TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
KA ʻOIHANA O KA LOIO KUHINA
THIRTY-THIRD LEGISLATURE, 2025

ON THE FOLLOWING MEASURE:
H.B. NO. 250, H.D. 2, RELATING TO HEALTH.

BEFORE THE:
SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

DATE: Monday, March 10, 2025 **TIME:** 1:00 p.m.

LOCATION: State Capitol, Room 225

TESTIFIER(S): Anne E. Lopez, Attorney General, or
Angela A. Tokuda, Deputy Attorney General

Chair San Buenaventura and Members of the Committee:

The Department of the Attorney General provides the following comments.

The purposes of this bill are to: (1) require utilization review entities to submit data related to the prior authorization of health care services to the State Health Planning and Development Agency (SHPDA); (2) establish timelines for the approval of prior authorization requests for health care services; and (3) establish a working group within SHPDA.

The Department notes that section 3 of the bill adds the definition of "health care service" to section 323D-2, Hawaii Revised Statutes (HRS), on page 11, lines 7-16. However, section 323D-2, HRS, already includes a definition of "health care service." The added definition differs from the existing definition and could create confusion as to which definition should apply in other provisions of chapter 323D, HRS. For example, section 323D-43, HRS, requires a certificate of need when a person alters, initiates, or modifies health care services in the State that require a capital expenditure that exceeds certain amounts. If the bill were to pass, it is unclear if section 323D-43, HRS, would apply to the added or existing definition of health care service.

Accordingly, we recommend that the added definition of "health care service" on page 11, lines 7-16, be deleted. If the Committee wishes to include wording from the added definition, we recommend amending the existing definition of "health care facility" and "health care service" in section 323D-2, HRS, as appropriate.

We respectfully ask the Committee to make the recommended amendments if this bill is to pass. Thank you for the opportunity to provide comments.

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

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

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

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

March 7, 2025

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

FROM: John C (Jack) Lewin MD, Administrator, SHPDA;
and Senior Advisor to Governor Green On Healthcare Innovation

RE: HB 250, HD2 -- RELATING TO HEALTH (Prior authorization)

HEARING: March 10, 2025 @ 1:00 pm

POSITION: SUPPORT with COMMENTS

Testimony:

SHPDA strongly supports HB250 HD2, with comments.

HB250 HD2 requires utilization review entities to submit data relating to the prior authorization of health care services to the State Health Planning and Development Agency (SHPDA) as part of HRS Chapter 323D to achieve transparency in prior authorization (PA) processes.

In HB250 HD1 the bill was amended to include timelines for the approval of prior authorization requests for urgent and non-urgent health care services, which have potential merit, but which include definitions inconsistent with SHPDA's HRS 323D about which our attorney general has expressed concern. Those additions would also require considerable regulatory and other costs not included in the original proposal, and SHPDA believes these two additions should be removed.

HB250 also positively establishes the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency to endeavor to achieve consensus among insurers, providers, and

purchasers/consumers of health care around nationally recognized and peer-reviewed standards, guidelines, and appropriate use criteria to be applied to prior authorization determinations to facilitate streamlining and automation of PA processes.

SHPDA further strongly favors the means of describing and inviting the members of the Health Care Appropriateness and Necessity Working Group described in HB250 HD2 as an improvement of the original proposal.

After conferring with key insurer, provider, and consumer stakeholders on this proposal, we believe the following substitute language best serves the original intent of HB250, and has a greater chance for achieving its ambitious goals as the potential HB250 HD2 SD1:

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

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

The legislature further finds that there is emerging consensus among health care providers that prior authorization increases administrative burdens and costs. In the 2023 physician workforce report published by the university of Hawaii John A. Burns school of medicine, physicians voted prior authorization as their top concern regarding administrative burden. Furthermore, a physician survey conducted by the American Medical Association reported that ninety-five per cent of physicians attribute prior authorization to somewhat or significantly increased physician burnout, and that more than one-in-three have staff who work exclusively on prior authorization. The survey also found that:

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

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

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

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

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

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

"**§323D- Prior authorization; reporting.** (a) Any utilization review entity doing business in the State shall submit data to the state agency relating to prior authorization of health care services, in a format specified by the state agency. Reporting shall be annual for the preceding calendar year and shall be submitted no later than January 31 of the subsequent calendar year. The state agency shall post the reporting format on its website no later than three months before the start of the reporting period.

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

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

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

(c) The state agency shall compile the 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 the purposes of this section:

"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.

"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:

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

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

(3) Diagnosis codes;

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

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

(6) 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

(7) Any other data identified by the state agency.

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

(1) An insurer that writes health insurance policies;

(2) 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

(3) 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."

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

(1) Determine by research and consensus:

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

(B) Clinical guidelines; and

(C) Appropriate use criteria published by federal agencies, academic institutions, and professional societies, that correspond to each of the most frequent clinical treatments, procedures, medications, diagnostic images, laboratory and diagnostic tests, or types of medical equipment prescribed by licensed physicians and other health care providers in the State that trigger prior authorization determinations by the utilization review entities;

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

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

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

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

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

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

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

The members of the working group shall elect a chairperson and vice chairperson from amongst themselves. The director of

health, insurance commissioner, and administrator of the med-QUEST division of the department of human services shall each appoint an ex-officio advisor for the working group.

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

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

(e) The state agency shall seek transparency and agreement among health care facilities, health care professionals, insurers, utilization review entities, and consumers related to the most respected clinical, scientific, and efficacious standards, guidelines, and appropriate use criteria corresponding to medical treatments and services most commonly triggering prior authorization determinations in order to reduce uncertainty around common prior authorization processes, and

also foster automation of prior authorization to the benefit of all. The state agency shall explore means of achieving statewide health sector agreement on means of automating prior authorization determinations in the near future."

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

""Enrollee" means an individual eligible to receive health care benefits from a health insurer in the State pursuant to a health plan or other health insurance coverage. "Enrollee" includes an enrollee's legally authorized representative.

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

"Health care service" means health care procedures, treatments, or services provided by:

(1) A health care facility licensed to provide health care procedures, treatments, or services in the State; or

(2) A doctor of medicine, doctor of osteopathy, or other health care professional, licensed in the State, whose scope of practice includes the provision of health care procedures, treatments, or services.

"Health care service" includes the provision of pharmaceutical products or services or durable medical equipment.

"Prior authorization" means the process by which a utilization review entity determines the medical necessity or medical appropriateness of otherwise covered health care services before rendering the health care services. "Prior authorization" includes any health insurer's or utilization review entity's requirement that an insured or a health care facility or health care professional notify the insurer or utilization review entity before providing health care services to determine eligibility for payment or coverage.

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

(1) Seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(2) Subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

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

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

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

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

SECTION 4. New statutory material is underscored.

SECTION 5. This Act shall take effect on .

Mahalo for the opportunity to testify.

- -- Jack Lewin MD, Administrator, SHPDA

JOSH GREEN, M.D.
GOVERNOR

SYLVIA LUKE
LIEUTENANT GOVERNOR

STATE OF HAWAIʻI
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
201 MERCHANT STREET, SUITE 1700
HONOLULU, HAWAII 96813
Oahu (808) 586-7390
Toll Free 1(800) 295-0089
www.eutf.hawaii.gov

TESTIMONY BY DEREK MIZUNO
ADMINISTRATOR, HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
DEPARTMENT OF BUDGET AND FINANCE
STATE OF HAWAII
TO THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES
ON HOUSE BILL NO. 250 HD2

March 10, 2025
1:00 p.m.
Conference Room 225 & Videoconference

WRITTEN ONLY

RELATING TO HEALTH

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

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) Board of Trustees has not taken a position on this bill. EUTF staff would like to provide comments.

The original version of this bill, which established reporting requirements for prior authorization for health care services and established a state agency to compile and analyze the data and recommend improvements to the process, based on the data and best practice guidelines, set forth a reasonable plan to address concerns related to the current prior authorization process. By adding tight turnaround times and automatic approvals in H.D. 1, the process to develop a well thought out plan through analysis of the actual data by experts in the field was circumvented. These deadlines/automatic approvals in H.D. 1 and 2 are estimated to add significant claims to the EUTF health plans – $20-$25 million annually ($10.6-$13.25 million for actives and $9.4-$11.75 million for retirees). This could increase the employers' unfunded liability by $428.6-$535.7 million.

Thank you for the opportunity to testify.

Hawaii Association of Health Plans

March 10, 2025

To: Chair San Buenaventura, Vice Chair Aquino, and Members of the Senate Committee on Health and Human Services

From: Hawaii Association of Health Plans Public Policy Committee
Date/Location: March 10, 2025;1:00 pm/Conference Room 225 & Videoconference

Re: Testimony with comments on HB 250 HD2 – Relating to Health.

