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

January 27, 2025

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

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

Re: HB 250 RELATING TO HEALTH (Prior authorization)

Position: SUPPORT

Testimony:

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

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

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

to challenge the denials on behalf of their patients. Meanwhile, insurers increasingly contract out their prior authorization determinations to other private companies that providers believe to be increasing denial rates with what appear to be perverse financial incentives to do so.

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

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

This bill proposes two methods to accomplish this improvement: first, mandatory reporting by insurers of all key parameters associated with prior authorization so that we can achieve transparency around the process. And second, creation of a commission with equal representation of insurers, providers, and purchasers of insurance (the latter including consumers, employers, and government) to collaborate on achieving statewide agreement on the best and peer-reviewed standards, guidelines, and criteria available nationally for prior authorization determinations. If we can achieve this, prior authorization can be largely automated and streamlined to the benefit of all. The determinations could be made before the patient leaves the office or immediately during hospital admission.

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

I would suggest three amendments to this bill as written after conferring with health sector members: first to change the suggestion of a commission to a less formal “work group” or “task force.” Second, that “laboratory and diagnostic tests” should be included to the list of things which commonly trigger prior authorizations; and third to require re-authorization of the Health Care

Appropriateness and Necessity Working Group (or Task Force) after it submits a report on its progress before the opening of the 2027 Legislative session.

Mahalo for the opportunity to testify.

- -- Jack Lewin MD, Administrator, SHPDA

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

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

REP. GREGG TAKAYAMA, CHAIR
HOUSE COMMITTEE ON HEALTH

Hearing Date: January 31, 2025 Room Number: 329

Department Testimony: Department Testimony: The Department of Health (DOH) supports HB250 but prefers HB1130, which is part of the Governor's Administrative Package.

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

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

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

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

Thank you for the opportunity to testify.

Testimony in Support of HB250

Testimony in Support of HB250 with Recommendations for Greater Transparency

Thank you for the chance to provide testimony in support of HB250. This bill aims to bring much-needed reform and openness to the prior authorization process. As someone deeply invested in the health of our community, I want to express my support for this bill's intent and provisions to make prior authorizations more fair and accountable. At the same time, I encourage you to consider requiring full disclosure of prior authorization data to the public.

Support for HB250
HB250 is an important step toward fixing the frustrating and confusing prior authorization processes that delay care for people in Hawaii. By requiring annual reporting from utilization review entities and creating a Health Care Appropriateness and Necessity Commission, this bill helps create transparency and drives meaningful change. These measures are crucial for:

1. Spotting Barriers to Care: Detailed reporting will help everyone understand where delays and denials are happening, so we can work on solutions.
2. Promoting Accountability: Requiring these reports will push entities to make their processes more efficient and reduce unnecessary headaches for providers and patients.
3. Improving Patient Outcomes: Streamlining the system means people can get care faster, which leads to better health and happier patients.
4. Decreasing Provider Administrative Burden: Reducing paperwork makes more time for patient care and reduces burnout in our healthcare community.

Recommendation for Public Disclosure
While HB250 does a good job of requiring annual reports, I strongly suggest that the bill go a step further by making sure all this data is available to the public. Specifically, the bill should:

1. Make Data Publicly Accessible: All collected data should be shared with the public in an easy-to-access format. This would allow patients, providers, and advocates to hold entities accountable.
2. Include Detailed Data Points: Reports should break down approval and denial rates, average response times, outcomes of appeals, and information about the patients affected. This will help uncover inefficiencies and inequities in the system.
3. Protect Privacy: Any public data must comply with privacy laws like HIPAA to ensure personal information remains secure while still sharing valuable insights.

Why Transparency Matters
Public access to prior authorization data is essential for accountability and fairness. Without full transparency, it is hard to see if entities are doing their job properly or creating unnecessary obstacles. Transparency also empowers providers and patients to push for improvements based on clear evidence, leading to better collaboration and trust.

Conclusion
In closing, I fully support HB250 as a critical measure to reform prior authorization practices in Hawaii. I respectfully urge the Committee to make an amendment to require full public disclosure of prior authorization data. This would make the bill even stronger by ensuring all stakeholders can work together to improve access to care.

Thank you for considering my testimony and for your efforts to make healthcare better for everyone in Hawaii. I am happy to answer any questions or provide more information if needed.

