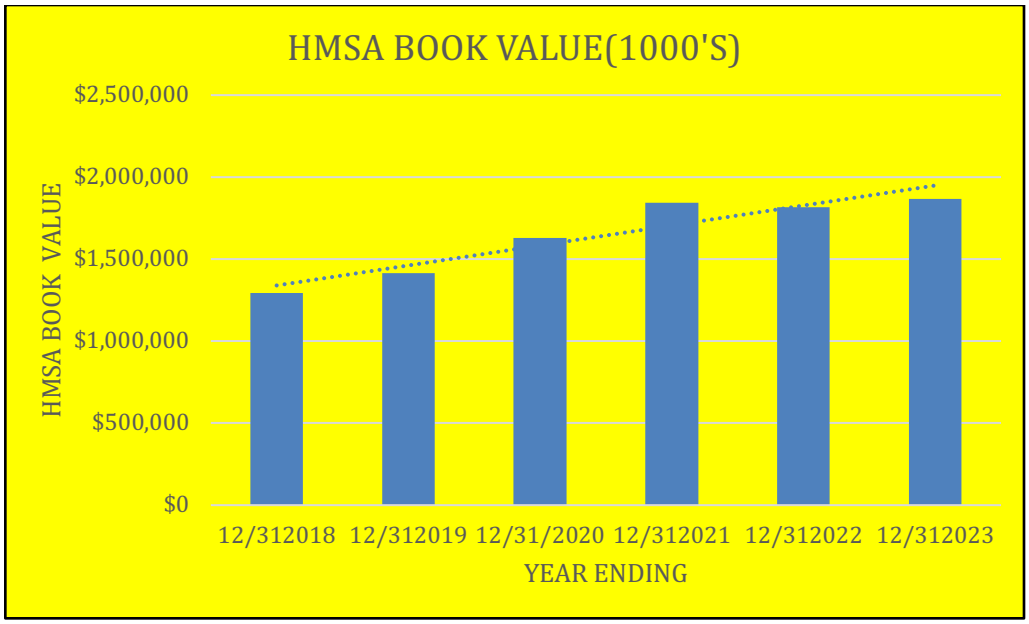
An investment company is a financial institution principally engaged in holding, managing, and investing securities. Think Blackrock, Vanguard, Fidelity.
Insurance companies are essentially investment vehicles driven by the principal of float. No one explains this better than Warren Buffett.

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

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

SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES
Senator Joy A. San Buenaventura, Chair
Senator Henry J.C. Aquino, Vice Chair

Date: February 5, 2025
From: Hawaii Medical Association (HMA)
Jerald Garcia MD - Chair, HMA Public Policy Committee

Re: SB 1449 RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES -SHPDA; Prior Authorization; Utilization Review Entity; Reporting
Position: Support with amendments

This measure would require utilization review entities in the State to submit to the State Health Planning and Development Agency data relating to prior authorization of health care services.

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 and harmful negative clinical outcomes, as well as excessive administrative burden for physicians already laboring under critical workforce shortages.

The disclosure and reporting of the relevant payor utilization data of PA is imperative for transparency, accountability and meaningful analyses of challenges, Additionally, a body for oversight is necessary to address deficiencies and 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 respectfully requests these additions/amendments for consideration:

REDUCTION OF PA DELAY AND UNNECESSARY VOLUME (language is taken from SB 1519)

Prior authorization request for urgent health care services; determination time frame; automatic approval.
(1) Urgent requests will be decided within twenty-four hours of receipt; and
(2) Non-urgent requests will be decided within three calendar days of receipt.
If an insurer fails to respond to a prior authorization request within the required timeframe, the request shall be deemed approved.

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 SB 1519)

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 SB 1519)

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 SB 1519)

Utilization review entities; annual report to insurance commissioner [and oversight Work Group]. (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.

HMA recommends that the utilization review entities doing business in the State shall submit data to a Work Group relating to prior authorization of health care services, in a format specified by the Work Group with 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 Work 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 reform 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 Accessed Jan 28 2025.

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 Accessed Jan 28 2025.

Pestaina K et al. Final Prior Authorization Rules Look to Streamline the Process, but Issues Remain. KFF.org May 2 2024. Accessed Feb 4 2025.

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.

SB-1449
Submitted on: 2/3/2025 8:31:45 AM
Testimony for HHS on 2/5/2025 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Marti Taba	Individual	Support	Written Testimony Only

Comments:

I am a Family Phyisican who has been greatly impacted by the prior authorization burden that puts patients at risk daily of delayed important and necessary care. It has driven up ER visits out of the necessity of getting timely care that is impeded by the prior authorization process.