The Hawaii Association of Health Plans (HAHP) appreciates the opportunity to offer comments and to share our concerns regarding HB 250 HD2. 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 improve prior authorization processes and emphasizes that prior authorization remains a critical, evolving mechanism essential for ensuring quality patient care. We recognize the importance of addressing providers' concerns and are committed to collaborating with stakeholders to enhance this process. However, we have specific concerns about the current legislation:

- The new statutory requirements mandated by this bill do not align with current best practices and could unintentionally disrupt a process we are diligently working to improve.
- The creation of state timelines and approval deadlines that conflict with CMS requirements set to take effect on January 1, 2026, are problematic and could clog the system, creating unnecessary delays in care.

Additionally, we are concerned that the proposed changes could have significant financial implications, potentially increasing healthcare costs and resulting in higher premiums for individuals and employer groups.

HAHP acknowledges the complexity of this issue and agrees that it warrants the formation of a working group to develop solutions that benefit all parties involved. Given our extensive experience with this matter, we respectfully request to be included in this working group to ensure that Hawaii's health plans can collaborate with lawmakers and stakeholders to ensure high-quality, affordable healthcare for our state.

Thank you for your consideration and the opportunity to testify on HB 250 HD2.

Sincerely,
HAHP Public Policy Committee
cc: HAHP Board Members

March 9, 2025

The Honorable Senator Joy A. San Buenaventura, Chair
The Honorable Senator Henry J.C. Aquino, Vice Chair
Committee on Health And Human Services
Hawaii State Legislature
415 S Beretania St.
Honolulu, HI 96813

RE: Amendment Request – Page 11, Lines 15 & 16

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

On behalf of the Pharmaceutical Care Management Association (PCMA), I write regarding our opposition to **HB 250, H.D. 2** and we would like to propose an Amendment to remove "pharmaceutical products or services or durable medical equipment." on page 11, lines 15 and 16, so that existing prior authorization standards for pharmaceuticals remain unchanged.

The existing prior authorization system already ensures patient safety, cost-effectiveness, and transparency. Adding pharmaceuticals to H.B. 250, H.D. 2 would introduce a second layer of oversight and duplicative prior authorization processes, which could lead to confusion, delays in patient care, and increased healthcare costs.

Why Pharmaceuticals Should Be Removed from H.B. 250, H.D. 2

1. **PBMs Currently Provide Transparent Prior Authorization System**

- Prior authorization processes are already subject to oversight and reporting requirements. They follow nationally recognized clinical guidelines and include electronic prior authorization (ePA), which covers 75% of pharmacy prior authorization requests and improves efficiency.
- Adding new state-mandated timelines and reporting requirements on top of prior authorization will create conflicting standards that confuse providers and delay medication access.

2. Duplicative Prior Authorization Requirements Could Harm Patients

Introducing an additional layer of prior authorization for pharmaceuticals could cause delays in care. Consider the following real-world scenarios:

- **Delayed Access to Critical Mental Health Medication**
    - A patient experiencing severe depression needs an antidepressant requiring a prior authorization. PBMs process these approvals electronically, often in real-time.
    - If H.B. 250, H.D. 2 imposes separate prior authorization timelines and reporting obligations, the provider may need to navigate two different systems, leading to delays in medication access. Even a few days without the needed drug can increase the risk of relapse, hospitalization, or self-harm.

- **Conflicting Approvals for Complex Chronic Conditions**
    - A patient with diabetes and heart failure is prescribed an insulin regimen that requires careful monitoring for drug interactions. PBMs, on behalf of the health plan sponsor, already conduct safety checks, formulary reviews, and cost-effectiveness evaluations before approving coverage.
    - Under H.B. 250, H.D. 2, the physician may receive approval but face additional delays under the state-mandated prior authorization process. This could lead to confusion, delayed insulin therapy, and dangerous fluctuations in blood sugar—potentially resulting in hospitalization.

3. Adding Prior Authorization Mandates to Pharmaceuticals will Drive Up Costs

- Studies show that prior authorization can reduce drug costs by up to 50% on targeted medications, while step therapy (ST) saves an additional 10%. However, restricting these tools can increase drug expenditures by 6.75%, costing states billions over a decade.
- PBMs on behalf of the health plan, already have systems in place to automate prior authorization decisions and prevent unnecessary denials. Imposing new state-mandated layers of prior authorization could increase administrative burdens and raise costs for patients, employers, and health plans.

Requested Amendment to H.B. 250, H.D. 2

To avoid these risks, we strongly urge the Committee to adopt the proposed amendment that removes “pharmaceutical products or services” from the bill’s definition of “health care service.” This amendment:

- Preserves prior authorization processes without creating confusing, redundant requirements.
- Ensures patients get timely access to medications while keeping safety and cost-containment measures intact.

For these reasons, we oppose H.B. 250, H.D. 2 unless amended to exclude pharmaceuticals. Protecting the existing prior authorization framework ensures safe, affordable, and efficient medication management for Hawaii’s patients.

Thank you for your time and consideration. Please feel free to contact me if you have any questions or need further information.

Sincerely,

Tonia Sorrell-Neal
Sr. Director of State Affairs

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

H.B. NO. 250 H.D. 2

A BILL FOR AN ACT

RELATING TO HEALTH.

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

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

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

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

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

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

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

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

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

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

Accordingly, the purpose of this Act is to:

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

(2) Establish timelines for the approval of prior authorization requests to reduce delays for urgent and non-urgent health care services; and

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

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

"§323D- **Prior authorization; reporting.** (a) Each utilization review entity doing business in the State shall file an annual report containing data related to the prior authorization of health care services for the preceding calendar year with the state agency no later than January 1 of each year, in a form and manner prescribed by the state agency. The state agency shall post each report on its website no later than three months before the start of the reporting period.

(b) The state agency shall compile the data in each report 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 following year after the reporting period.

§323D- **Prior authorization for non-urgent health care services; submission of request; determination time frame; automatic approval.** (a) A health care professional shall submit a prior authorization request for a non-urgent health care to the utilization review entity no later than five calendar days before the provision of the health care service.

(b) A prior authorization request submitted pursuant to subsection (a) shall be deemed approved forty-eight hours after

the submission of the request if the utilization review entity fails to:

(1) Approve or deny the request and notify the enrollee or the enrollee's health care facility or health care professional;

(2) Request from the health care facility or health care professional all additional information needed to render a decision; or

(3) Notify the health care facility or health care professional that prior authorization is being questioned for medical necessity,

within the forty-eight-hour period. The utilization review entity shall have an additional twenty-four hours to process the request from the time the health care facility or health care professional submits the additional information requested pursuant to paragraph (2).

(c) Any health care facility or health care professional who fails to submit the information requested pursuant to subsection (b)(2) within fourteen days shall submit a new prior authorization request.

§323D- Prior authorization request for urgent health care services; determination time frame; automatic approval.

(a) A prior authorization request submitted for an urgent health care service shall be deemed approved twenty-four hours after the submission of the request if the utilization review entity fails to:

(1) Approve or deny the request and notify the enrollee or the enrollee's health care provider;

(2) Request from the health care facility or health care professional all additional information needed to render a decision; or

(3) Notify the health care facility or health care professional that prior authorization is being questioned for medical necessity,

within the twenty-four-hour period. The utilization review entity shall have an additional twelve hours to process the request from the time the health care facility or health care professional submits the additional information requested pursuant to paragraph (2).

(b) Any health care facility or health care professional who fails to submit the information requested pursuant to

subsection (a)(2) within twelve hours shall submit a new prior authorization request.

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

(1) Determine by research and consensus:

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

(B) Clinical guidelines; and

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

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

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

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

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

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

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

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

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

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

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

(d) The recommendations of the working group shall be advisory only and not mandatory for health care facilities, health care professionals, insurers, and utilization review

entities. The state agency shall promote the recommendations among health care facilities, health care professionals, insurers, and utilization review entities and shall publish annually in its report to the legislature the extent and impacts of its use in the State.

(e) The state agency shall seek transparency and agreement among health care facilities, health care professionals, insurers, utilization review entities, and consumers related to the most respected clinical, scientific, and efficacious standards, guidelines, and appropriate use criteria corresponding to medical treatments and services most commonly triggering prior authorization determinations in order to reduce uncertainty around common prior authorization processes, and also foster automation of prior authorization to the benefit of all. The state agency shall explore means of achieving statewide health sector agreement on means of automating prior authorization determinations in the near future."