Sincerely,
Esther Yu Smith, MD
COO Mohala Health
Medical Director Ka'u Hospital
Hawai'i Provider Shortage Taskforce

Hawaii Medical Association
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HOUSE COMMITTEE ON HEALTH
Representative Gregg Takayama, Chair
Representative Sue Keohokapu-Lee Loy, Vice Chair

Date: January 31, 2025
From: Hawaii Medical Association (HMA)
Jerald Garcia MD - Chair, HMA Public Policy Committee

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

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

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

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

HMA respectfully requests these additions/amendments for consideration:

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

Prior authorization request for urgent health care services; determination time frame; automatic approval.

(1) Urgent requests will be decided within twenty-four hours of receipt; and
(2) Non-urgent requests will be decided within three calendar days of receipt.

If an insurer fails to respond to a prior authorization request within the required timeframe, the request shall be deemed approved.

Repeat prior authorization is prohibited for chronic unchanged conditions.

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

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

Duration of prior authorization for treatment for chronic or long-term care conditions. If a utilization review entity requires a prior authorization for a health care service for the treatment of a chronic or long-term care condition, the prior authorization shall remain valid for the duration of the treatment and the utilization review entity shall not require the enrollee to obtain a new prior authorization again for the health care service.

Continuity of care for enrollees; prior authorization transfers.
(a) Upon receipt of information documenting a prior authorization from the enrollee or from the enrollee's health care provider, a utilization review entity shall honor a prior authorization granted to an enrollee from a previous utilization review entity for at least the initial ninety days of an enrollee's coverage under a new health plan.
(b) During the time period described in subsection (a), a utilization review entity may perform its own review to grant a prior authorization.
(c) If there is a change in coverage of, or approval criteria for, a previously authorized health care service, the change in coverage or approval criteria shall not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's plan year.
(d) A utilization review entity shall continue to honor a prior authorization it has granted to an enrollee when the enrollee changes products under the same health insurance company.

Gold card or exemption program for providers
Prior authorization exemptions for health care providers.
(a) A utilization review entity shall not require a health care provider to complete a prior authorization request for a health care service for an enrollee to receive coverage; provided that in the most recent twelve-month period, the utilization review entity has approved or would have

approved not less than eighty per cent of the prior authorization requests submitted by the health care provider for that health care service, including any approval granted after an appeal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

QUALITY (language is taken from HB 954)

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

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

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

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

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

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

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

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

TRANSPARENCY (language is taken from HB 954)

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

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

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

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

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

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

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

Denials - Adverse determination; notice and discussion required. Any utilization review entity questioning the medical necessity of a health care service shall notify the enrollee's

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

OVERSIGHT (language is taken from HB 954)

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

(1) A list of all health care services that require prior authorization;

(2) The number and percentage of prior authorization requests that were approved;

(3) The number and percentage of prior authorization requests that were denied;

(4) The number and percentage of prior authorization requests that were initially denied and approved after appeal;

(5) The number and percentage of prior authorization requests for which the timeframe for review was extended, and the request was approved;

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

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

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

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

provided that the information required by paragraphs (2) through (9) shall be individualized for each listed health care service for each health care service listed in paragraph (1).

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

HMA recommends that the commission in HB 250 be replaced by a Task Force or Working Group with the following composition of members:

-Director of Health, or the Director's designee

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

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

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

-Representative from the Hawaii Association of Health Plans

-Healthcare organizations (each with a representative):
Hawaii State Center for Nursing
Hawaii Medical Association (HMA)
Hawaii State Rural Health Association
Healthcare Association of Hawaii

The Task Force will regularly review PA policies and make recommendations for
Ongoing reduction of volume. This requires coordinated review of PA data, trends, population health characteristics and standards of care as well as utilization use and overuse.
- Identifying drugs and services for which PA is rarely denied, have high approval rates on appeal, are important to provide expeditiously
- Examine PA that disproportionately impacts marginalized patients

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

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

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

REFERENCES AND QUICK LINKS

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

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

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

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

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To: The Honorable Chair Gregg Takayama, the Honorable Vice Chair Sue L. Keohokapu-Lee Loy, and the House Committee on Health

Subject: TESTIMONY IN STRONG SUPPORT OF HB250

Aloha Esteemed Committee Members,

The Philippine Medical Association of Hawaii (PMAH) strongly supports HB250, which seeks to reform the prior authorization process to reduce delays in patient care, lessen administrative burdens on healthcare providers, and improve overall healthcare outcomes in our state.

PMAH represents approximately 200 primary care physicians and specialists across Hawaii, many of whom serve vulnerable populations who cannot afford unnecessary delays in receiving medically necessary treatment. As frontline healthcare providers, we have witnessed firsthand the significant harm caused by burdensome prior authorization requirements. The current system often forces patients to wait days or even weeks for approval of critical treatments, medications, diagnostic tests, and procedures—delays that can result in disease progression, worsening symptoms, emergency room visits, and preventable hospitalizations.