In addition to the actions included in SB1449, I would also like to request that primary care be an integral part of the discussions around prior authorization reform, that requirements be available to providers and patients free of charge.

Decisions of urgent requests be avialable in 24 hour and nonurgent 72 hours. If the insurer is delayed, that would be an automatic approval -- which would allow timely scheduling of procedures and imaging studies.

Mahalo for your consideration of my testimony,

Marti Taba, MD

Prior Authorization as policies used by our medical insurance companies are harming patients and out community.

They are not only inefficient, they are now perverted into destructive results.

This bill is a good start, necessary but not sufficient,

to reverse this unnecessary and destructive effect on healthcare in our communities.

Please ALSO approve the other associated bills coming up this session.

Please see (attached) recent article by Prof. Rosenbloom, former Commissioner of Health and Hospitals, City of Boston,

who correctly calls it A SCAM based on his expert knowledge as a designer of these policies, and present remorse for doing so.

warmest aloha

Edward Gutteling, MD, FAAOS

Team Physician,
University of Hawaii Hilo Vulcan Athletics

The Boston Globe

https://www.bostonglobe.com/2025/01/28/opinion/insurance-companies-delay-deny-health-care/

Opinion I Health insurance:

Prior authorization is a scam

I know, because I helped design it

January 28, 2025

David L. Rosenbloom, PhD
Professor emeritus Boston University School of Public Health,
Commissioner of Health and Hospitals for the City of Boston 1975 to 1983

Here's how to stop health insurance companies from using delay-and-deny tactics.

Killing a CEO is not the way to stop outrageous behavior by health insurance companies.

So what is?

The companies and agencies that buy commercial health insurance and the Medicaid, Medicare, and Affordable Care Act marketplace programs can stop health insurance practices that delay and

deny care to patients by taking three actions:

They should

- demand the abolition of prior approval for medical care and prescriptions;
- require that insurance company denial rates be posted in all marketing materials;
- and force speedy and fair denial claim appeals. Insurance companies have lied to their customers about how their practices protect patients and save money.

They don't.

Health insurance deny-and-delay practices block access to needed care and shift costs to patients
and providers, while increasing insurance company profits.

Prior authorization for medical care was started in the mid-1980s as a marketing scheme by health insurance companies. I know. I was in the room where it happened when I was an officer of the Health Data Institute, a company that developed managed care tools and techniques.

The insurance companies wanted to show they were "doing something" to help control rapidly rising health care costs. Some insurance companies made money charging extra for "pre-admission certification." **There was no evidence then that prior authorizations for any medical
test or procedure would protect patients, improve care quality, or save money.**

Forty years later, there is still not much evidence they do any good.

In fact, they cause harm.

About 25 percent of physicians in a recent national survey reported that prior authorization delays led to a patient's
hospitalization, a life-threatening event that required emergency intervention, or permanent disability, birth defect, or death.

Some things are too broken to be fixed or reformed.

Prior authorization is one of them.

Problems with prior authorizations are responsible for almost half of all medical claim denials and are the starting point for additional claim denials that increase costs to patients or prevent them from getting needed care.

One out of 6 patients and 23 percent of patients with mental illness reported difficulties with a prior authorization in a 2023 Kaiser Family Foundation
survey. More than half the patients who reported prior authorization problems also encountered other claim denials such as the inability to get medications ordered by their doctors. Nearly all physicians (95 percent) reported that prior authorizations "somewhat or significantly" increased physician burnout in a recent American Medical Association survey.

Eliminating prior authorizations would be a win-win for patients and health care providers, and would probably not
raise total health care costs despite the unfounded fears of insurance company actuaries. More timely access to needed care may save more money than delaying or denying it.

Requiring insurance companies to publish their prior authorization denial rates on all marketing materials and platforms would let patients and plan sponsors know how likely it is that their claim would be paid before they bought the insurance.

The Affordable Care Act ***requires*** insurance companies to compile denial rates for plans offered on its marketplaces, **but the information is not**

widely available, and the regulations to publish it have not been enforced.

There are no similar requirements for commercial, Medicaid, or Medicare plans.

Denying claims is a very effective way for health insurance companies to make money.

Only about half of all bill denials are ultimately overturned, resulting in payments to care providers.

The process for appealing a denial is so complicated that fewer than 1 percent of patients bother to appeal, and most of them lose in a process that is controlled by insurance companies. Very few patients even know they have a right to an external appeal when the insurance company turns them down. Pharmacy benefit managers, often owned by health insurance companies, increase their profits through prior authorization. Sometimes they pay for only the brand-name drugs the benefit managers get a kickback for promoting.

Transparent, speedy, and independent reviews of medical care, prescription, and bill denials can be implemented if the companies and agencies
buying insurance tell the insurance companies to do so.