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

""Enrollee" means an individual eligible to receive health care benefits from a health insurer in the State pursuant to a health plan or other health insurance coverage. "Enrollee" includes an enrollee's legally authorized representative.

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

"Health care service" means health care procedures, treatments, or services provided by:

(1) A health care facility licensed to provide health care procedures, treatments, or services in the State; or

(2) A doctor of medicine, doctor of osteopathy, or other health care professional, licensed in the State, whose scope of practice includes the provision of health care procedures, treatments, or services.

~~"Health care service" includes the provision of pharmaceutical products or services or durable medical equipment.~~

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

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

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

(1) Seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(2) Subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

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

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

(1) An insurer governed by chapter 431, article 10A; a mutual benefit society governed by chapter 432,

article 1; a fraternal benefit society governed by chapter 432, article 2; or a health maintenance organization governed by chapter 432D; or

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

SECTION 4. New statutory material is underscored.

SECTION 5. This Act shall take effect on July 1, 3000.

H.B. NO. 250 H.D. 2

Report Title:
Prior Authorization; Utilization Review Entities; Reporting; Health Care Appropriateness and Necessity Working Group; State Health Planning and Development Agency

Description:
Requires utilization review entities to submit data relating to the prior authorization of health care services to the State Health Planning and Development Agency. Establishes timelines for the approval of prior authorization requests for urgent and non-urgent health care services. Establishes the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency. Effective 7/1/3000. (HD2)

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

An Independent Licensee of the Blue Cross and Blue Shield Association

March 10, 2025

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

Re: HB250 HD2 - RELATING TO HEALTH

Dear Chair San Buenaventura, Vice Chair Aquino, and members of the committee,

HMSA would like to offer comments on the current version of HB 250 HD2, which requires utilization review entities to submit data relating to the prior authorization of health care services to the State Health Planning and Development Agency, establishes timelines for the approval of prior authorization requests for urgent and non-urgent health care services, and establishes the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency.

Acknowledgement and Collaboration

We thank the legislature for recognizing the importance of prior authorization (PA). It is one of many important components that help to maintain the high quality of health care delivered in Hawaii while ensuring the long-term sustainability of our state's healthcare system. HMSA has been actively collaborating with all stakeholders, including the State Health Planning and Development Agency, the Hawaii Medical Association, and the Hawaii Department of Health, to draft amendments to the current legislation and strike a compromise position. We all agree that our shared goal is to identify areas of improvement and lessen the administrative burden on providers. We are supportive of HMA's amendments that look to enhance the scope and deliverables from the proposed working group.

Concerns with Section 2

Our concerns are focused specifically on language found in Section 2, (Page 4, line 14 to page 7, line 2), which establishes state timelines and approval deadlines that are unworkable. If forced to comply, HMSA faces two highly undesirable options:

1. **Denying all prior authorization request** to meet these deadlines, which would further clog the system resulting in unnecessary delays in care and negative outcomes for both providers and patients.
2. **Approving all prior authorization requests,** which would significantly increase costs, subsequently passed on in the form of premiums. The estimated impact to the EUTF and QUEST, which make up a large percentage of HMSA's membership, would be roughly $20M and $90M respectively.

An Independent Licensee of the Blue Cross and Blue Shield Association

HMSA Prior Authorization

HMSA currently meets, and typically exceeds, Centers for Medicare & Medicaid Services and National Committee for Quality Assurance timeliness requirements for PA. We do not require PA for emergency care or care that members receive when hospitalized. Of our 17 million claims processed last year, only 204,000 (1%) required PA. Of these 81,600 (40%) did not require submission. 163,200 (80%) of the PA submissions we receive are via fax machine despite the availability of an online option increasing errors and requiring additional time for review and communication. Large numbers of claims are also incomplete or have incorrect documentation and require multiple back and forth communications forcing longer timeframes for decisions.

We want to thank Hawaii Medical Association (HMA) for its 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 solutions to 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.

Request for Senate Version Adoption

We would like to express our gratitude for the diligent work and thoughtful consideration that went into the Senate version of this bill. We believe the language and provisions in SB1449 SD1 effectively address the key issues and align with our shared goals. Therefore, we respectfully request that you consider adopting the language from SB1449 SD1, with the addition of the proposed working group found in HB250 HD2. We would also ask that the committee delete the language found in Section 2, Page 4, line 14 to page 7, line 2, due to the aforementioned concerns we have expressed in our testimony.

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

Sincerely,

Dawn Kurisu
Assistant Vice President
Community and Government Relations

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

March 10, 2025
1:00 p.m.
Conference Room 225
Via Videoconference

Re: HB 250, HD 2, Relating to Health.

Chair San Buenaventura, Vice Chair Aquino, and committee members, thank you for this opportunity to provide testimony on HB 250, HD2, which requires utilization review entities to submit data relating to the prior authorization of health care services to the State Health Planning and Development Agency, establishes timelines for the approval of prior authorization requests for urgent and non-urgent health care services, and establishes the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency.

Kaiser Permanente Hawai‘i provides the following COMMENTS on HB 250, HD 2 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.

Prior 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,

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

accurate, consistent, fair and equitable prior authorization decisions. We further support policies that promote the development and use of technology to streamline administrative processes and facilitate communication between health plans, providers and patients.

While we support the intent of HB 250, HD 2 additional amendments are needed to make the requirements workable and ensure the bill accomplishes its objectives. We are prepared to work with the proponents of the bill to make these adjustments, which generally would align the reporting requirements and approval timelines with analogous federal standards.

We humbly request the following amendments:

Page 4, Section 2, to be replaced with language from Senate Bill 1449:

"§323D- Prior authorization; reporting.

(a) Any utilization review entity doing business in the State shall submit prior authorization data to the state agency, 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 before the start of the reporting period.

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

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

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

(c) The state agency shall compile the 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.

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

Page 8, Section 2, Line 14, Add the following to the scope of the Health Care Appropriateness and Necessity Working Group:

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

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

Page 12, Section , Line 5, Add the following definition for "Prior authorization data":

"Prior authorization data" means data 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).

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

‘Ahahui o nā Kauka

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

March 7, 2025

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

Group Testimony in Support of
HB250HD2 RELATING TO HEALTH (Prior Authorization)

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

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

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

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

Testimony to the Senate Committee on Health and Human Services
Monday, March 10, 2025; 1:00 p.m.
State Capitol, Conference Room 225
Via Videoconference

RE: HOUSE BILL NO. 0250, HOUSE DRAFT 2, RELATING TO HEALTH.

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

The Hawaii Primary Care Association (HPCA) is a 501(c)(3) organization established to advocate for, expand access to, and sustain high quality care through the statewide network of Community Health Centers throughout the State of Hawaii. The HPCA **SUPPORTS** House Bill No. 0250, House Draft 2, RELATING TO HEALTH.

By way of background, the HPCA represents Hawaii's Federally Qualified Health Centers (FQHCs). FQHCs provide desperately needed medical services at the frontlines to over 150,000 patients each year who live in rural and underserved communities. Long considered champions for creating a more sustainable, integrated, and wellness-oriented system of health, FQHCs provide a more efficient, more effective and more comprehensive system of healthcare.

This measure, as received by your Committee, would:

(1) Require utilization review entities to report certain data to the State Health Planning and Development Agency (SHPDA);

(2) Establish timelines for the approval of prior authorization requests to reduce delays for urgent and non-urgent health care services; and

(3) Establish the Health Care Appropriateness and Necessity Working Group (Working Group) to make recommendations to improve and expedite the prior authorization process.

We note that the bill, as presently written, would require that one consumer member of the Working Group be selected by the HPCA.

This measure would take effect on July 1, 3000.

ADD 1003 BISHOP STREET PAUAHI TOWER SUITE 1810 HONOLULU, HI 96813 TEL 808.536.8442 WEB HAWAIIPCA.NET

The HPCA asserts that current prior authorization requirements utilized by insurers and managed care plans have greatly diminished the provision of essential services to patients on a timely basis. This has negatively impacted the health care outcomes of the most vulnerable populations in the State. Because of this, the HPCA believes that convening a panel of stakeholders to look at this issue would be beneficial to investigate ways of improving the situation for our citizens.

The HPCA notes that the Department of Health does not have any licensing or regulatory authority over health insurers. This authority falls under the jurisdiction of the Department of Commerce and Consumer Affairs (DCCA). As such, this Committee may want to consider adding a representative from DCCA's Insurance Division to this Working Group.

Accordingly, the HPCA urges your favorable consideration of this measure.

Thank you for the opportunity to testify. Should you have any questions, please do not hesitate to contact Public Affairs and Policy Director Erik K. Abe at 536-8442, or eabe@hawaiipca.net.