The excessive administrative requirements placed on physicians further compound these issues. Prior authorization forces doctors to spend hours navigating bureaucratic hurdles rather than caring for patients. In many cases, physicians are required to justify treatments that are already standard medical practice, only to have decisions made by insurance representatives who may lack the expertise in the relevant medical specialty. This unnecessary red tape does not enhance patient safety—it obstructs it.

The negative impact of prior authorization on patient health is well-documented. A nationwide physician survey conducted by the American Medical Association found that:

- **94% of physicians reported that prior authorization delays** necessary medical care for patients.
- **83% of denials were ultimately overturned,** raising serious concerns about the appropriateness of initial denials.
- **19% of doctors reported that prior authorization delays led to serious adverse** events requiring hospitalization.
- **7% of doctors reported that these delays resulted in permanent disability**

or even death.

Hawaii's physician workforce is already strained due to provider shortages and an aging population with increasing healthcare needs. Prior authorization requirements exacerbate physician burnout, leading to reduced workforce retention and even more limited access to care for patients. Requiring doctors to dedicate staff solely to prior authorization paperwork is a waste of healthcare resources that should be directed toward patient care, not administrative bottlenecks.

HB250 is an essential step toward protecting patients from unnecessary harm and ensuring that medical decisions remain in the hands of those who are trained to make them—physicians. Establishing the Health Care Appropriateness and Necessity Commission and requiring greater transparency in prior authorization practices will help eliminate inefficiencies, reduce unnecessary delays, and ensure that patients receive timely, appropriate, and evidence-based care.

The Philippine Medical Association of Hawaii urges the committee to pass HB250 to alleviate unnecessary burdens on Hawaii's physicians and, most importantly, to protect the health and safety of our patients.

Respectfully submitted,

Rainier Dennis D. Bautista, MD, DABFM, FAAFP

President, Philippine Medical Association of Hawaii

HB-250
Submitted on: 1/30/2025 9:12:25 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Ariel Flores	Waipahu Therapy Center, LLP	Support	Written Testimony Only

Comments:

Aloha,

As a healthcare services provider in Hawaii, I have witnessed firsthand how prior authorization delays prevent patients from receiving necessary care. The lack of transparency in these processes creates undue administrative burdens on providers and unnecessary roadblocks for patients. HB250 is a crucial step forward—it holds utilization review entities accountable, ensures oversight through the newly established Health Care Appropriateness and Necessity Commission, and prioritizes patient care over bureaucratic inefficiencies. I strongly urge lawmakers to support this bill to improve healthcare access and outcomes in our state.

Respecfully,

Dr. Ariel Flores, PT, DPT

Waipahu Therapy Center, LLP

An Independent Licensee of the Blue Cross and Blue Shield Association

January 31, 2025

The Honorable Gregg Takayama, Chair
The Honorable Sue L. Keohokapu-Lee Loy, Vice Chair
House Committee on Health

Re: HB250- RELATING TO HEALTH

Hawaii Medical Service Association (HMSA) appreciates the opportunity to provide comments on HB 250, 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 and establishes the Health Care Appropriateness and Necessity Commission within the State Health Planning and Development Agency.

Thank you to the legislature for recognizing the importance of prior authorization (PA). It is one of many important components that help to keep health care premiums affordable and will continue to help ensure the long-term sustainability of Hawaii's overall healthcare system. As a health organization partnering with over 7,500 providers across the state we understand the challenges and are committed to working collaboratively to improve the prior authorization process and also ensuring the highest quality of care for our members.

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

HMSA Prior Authorization
HMSA currently meets, and typically exceeds, Centers for Medicare & Medicaid Services and National Committee for Quality Assurance timeliness requirements for PA. PA does not apply to emergency care or care that members receive when hospitalized. Of our 17 million claims processed last year, only 204,000 (1%) required PA. Of these 81,600 (40%) did not require submission. 163,200 (80%) of the PA submissions we receive are via fax machine despite the availability of an online option increasing errors and requiring additional time for review and communication. Large numbers of claims are also incomplete or have incorrect documentation and require multiple back and forth communications forcing longer timeframes for decisions. We want to thank Hawaii Medical Association (HMA) for their leadership and partnership as we continue to work with our provider partners to make progress in these areas. HMSA is committed to forward progress and we have already participated in and convened

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

conversations around solutioning around administrative burden, eliminated PA requirements for certain procedures, expanded our Fast Pass Program for qualifying providers, and are moving towards a fully integrated and digitized PA process to further improve accuracy, efficiency, and turnaround time and minimize errors and administrative burden. We are certainly open to continuing the conversations around PA improvement, again, noting above that this measure may be premature given the aforementioned approaching federal regulations.