Ending prior authorization, publishing denial rates, and forcing speedy, fair appeals would eliminate the majority of medical claim denials and delays in care. These changes would increase access to medical services and reduce patients' anxiety. They would also create an atmosphere for
legitimate research into policies that improve patient outcomes, improve quality of care, and prevent wasteful, harmful medical practices.

David L. Rosenbloom is a professor emeritus at Boston University School of Public Health. He served as commissioner of health and hospitals for the city of Boston from 1975 to 1983.

SB-1449
Submitted on: 2/4/2025 9:22:34 AM
Testimony for HHS on 2/5/2025 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Cathy Wilson	Individual	Support	Written Testimony Only

Comments:

Dear Chair Senator Joy A. San Buenaventura, Co-chair Senator Henry Aquino and HHS Committee,

As a patient advocate in Hawai‘i, I have witnessed firsthand how prior authorization delays prevent patients from receiving necessary care. The lack of transparency in these processes creates undue administrative burdens on healthcare providers and unnecessary roadblocks for patients. SB1449 is a crucial step forward—it holds utilization review entities accountable, ensures oversight through the newly established Health Care Appropriateness and Necessity Commission, and prioritizes patient care over bureaucratic inefficiencies.

From my perspective as someone who works closely with patients, I have seen the real-world impact of these delays. Patients often struggle to navigate the complex prior authorization process, leading to frustration, anxiety, and in some cases, deterioration of their health conditions while waiting for approval.

The establishment of the Health Care Appropriateness and Necessity Commission is particularly important. This commission will provide much-needed oversight and ensure that decisions about patient care are made with proper medical considerations, rather than purely financial ones.

SB1449 also addresses the critical issue of transparency. By holding utilization review entities accountable, we can expect clearer communication and more streamlined processes, which will ultimately benefit both patients and healthcare providers.

As a patient advocate, I strongly urge lawmakers to support this bill. It has the potential to significantly improve healthcare access and outcomes in our state by reducing unnecessary delays and putting patient care at the forefront of decision-making processes.

Thank you for your consideration.

LATE

SB-1449
Submitted on: 2/5/2025 8:38:31 AM
Testimony for HHS on 2/5/2025 1:00:00 PM

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

Comments:

Please see HMA written testimony.

February 5, 2025

LATE

Senator Joy San Buenaventura, Chair
Senate Committee on Health and Human Services
Room 213, Hawaii State Capitol
415 South Beretania St.
Honolulu, HI 96813

Dear Chair San Buenaventura and Members of the Senate Committee on Health and Human Services,

The Hawaii Society of Clinical Oncology (HSCO) and the Association for Clinical Oncology (ASCO) are pleased to support SB 1449, which would increase transparency regarding prior authorization.

HSCO is a community of oncologists, nurse practitioners, physician assistants, and other allied health professionals who provide a passionate voice for multidisciplinary cancer care teams and the patients they serve. ASCO is an organization representing physicians who care for people with cancer. With more than 50,000 members, our core mission is to ensure that cancer patients have meaningful access to high-quality cancer care.

Prior authorization requires patients or their providers to secure pre-approval as a condition of payment or insurance coverage of services. In a recent ASCO survey, 80% of respondents said that a patient has experienced significant impacts on their health, such as disease progress, because of prior authorization processes. The most common harms to patients include delays in treatment (95%) and diagnostic imaging (94%), patients being forced onto second-choice therapy (93%) or denied therapy (87%) and increased out-of-pocket costs (88%). These survey responses confirm that prior authorization results in unnecessary delays or denials of cancer care.

HSCO and ASCO are committed to supporting policies that reduce cost while preserving quality of cancer care; however, it is critical that such policies be developed and implemented in a way that does not undermine patient access. Payer utilization management approaches like prior authorization are of particular concern because they represent greater likelihood of raising barriers to appropriate care for individuals with cancer.

We appreciate that SB 1449 improves transparency by implementing prior authorization statistic reporting requirements. Data are critical to evaluating the effectiveness, impact, and costs of prior authorization on both patients and clinicians. Though barriers imposed by prior authorization will not be resolved solely by increasing transparency, having access to relevant data can serve as a first step to improving timely access to care.

For a more detailed understanding of our policy recommendations on this issue, we invite you to read the attached ASCO Position Statement: Prior Authorization. If you have any questions about prior authorization, please do not hesitate to contact Sarah Lanford at Sarah.Lanford@asco.org.

Sincerely,

Michael Carney, MD
President
Hawaii Society of Clinical Oncology

Eric P. Winer, MD, FASCO
Chair of the Board
Association for Clinical Oncology