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: March 10, 2025
From: Hawaii Medical Association (HMA)
Jerald Garcia MD - Chair, HMA Public Policy Committee

Re: HB 250 HD2 RELATING TO HEALTH - Prior Authorization; Utilization Review Entities; Reporting; Health Care Appropriateness and Necessity Working Group; State Health Planning and Development Agency
Position: Support with amendments

This measure would require utilization review entities to submit data relating to the prior authorization of health care services to the State Health Planning and Development Agency, establish timelines for the approval of prior authorization requests for urgent and non-urgent health care services, establish the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency.

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

The disclosure and reporting of the relevant payor utilization data of PA is imperative for meaningful analyses of challenges, and a body for oversight is necessary to address deficiencies as well as monitor progress. Given the complexities of PA and healthcare delivery, modifications and revisal will require ongoing assessment and review over time. **HMA strongly supports the establishment of the Health Care Appropriateness and Necessity Working Group.**

The group work to eliminate PA barriers may include specific consensus recommendations that 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. Therefore, **HMA also respectfully requests these two (2) amendments for consideration:**

- *Addition in subsection (a), insert (5):*

(5) Make recommendations on treatments for common chronic or long term conditions, for which prior authorization may remain valid for the duration of the treatment in the appropriate clinical setting.

- *Addition in subsection (e):*

(e) The state agency shall seek transparency and agreement among health care facilities, health care professionals, insurers, utilization review entities, and consumers related to the most respected clinical, scientific, and efficacious standards, guidelines, and appropriate use criteria corresponding to medical treatments and services most commonly triggering prior authorization determinations in order to reduce uncertainty around common prior authorization processes, and also foster automation of prior authorization to the benefit of all. The state agency shall explore means of achieving statewide health sector agreement on means of automating prior authorization determinations **that decrease delays and disruptions of medically necessary patient care** in the near future."

HMA strongly supports Prior Authorization reform 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. HMA greatly appreciates the continued thoughtful discussions and aloha of collaborators in SHPDA and HMSA as we explore solutions together.

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

REFERENCES AND QUICK LINKS

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

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

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

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

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

Date: March 6th, 2025
From: Medical Students at the John A. Burns School of Medicine (JABSOM)

Re: **HB 250 HD2 RELATING TO HEALTH -** Prior Authorization; Utilization Review Entities; Reporting; Health Care Appropriateness and Necessity Commission; State Health Planning and Development Agency
Position: **SUPPORT**

Aloha Chair San Buenaventura, Vice Chair Aquino and Members of the Committee,

As medical students training in Hawai‘i, we are deeply invested in the future of healthcare in our state. We are testifying in strong support of HB250 because we have witnessed how prior authorization delays and administrative burdens negatively impact patient care. Based on a 2024 survey of 100 physicians practicing in Hawai'i, physicians and their staff spend nearly 20 hours per week on prior authorization paperwork, reducing the time available for direct patient care.[1] As future doctors, we hope to practice medicine without these barriers to deliver compassionate care to the people of Hawai‘i.

However, the real burden of the prior authorization process is placed on patients. We would like to share three stories collected from Hawai’i doctors that describe the direct consequences of failures in the prior authorization process.

An 85-year-old woman with severe atopic dermatitis had her medication (rinvoq) denied multiple times, resulting in the worsening of her condition. This eventually led to a severe skin infection that required hospitalization, IV antibiotics, and surgical intervention, significantly prolonging her suffering.

A patient with advanced esophageal cancer was denied a fentanyl patch, which was necessary for pain management because he could not safely swallow medication. The delay in receiving the appropriate pain management led to the patient experiencing horrific, inhumane conditions before he passed away.

A patient with lung cancer had to wait over 3 months for prior authorization for a CT-guided biopsy. This delay ultimately leading to the patient’s death before they could start the necessary treatment.

The data puts these stories into perspective; 42% of Hawai‘i physicians report that prior authorization has contributed to a serious adverse event for a patient in their care.[1] These delays are not just statistics—they translate to unnecessary suffering and in some cases, life-threatening consequences. As medical students, we respect the importance of systems that ensure patients the correct care. However, when insurance companies block medically necessary and appropriate care, it is the patients who suffer.

To retain and recruit physicians to Hawai‘i, we must create a system that allows doctors to focus on patient care rather than paperwork. A great many of us hope to serve in Hawai‘i in the future, and reducing administrative burdens would make that path more sustainable and fulfilling. HB250 takes essential steps toward transparency and accountability, ensuring that prior authorization policies do not impede timely access to medical treatment. We urge you to pass HB250 and reduce these barriers to care.

Mahalo for your time and consideration.

Sincerely,
Students at the John A. Burns School of Medicine

Elizabeth Rooks
Sarah Bellatti
Ashley Lee
Kirsten Chun
Kaela Akina-Magnussen
D-Dré Wright
David Coleman
Lauren Muraoka
Alnor Carnate Jr.
Jasmine Padamada
Kaela Iwai
Elise Chong
Lauren Kirkwood-Johnson
Simone Evett
Sydney Maarat
Matthew Winters
Justin Lee
Amily Tam
Heather Zimmerman
Nicholas Van
Darcy Tokunaga
Lexie Matsunaga
Erin Jyo
Sarini Saksena
Krystin Wong
Michelle Kimura
Christyn Mellor
Kennedy Tamashiro
Chloe McCreery
Thomas Clausen
Doris Yang
Johnathan Kim
Justin Abe
Katherine Koch
Joseph Li
Jonathan Carino
Liana Owen
Kyle Xia
Kerri Niino
Tony Head
Duke Escobar
Dylan Lawton
Amanda Tsuhako
Saskia Leonard
April Hamachi
Serena Myatt
Michelle Trinh
Maya Ushijima
Eyrica Sumida
Quinci Salvador
Kirra Borrello
Eli Snyder
Richard Chen
Erin Annick
Alyssa Kameoka

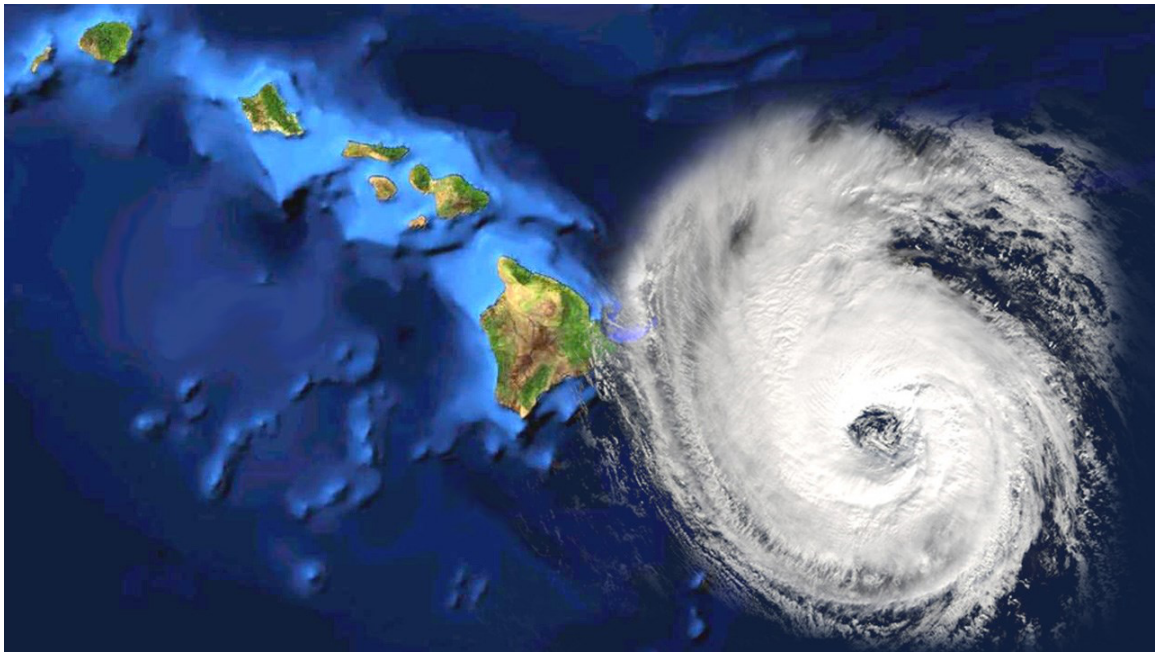
References:

1. Chinen L, Rooks E, Withy K. Impact of Prior Authorizations on Healthcare in Hawai'i. Sep 2024; Hawaii Health Workforce Summit, Honolulu, HI.