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

1. Amending Section 2 to include amending chapter 431:2:
    a. **Prior authorization; reporting** (parts a and b)
        i. to replace "utilization review entity" with "health plan".
        ii. to include prior authorization reporting of aggregate data.
    b. **Health care appropriateness and necessity commission, established** section to be amended to read:

§431:2- Prior authorization working group; established. (a) There is established the prior authorization working group to consider the issues of administrative burden in the health care delivery system convened by the insurance commissioner. The working group shall assess and evaluate the prior authorization process, identify inefficiencies and pain points for stakeholders, and make recommendations to improve speed, transparency, and overall efficiency. The working group shall consider:

(1) Evaluation of current prior authorization practices;

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

(2) Potential for digitization and technology;

(3) Compliance and risk review;

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

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

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

An Independent Licensee of the Blue Cross and Blue Shield Association

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

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

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

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

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

(5) A representative from the Hawaii Medical Association;

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

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

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

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

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

Sincerely,

Dawn Kurisu
Assistant Vice President
Community and Government Relations

Hawaii Association of Health Plans

January 31, 2025

To: Chair Takayama, Vice Chair Keohokapu-Lee Loy and Members of the House Committee on Health (HLT)

From: Hawaii Association of Health Plans Public Policy Committee

Date/Location: January 31, 2025; 9:15 a.m./Conference Room 329 & Videoconference

Re: Testimony with comments on HB 250 – Relating to Prior Authorizations.

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

HAHP appreciates the efforts of lawmakers to address prior authorization improvements and want to emphasize that we believe prior authorization continues to be a critical process that is constantly evolving and is critical to ensuring quality patient care. We recognize the importance of addressing concerns of providers and are committed to continuing to work with stakeholders to improve the issue. HAHP believes this is a nuanced and complicated issue, with multiple bills in both houses this session. We would be willing to participate in further conversations with lawmakers and stakeholders.

Thank you for your consideration and the opportunity to share our comments on HB 250.

Sincerely,

HAHP Public Policy Committee
cc: HAHP Board Members

Hawai'i Association of Professional Nurses (HAPN)

To: The Honorable Representative Gregg Takayama, Chair of the House Committee on Health

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

Subject: HB250 – Relating to Health

Hearing: January 31, 2025, 9:15 a.m.

Aloha Representative Takayama, Chair; Representative Keohokapu-Lee Loy, Vice Chair; and Members of the Committee,

On behalf of the Hawai'i Association of Professional Nurses (HAPN), we strongly support HB250, which seeks to bring much-needed transparency, efficiency, and accountability to the prior authorization process in Hawai'i.

The Need for Prior Authorization Reform

Prior authorization was originally designed as a cost-control measure, but it has since become a significant barrier to timely patient care, contributing to delays, administrative burden, and negative health outcomes. Healthcare providers, including advanced practice registered nurses (APRNs), spend substantial time navigating complex, inconsistent, and non-transparent prior authorization processes that ultimately hinder patient care.

Recent data highlights the urgency of this issue:

• 83% of prior authorization denials are later overturned, indicating that these denials were unnecessary in the first place.

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

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

APRNs, like physicians, experience these burdens and the negative impact they have on their ability to provide efficient and effective care to patients in need.

Key Provisions of HB250

HB250 takes meaningful steps to address these concerns by:

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

2. Creating the Health Care Appropriateness and Necessity Commission – This commission will establish evidence-based guidelines to ensure that prior authorization requirements are grounded in clinical best practices, rather than arbitrary cost-control measures.

3. Promoting accountability – By increasing oversight and transparency, this bill will ensure that health plans operate in the best interest of patients and providers alike.

Recommended Amendment: Inclusive Language for Healthcare Providers

While we appreciate the bill's intent, we strongly recommend an amendment to replace references to "physicians" with "physician, advanced practice registered nurse, physician assistant, or other qualified licensed healthcare provider."

This change is essential to reflect the full scope of licensed, independent providers who diagnose, treat, and prescribe medical care for patients. APRNs, physician assistants, and other healthcare professionals are equally impacted by prior authorization requirements and must be included in reform efforts.

Conclusion

HB250 is a necessary and well-balanced step toward ensuring that prior authorization processes are transparent, efficient, and clinically appropriate. By reducing unnecessary administrative burdens, we can enhance patient access to timely care and support healthcare providers across all disciplines in delivering high-quality services.