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

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

The Perfect Storm: Sebastian Junger



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

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

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

John Lauris Wade MD
Hawaii Provider Shortage Crisis Task Force

The Perfect Storm

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

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

We do not have enough Doctors.

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

We do not have enough Healthcare Workers.

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

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

The Physician Workforce Shortage

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

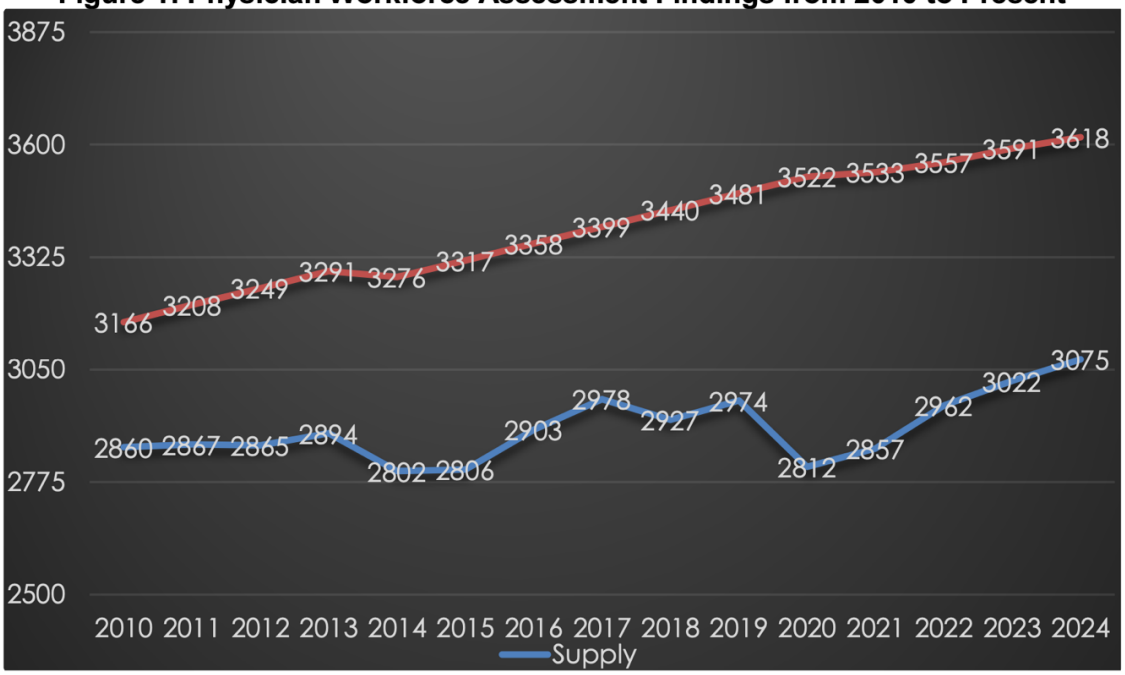
For 15 years, the HI Physician Workforce Assessment Project has studied the ongoing Physician Workforce Shortage.

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

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

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

Figure 1: Physician Workforce Assessment Findings from 2010 to Present



Takeaways

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

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

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

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

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

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

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

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

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

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

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

Hawai'i needs to attract and retain 768 physicians

Healthcare access for our most vulnerable patients is at stake.

Hawaii's Healthcare Future

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

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

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

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

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

Physician and Healthcare Workers Decide

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

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

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

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

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

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

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

Storm Front 1:
Inadequate Federal Payments for Medical Services

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

Medicare's Primacy

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

Medicare Payments

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

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

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

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

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

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

GPCI: Geographic Price Cost Indices

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

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

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

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

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

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

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

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

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

Medicare GPCI and its Effect on Payments

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

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

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

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

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

US Congressman Ed Case (D-HI)

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

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

Hawaii and Comparison States Cost of Living

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

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

What Cost Change?

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

Alaska: A Brief History of Alaska Medicare

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

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

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

Hawaii: Facing Similar Medicare Challenges

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

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

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

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

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

A Simple Medicare Solution

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

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

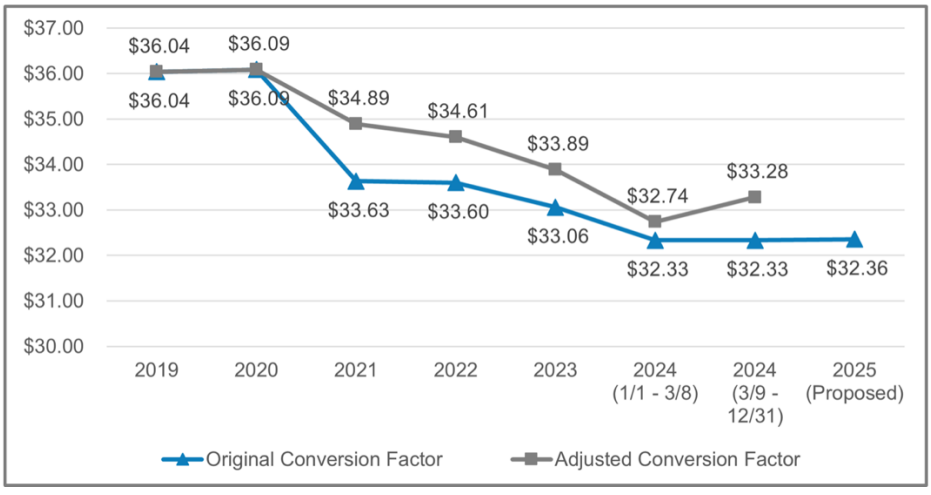
The HI Medicare issue could be addressed by requesting an amendment to the Social Security Act adding Hawaii to Section 42 U.S.C. 1395w–4(e)(1)(G)) which reads….

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

Medicare Cuts and Inflation

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

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



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

Storm Front Two:
Hawaii General Excise Tax on Medical Services

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

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

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

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

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

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

Storm Front Three
A Payor Monopsony

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

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

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

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

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

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

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

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

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

HMSA Functions as a Monopsony.

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

HMSA is a Barrier to Care

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

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

HMSA Refuses to Pay for Care Provided

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

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

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

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

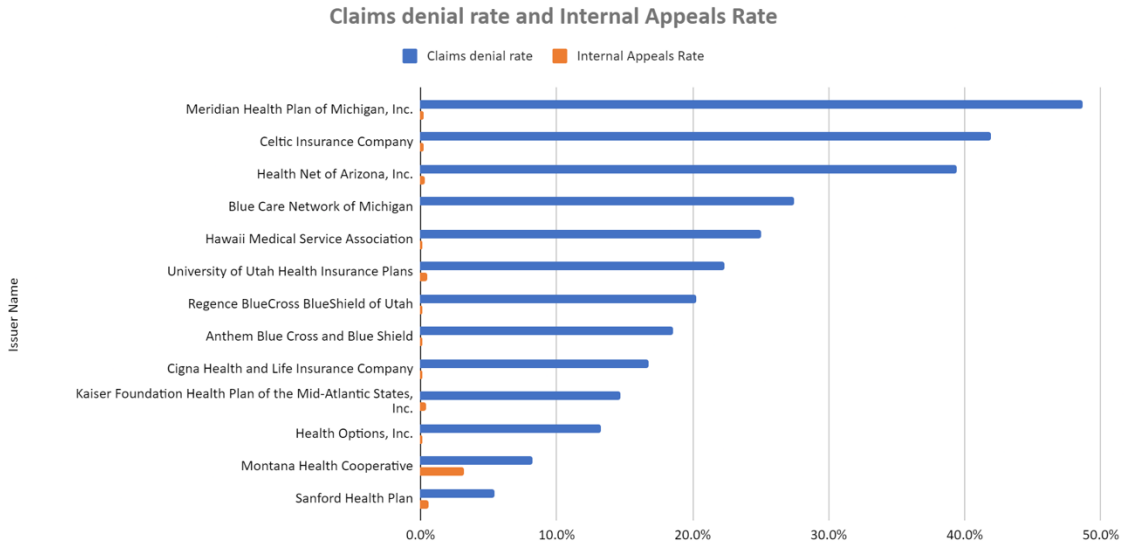
Over the last six years, the HMSA Claim Denial Rate for patients who have purchased their insurance on the HealthCare.gov and obtained care In Network is a stunning 25.1%.