We respectfully urge the committee to pass HB250 with our recommended amendment to ensure inclusivity among healthcare providers.

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

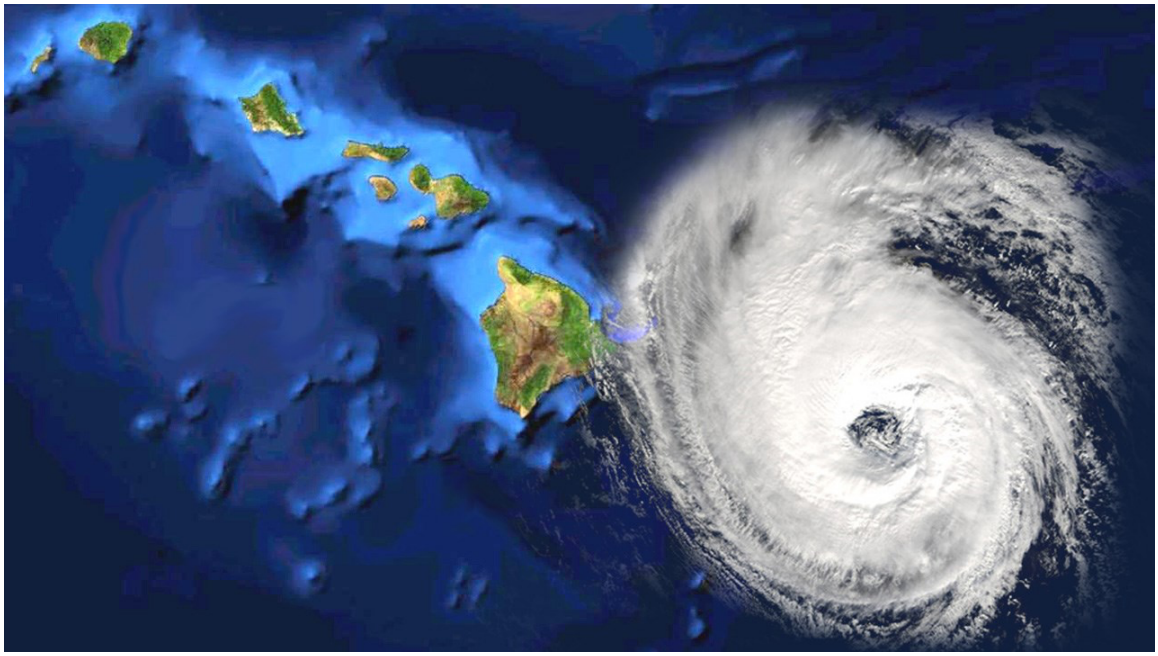
Respectfully,

Dr. Jeremy Creekmore, APRN
HAPN President

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.

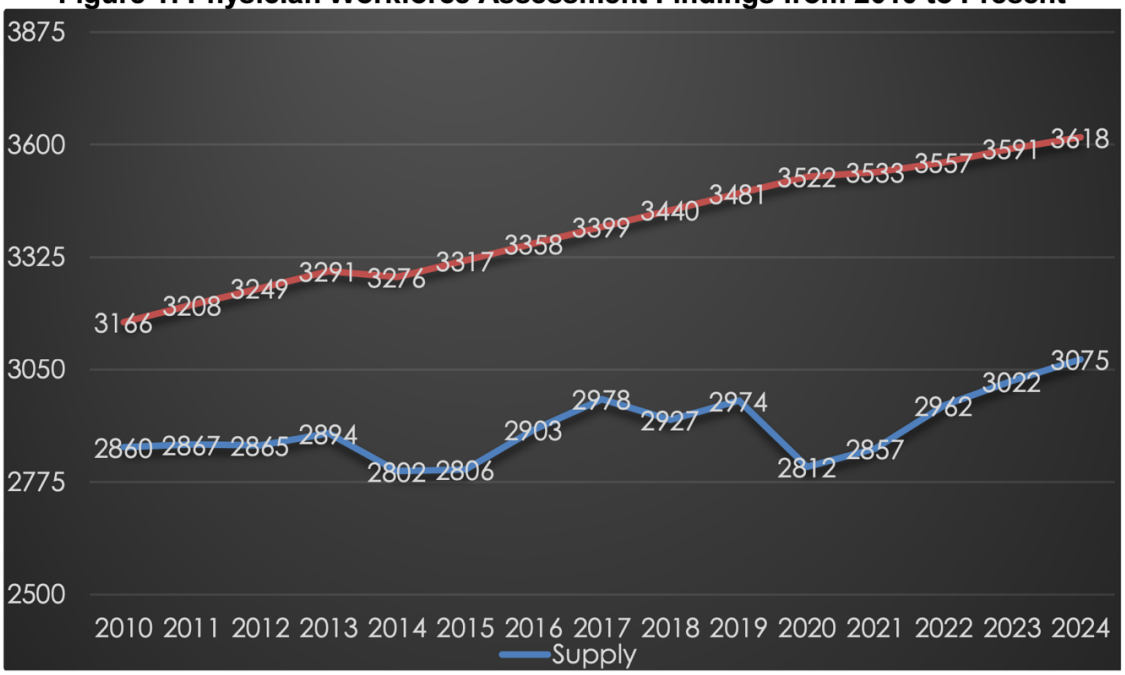
For 15 years, the HI Physician Workforce Assessment Project has studied the ongoing Physician Workforce Shortage.