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

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

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

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



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

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

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

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

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

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

HMSA Practices Medicine Without a License

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

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

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

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

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

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

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

HMSA is a Financial Investment Company

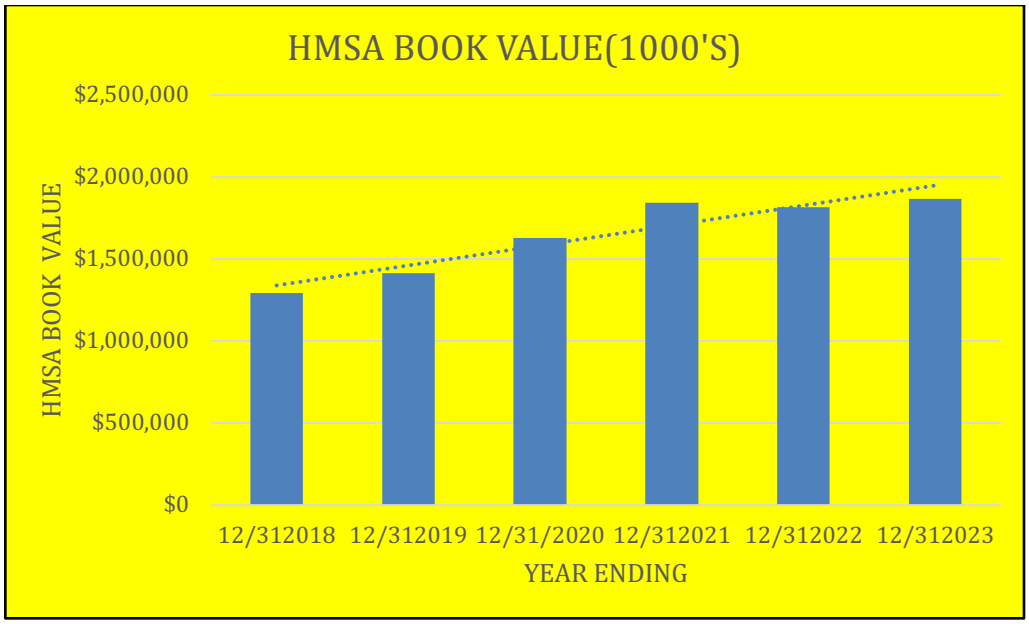
An investment company is a financial institution principally engaged in holding, managing, and investing securities. Think Blackrock, Vanguard, Fidelity.
Insurance companies are essentially investment vehicles driven by the principal of float. No one explains this better than Warren Buffett.

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

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

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

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



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

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

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

HMSA Weakens HI Healthcare

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

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

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

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

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

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

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

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

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

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

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

HMSA Practices Result in an Inadequate Healthcare System

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

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

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

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

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

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

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

Provider Contract Authorization Processes should be reformed or abolished altogether.

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

Storm Shelter

Hawaii Provider Shortage Crisis Task Force Successes

Hawaii Medicare
Health Professions Shortage Area Designation:

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

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

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

Hawaii General Excise Tax
Medicaid, Medicare, and Tricare Exemption

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

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

Storm Report Summary:

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

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

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

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

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

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

Weathering The Storm:
Reforms to Survive and Thrive

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

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

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

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

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

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

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

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

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

Perfect Storm Summary:

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

Pono

Pono is beautiful word with great depth and meaning.

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

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

Mahalo for your consideration and all your hard work.

John Lauris Wade MD
Hawaii Provider Shortage Crisis Task Force

HB-250-HD-2
Submitted on: 3/9/2025 11:24:23 AM
Testimony for HHS on 3/10/2025 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 refer to HMA testimony.

Dear Chair San Buenaventura, and Committee Members,

My name is James LaBrie and I am a person with a developmental disability who relies on a custom-modified electric wheelchair for mobility. I strongly support HB250 because it addresses the significant delays caused by the prior authorization (PA) process, which directly impacts my ability to live independently and maintain my quality of life.

When my wheelchair breaks, I am forced to wait weeks—sometimes even longer—for a prior authorization approval before repairs can be made. In the meantime, I am left without mobility. The situation is even more frustrating because even the request for a temporary manual wheelchair—just so I can have someone push me around—is also delayed due to PA requirements. The result is unnecessary suffering, loss of independence, and preventable hardship.

HB250 is a crucial step in addressing these issues by:

1. **Requiring transparency** in PA decisions to ensure that approvals or denials are based on clear medical criteria.
2. **Setting reasonable timeframes** for urgent and non-urgent requests, preventing unnecessary delays.
3. **Creating a working group** to improve and streamline the PA process, reducing administrative burdens and ensuring timely access to medically necessary services.

The statistics in the bill highlight what many of us experience firsthand: delayed care leads to worsened conditions, hospitalization, and even permanent disability. The PA system, as it stands, is not working for the people it is supposed to help.

I urge you to pass HB250 to protect individuals like me from unnecessary delays in accessing essential medical equipment and services.

Thank you for your time and consideration.

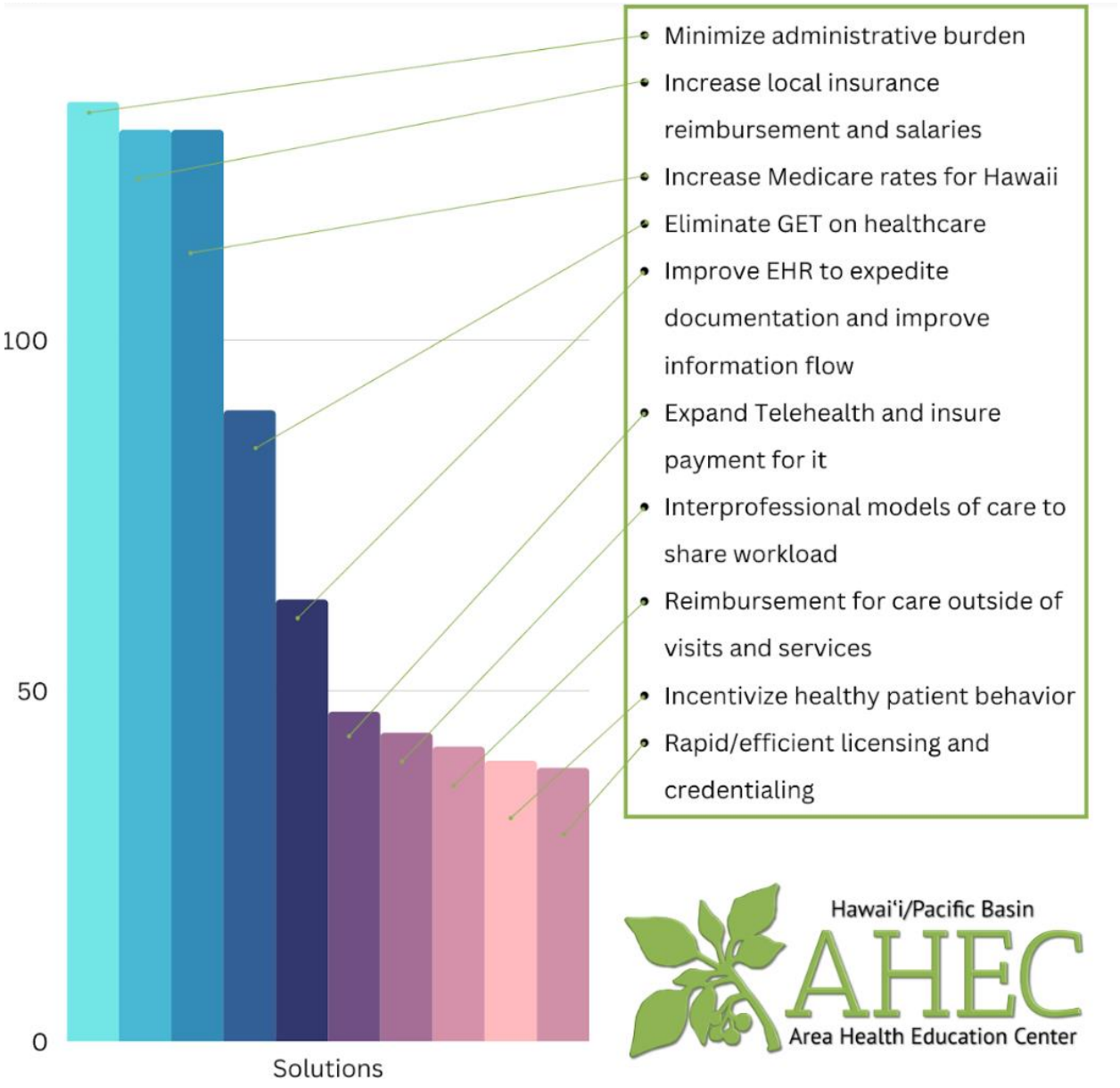
Sincerely,

James LaBrie

Please SUPPORT HB250!!

Prior Authorization is the TOP action that local healthcare workers report should be addressed to recruit and retain Hawaii's health workforce. A workforce with severe shortages!!