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.

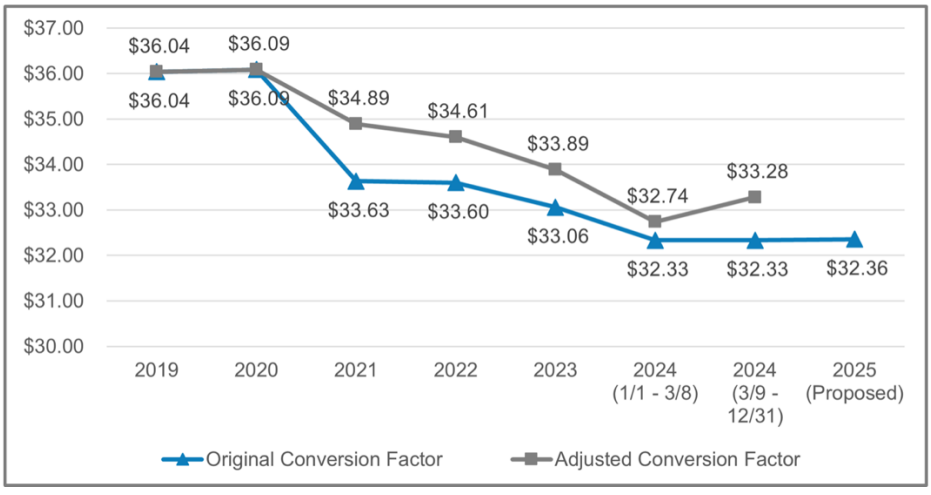
The HI Medicare issue could be addressed by requesting an amendment to the Social Security Act adding Hawaii to Section 42 U.S.C. 1395w–4(e)(1)(G)) which reads….

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.

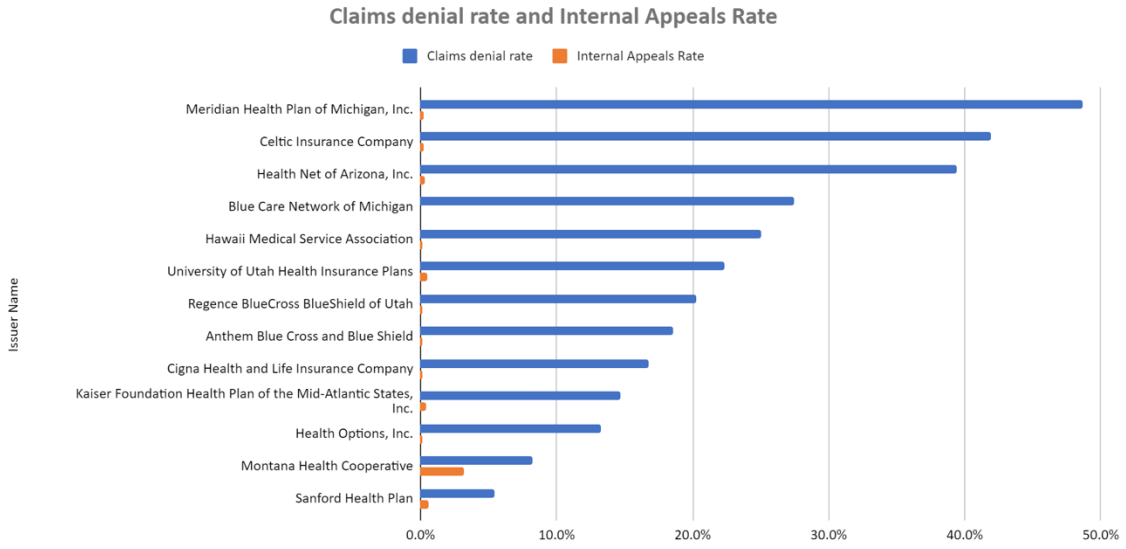
Over the last six years, the HMSA Claim Denial Rate for patients who have purchased their insurance on the HealthCare.gov and obtained care In Network is a stunning 25.1%.

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

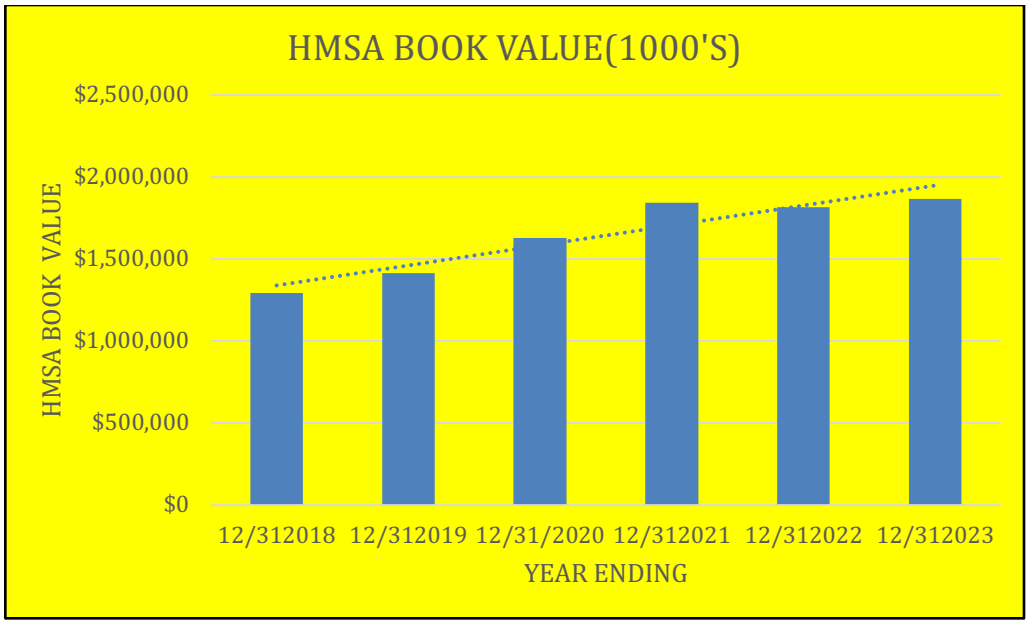
An investment company is a financial institution principally engaged in holding, managing, and investing securities. Think Blackrock, Vanguard, Fidelity.
Insurance companies are essentially investment vehicles driven by the principal of float. No one explains this better than Warren Buffett.

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
Submitted on: 1/30/2025 11:35:33 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Clayton Everline MD	Waves of Health Inc	Support	Written Testimony Only

Comments:

As a triple board certified physician I am left wondering why I spent so many years training and passing the multiple board exams to have the very materials I was trained and tested on countermanded by insurance prior authorization policies that engage in sham "peer review" often by providers not even in same specialties or even licensed in our state that delay care and diminish outcomes. Please end this dangerous and greedy practice

HB-250
Submitted on: 1/30/2025 2:12:29 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

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

Comments:

HOUSE COMMITTEE ON HEALTH

Rep. Gregg Takayama, Chair

Rep. Sue L. Keohokapu-Lee Loy, Vice Chair

Date: January 30, 2025

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

Robert Carlisle, MD, MPH

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

Position: Support

Thank you for allowing testimony on HB250. In caring and advocating for the people and primary care physicians of Hawai‘i, HAFP endorses the need to mitigate the profound adverse impact of prior authorization burden leading to frustration of patients and physicians seeking appropriate health care. SECTION 1 of HB250 concisely recites some of the statistics involved.

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

A 15-member Health Care appropriateness and Necessity Commission, while attempting to capture all appropriate voices for input, may prove too large and unwieldy. Consideration of a smaller committee with a smaller percentage of political appointees and move to "nominees" may achieve the intentions of research, consensus, and assessment of each prior authorization consideration more responsively.

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

- Readily accessible, easily identifiable prior authorization requirements on insurer websites free of charge to patients and health care providers
- Decision on urgent requests for medical care within 24 hours of submission
- Decision on nonurgent requests for medical care with 72 hours or 3 working days
- If insurers do not respond within the designated timeframes, then requests are reflexively approved
- Authorizations of services are valid for one year or the duration of treatment course—whichever is longer
- Review of appeals for denied services will be executed with an insurer physician who typically manages the medical condition
- Prohibition on prior authorization requirements for medication use for opioid disorder; for buy-and-bill provision of services for family planning and reproductive health pharmaceuticals and supplies; and for the associated medical services
- Rollover of authorized services from one insurer to another for a designated period
- Exemption of physicians from prior authorization if their approval rate exceeds a set standard

"Insurer" is used inclusively of health or sickness insurers, mutual benefit societies, and health maintenance organizations operating in the state of Hawai‘i.