Over 400 participants from the Hawaii Health Workforce Summit voted on what needs to be done to recruit and retain healthcare worker:

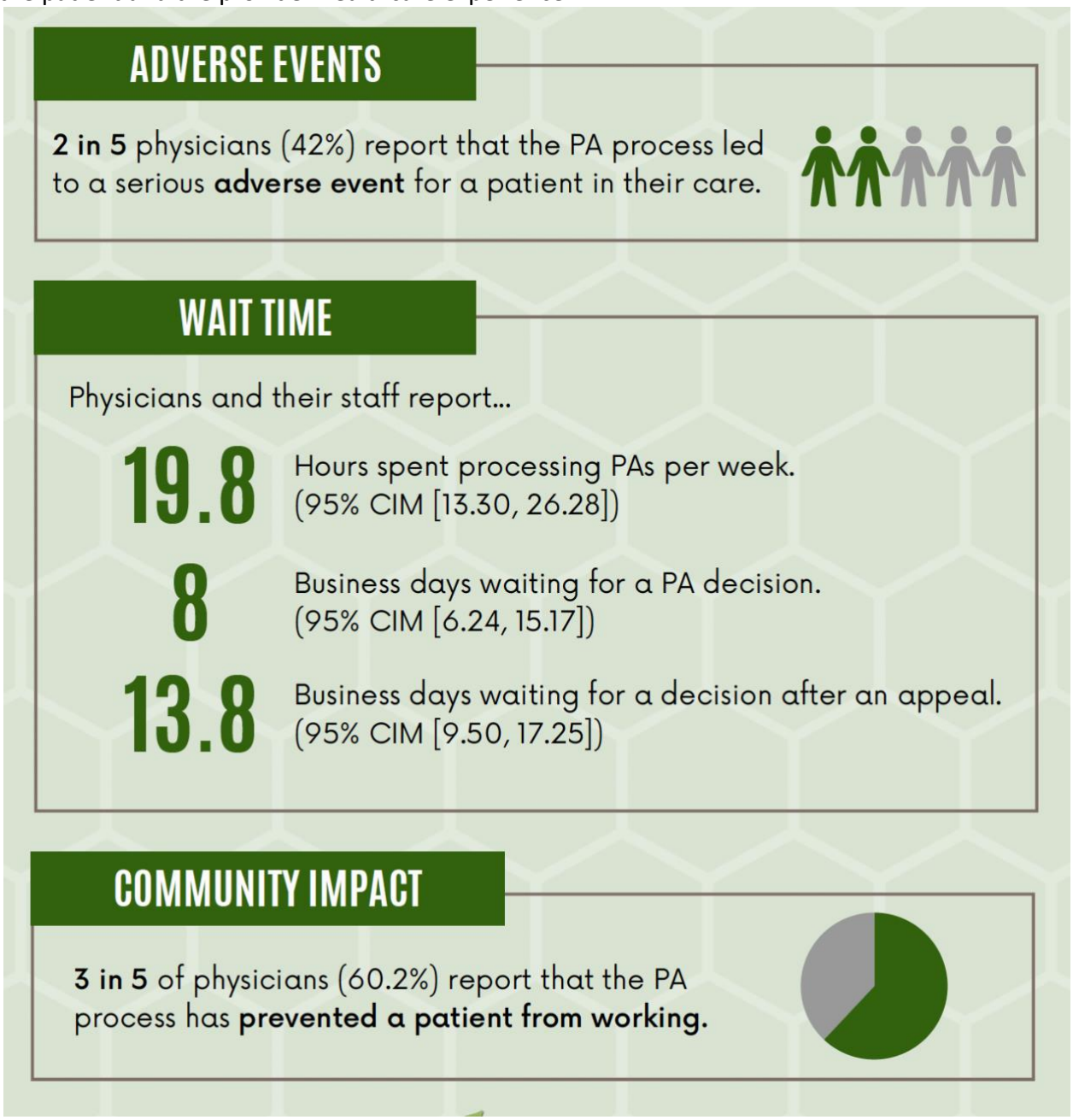


Following that, 112 physicians voted on what is most important for simplifying ADMINISTRATIVE BURDEN and the most common responses were:

- *Prior Authorization*
- *Training or personnel hires*
- *EMR*

- *Billing*
- *Credentialing/licensure*
- *Quality Metrics*
- *Pharmacy*
- *Telehealth*
- *Travel (patients or providers)*

More recently, physicians answered an ongoing UH survey about prior authorization. The results indicate that transparency, active discussion and collaborative change is needed to improve both the patient and the provider healthcare experience:



HB-250-HD-2
Submitted on: 3/7/2025 11:52:44 AM
Testimony for HHS on 3/10/2025 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Shana Metsch	Individual	Support	Written Testimony Only

Comments:

TESTIMONY IN SUPPORT OF HB250

Dear Chair and Committee Members,

My name is Shana Metsch, and I am submitting testimony in **strong support** of **HB250**, which seeks to reform the prior authorization process by requiring utilization review entities to submit relevant data to the State Health Planning and Development Agency and by establishing the Health Care Appropriateness and Necessity Commission.

The need for this reform is undeniable. According to the American Medical Association, 83% of appealed medical denials are overturned. This statistic underscores a systemic issue—patients are often wrongfully denied necessary medical care, forcing them into an arduous appeals process that delays essential treatment. These delays not only jeopardize patients' health but also increase costs for insurers when untreated conditions escalate into more severe, costly complications.

As a **f**amily member, caregiver, and advocate for my daughter with disabilities, I have personally witnessed the devastating impact of these unjustified denials. For instance**,** my daughter, who has never walked, is currently being denied a wheelchair by her insurance provider on the basis that it is "not medically necessary." This is despite the fact that she was previously approved for a wheelchair in 2019, and her condition has not changed—she still cannot ambulate independently. This is a clear example of how insurers default to denials, disregarding medical necessity and patient well-being.

HB250 is a critical step toward transparency and accountability in the prior authorization process. This bill will help reduce unnecessary delays, prevent harmful denials, and improve patient outcomes across Hawai‘i by mandating the submission of prior authorization data and establishing an oversight commission.

I respectfully urge you to pass HB250 to protect our most vulnerable community members and ensure that medically necessary care is not withheld from those who need it most.

Thank you for your time and consideration.

Sincerely,

Shana Metsch

HB-250-HD-2
Submitted on: 3/8/2025 12:03:38 PM
Testimony for HHS on 3/10/2025 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Allen Novak	Individual	Support	Written Testimony Only

Comments:

I wish to testify in support of HB250 as this measure will promote much needed consumer advocacy for healthcare service. It addresses an issue which in recent months has become a lightning rod for consumer resentment toward insurance providers.

HB-250-HD-2
Submitted on: 3/8/2025 2:50:12 PM
Testimony for HHS on 3/10/2025 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Colleen Inouye	Individual	Support	Written Testimony Only

Comments:

Dear Senators Buenaventura and Aquino and the Committee on Health and Human Services,

Please support HB250 HD2.

This bill is designed to make Prior Authorization more efficient and effective. Also, requiring data reporting to SHPDA will keep the Prior Authorization processes by utilization review entities transparent.

Again, please support HB250 HD2.

Sincerely,

Colleen F Inouye MD MMM MS-PopH FACHE FAAPL FACOG

HB-250-HD-2
Submitted on: 3/8/2025 9:36:55 PM
Testimony for HHS on 3/10/2025 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Ronald Taniguchi, Pharm.D., MBA	Individual	Support	Written Testimony Only

Comments:

I fully support HB250 HD2. Mahalo

HB-250-HD-2
Submitted on: 3/9/2025 9:47:32 AM
Testimony for HHS on 3/10/2025 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Thomas Weiner	Individual	Support	Written Testimony Only

Comments:

Dear Representitives,

I am writing in support of HB250 because it addresses, in a small way, the growing problem of prior authorizations. A tactic used by insurance companies to avoid paying for care under a guise of "waste reduction" and "affordability". In reality these measures are increasingly used to avoid paying ofr necessary treatment and tests. They intentionally delay care leading to wasted time for docotor's offices and worse health outcomes for patients.

Thank you,

Thomas Weiner MD

Alistair W Bairos, MD, CWSP, FACCWS

General Surgery, Wound Care Specialist

PO Box 670
Kealakekua, Hawai'i, 96750
[808] 960.3383 cell
(808) 900.3381 fax

3/09/2025

TO: COMMITTEE ON HEALTH AND HUMAN SERVICES
Senator Joy Buenaventura, Chair
Senator Henry Aquino, Vice Chair

RE: HB 250, HD2

I am writing in strong support of HB 250 HD2 to streamline and improve Prior Authorization effectively.

This may seem, to nonmedical folks, a rather boring issue whose primary benefit is to make life easier for health care practitioners – little could be further from the truth – this is in fact a vital issue that not infrequently touches on the very life and limb of patients. **PLEASE KEEP READING:**

Through forty years of practice on the Big Island, I have seen prior authorization morph from an infrequent, sometimes justifiable, requirement to an outright scourge inappropriately applied across a range of routine procedures and not infrequently resulting in catastrophic, irremediable consequences for patients.

Three weeks ago I had a delightful 91 year old gentleman with a non-healing diabetic foot ulcer, urgently referred by me – a board-verified wound care specialist - to a board certified vascular surgeon for urgent angioplasty – the authorization was delayed, 2 days beyond the supposed two day response time for urgent prior authorization requests, causing the patient to miss the vascular surgeon's Big Island schedule and delaying the procedure for two weeks, until the surgeon's next Big Island visit, putting the patient at serious risk of losing his foot, his leg, his life – all because of the insipid prior authorization regulation that should never have been applied in such a case.

And, indeed, worst fears have been realized and this patient's wound has further deteriorated, with infection now spreading to the bone, seriously raising the possibility of amputation or, at the very least, months of extensive therapy in hopes of resolving this problem; a problem that was unequivocally worsened by Hawai'i's current prior authorization rules.

The above is an oft-repeated reality of the effects of prior authorization – not some abstract irritation for providers – this is where the rubber meets the road – or, in this case, where the foot meets the leg, where the leg meets the body…

End this now…please. Pass his bill and help make a start to resolving this issue.

Yours truly and aloha,

Ali Bairos, MD

Alistair W Bairos, MD, CWSP, FACCWS
President
American Board of Wound Management
1800 M Street, NW | Suite 400S | Washington, DC 20036

Cell: 808.960.3383 | Fax: 808.900.3381
alibaba@hawaii.rr.com | www.abwmcertified.org2

Electronically signed 03/09/2025, 10:57:31AM

LATE

HB-250-HD-2
Submitted on: 3/10/2025 4:51:36 AM
Testimony for HHS on 3/10/2025 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Ricardo Molero Bravo	Individual	Support	Written Testimony Only

Comments:

I support this bill. Fixing prior authorizations is fundamental in helping healthcare practices stay open and reducing the physician workforce needs of our State. It also improves timely patient care tremendously to avoid long wait times and gaps in care.

LATE

HB-250-HD-2
Submitted on: 3/9/2025 9:01:30 PM
Testimony for HHS on 3/10/2025 1:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Maya Maxym	Individual	Support	Written Testimony Only

Comments:

As a pediatrician who practices evidence-based medicine, I strongly support this bill. It would help to reduce the administrative burden for physicians and other members of the healthcare team, increase prompt access to necessary tests and treatments for patients, and improve satisfaction for both patients and the care team alike. I urge you to support this bill.

Mahalo,

Maya Maxym, MD PhD FAAP

ALOHACARE

LATE

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

From: Paula Arcena, External Affairs Vice President
Mike Nguyen, Director of Public Policy
Sarielyn Curtis, External Affairs Specialist

Hearing: Monday, March 10, 2025, 1:00PM, Conference Room 225

RE: **HB250 HD1 Relating to Health**

AlohaCare appreciates the opportunity to provide **comments** on **HB250 HD2.** This measure requires utilization review entities to submit data relating to the prior authorization of health care services to the State Health Planning and Development Agency, establishes timelines for the approval of prior authorization requests for urgent and non-urgent health care services, and establishes the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency.

Founded in 1994 by Hawai'i's community health centers, AlohaCare is a community-rooted, non-profit health plan serving over 70,000 Medicaid and dual-eligible health plan members on all islands. Approximately 37 percent of our members are keiki. We are Hawai'i's only health plan exclusively dedicated to serving Medicaid and Medicaid-Medicare dually-eligible beneficiaries. Our mission is to serve individuals and communities in the true spirit of aloha by ensuring and advocating for access to quality, whole-person care for all.

AlohaCare is committed partnering with community healthcare providers to advance the goals of the triple aim: improving the patient experience of care including quality and satisfaction, improving the health of the population, and reducing per capita cost of care. We **support the intent** of the measure to reduce administrative burdens on provider, but we respectuflly offer **comments with concerns with the timelines proposed in section two of the bill**. These provisions will likely have the unintended consequence of actually increasing administrative burden on both health plans and the providers, not to mention the administrative oversight of and burden on SHPDA. We are concerned that these timelines will weaken controls over increasingly expensive medical treatment and diagnostics and drive up healthcare costs not only for AlohaCare but for health payors broadly across Hawai'i. We would note that for prescription drugs dispensed by pharmacies, we already review standard and urgents requests within 24 hours. For medical prior authorization requests under this proposed measure, we will

certainly need to increase staffing to accommodate the timelines, but we are also concerned about likely increased medical costs and potential waste. Also, we would note that CMS last year issued a final rule that would shorten the timeline for prior authorization decisions, starting Janaury 2026. **We would respectfully request that the timelines proposed in section two of the bill be removed.**

Mahalo for this opportunity to provide testimony offering our **comments** on **HB250 HD2.** Below we offer additional background and context.

Our Approach. Prior authorization is one tool in a broad strategy to deliver safe and necessary care consistent with evidence-based guidelines and best practices. At AlohaCare, we use prior authorization on a limited basis to maintain high standards of care and gauge medical necessity or appropriateness, directing care to cost-effective, higher-quality, and in-network settings and avoiding potentially harmful care. For example, prior authorization allows AlohaCare to prevent harmful drug interactions and to ensure that prescribed services are the right fit for members, such as confirming that wheelchairs can fit through the door of a member's home. Further, we utilize prior authorization data internally to allow care managers to better understand a member's needs and care, and we share data with network providers to enhance the provision of care and to assist with discharges and transitions in care settings. Prior authorization may also shield families from unnecessary health care bills, protect patients from bad actors in the health care provider community, and help ensure that limited health care dollars are wisely spent.

Gold Carding. Acknowledging the administrative burden that prior authorization places on healthcare providers and in recognition of our providers that consistently provide care consistent with evidence-based guidelines and best practices, we have begun to implement a "gold carding" pilot. Gold carding is a process where prior authorization requirements are lifted for providers who consistently practice evidence-based medicine and rarely receive denials for their service requests. This approach recognizes the high standards of care provided by these physicians, streamlines the prior authorization process, improves efficiency, and reduces the administrative load on healthcare providers.

We would note that we also use prior authorization data to understand where the plan-provider relationship can be enhanced, how provider education can be improved, and how provider burden can be reduced. For example, linking prior authorization processes and data with claims systems ensures claims are paid quickly and accurately. Prior authorization can also help to ensure access to

payment, avoid backend disputes, and can even encourage some providers to accept patients because they can be assured of payment in advance.

Government Oversight for Medicaid Managed Care. State Medicaid agencies are required by federal rules to collect and review data on appeals of denials and state fair hearings, conduct external quality reviews of Medicaid health plans, and assess timeliness requirements, plus have discretion to conduct additional oversight activities. Accordingly, Medicaid health plans submit prior authorization policies and data for review to state Medicaid agencies when required, complying with state and federal laws on utilization management and prior authorization and following state contracts and guidelines.[1]

Medicaid health plans are subject to additional requirements meant to ensure that they do not use prior authorization to restrict access to medically necessary care. Medicaid health plans must adopt practice guidelines that reflect clinical evidence and expert consensus, and use those guidelines for making utilization management decisions (42 CFR §438.236). Federal regulations also detail the processes and timelines by which Medicaid health plans must make prior authorization decisions. Medicaid health plans must have tools in place to ensure that prior authorization review criteria are applied consistently, and any Medicaid health plans decisions to deny services must be made by individuals with appropriate clinical expertise to address the beneficiary's health care needs. Medicaid health plans must also supply denial notifications to requesting providers and give beneficiaries a notice of denial in writing. Current regulations require that standard decisions be made within 14 days and expedited decisions be made within 72 hours, though these time frames will be reduced by the new requirements from the 2024 Interoperability and Prior Authorization final rule, which will take effect January 2026 (42 CFR § 438.210, CMS 2024a). Starting January 1, 2026, the rule requires impacted health plans to make prior authorization decisions within 7 calendar days for standard requests and 72 hours for expedited requests.

[1] Medicaid and CHIP Payment and Access Commission (MACPAC). *Prior Authorization in Medicaid.* August 2024. https://www.macpac.gov/publication/prior-authorization-in-medicaid-2/