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

KAISER PERMANENTE®

Government Relations

Testimony of
Jonathan Ching
Government Relations Director

Before:
House Committee on Health
The Honorable Gregg Takayama, Chair
The Honorable Sue L. Keohokapu-Lee Loy, Vice Chair

January 31, 2025
9:15 a.m.
Via Videoconference
Conference Room 329

Re: HB 250, Relating to Health.

Chair Takayama, Vice Chair Keohokapu-Lee Loy, and committee members, thank you for this opportunity to provide testimony on HB 250, 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 and also establishes the Health Care Appropriateness and Necessity Commission.

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

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

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

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, accurate, consistent, fair and equitable prior authorization decisions. We further support policies

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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 that by "reducing the burdens of prior authorization will assist health care providers, thereby ensuring the health and safety of their patients," we suggest that the reporting requirements sought in Section 2 should align any state reporting requirements with the federal requirements in the 2024 Interoperability and Prior Authorization final rule.[1] This should help alleviate some administrative burden on all plans and allow more useful comparisons with federal data. We respectfully request Section 2 be amended as follows:

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

"[~~§323D-]~~ **§431- 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 commissioner. The state agency shall post each report on its website no later than three months before the start of the reporting period~~] an annual report to the insurance division, by provider of health insurance, all prior authorization metrics 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).

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

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(b) The [~~state agency~~] insurance division shall compile the data in each report by provider of health insurance and shall post a report of findings on its website no later than March 1 of the following year after the reporting period.

We believe the "Health care appropriateness and necessity commission" sought under Section 2 is premature at this point. The need for a commission or work group should be considered after any new reporting requirements have been implemented and the data evaluated by the Insurance Division, which is the appropriate department to review and make any recommendations.

Mahalo for the opportunity to testify on this important measure.

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HB-250
Submitted on: 1/30/2025 7:47:57 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Scott Morioka	Individual	Support	Written Testimony Only

Comments:

As a physician in Hawaii, I have witnessed firsthand how prior authorization delays/prevents patients from receiving necessary care. The lack of transparency in these processes creates undue administrative burdens on providers and unnecessary roadblocks for patients. HB250 is a crucial step forward—it holds utilization review entities accountable, ensures oversight through the newly established Health Care Appropriateness and Necessity Commission, and prioritizes patient care over bureaucratic inefficiencies. I strongly urge lawmakers to support this bill to improve healthcare access and outcomes in our state.

HB-250
Submitted on: 1/30/2025 7:49:08 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

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

Comments:

Dear Rep. Gregg Takayama, Chair, Rep. Sue L. Keohokapu-Lee Loy, Vice Chair and the House Committee on Health,

As a patient advocate in Hawaii, I have witnessed firsthand how prior authorization delays prevent patients from receiving necessary care. The lack of transparency in these processes creates undue administrative burdens on healthcare providers and unnecessary roadblocks for patients. HB250 is a crucial step forward—it holds utilization review entities accountable, ensures oversight through the newly established Health Care Appropriateness and Necessity Commission, and prioritizes patient care over bureaucratic inefficiencies.

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

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

HB250 also addresses the critical issue of transparency. By holding utilization review entities accountable, we can expect clearer communication and more streamlined processes, which will ultimately benefit both patients and healthcare providers.

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

Thank you for your consideration.

HB-250
Submitted on: 1/30/2025 8:02:25 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Brandon Shirai	Individual	Support	Written Testimony Only

Comments:

As a physician in Hawaii, I have seen firsthand how prior authorization delays create unnecessary barriers that prevent patients from receiving the care they urgently need. These delays are not just bureaucratic inconveniences—they can lead to worsening health conditions, increased hospitalizations, and unnecessary suffering. The current lack of transparency in the prior authorization process places an overwhelming administrative burden on healthcare providers, forcing them to spend valuable time navigating red tape instead of focusing on patient care.

HB250 is a critical step toward addressing these issues. By holding utilization review entities accountable, establishing the Health Care Appropriateness and Necessity Commission for oversight, and prioritizing patient well-being over inefficient approval processes, this bill paves the way for a more effective and patient-centered healthcare system. Ensuring that medical decisions are guided by clinical necessity rather than bureaucratic hurdles will improve health outcomes and reduce the strain on both patients and providers.

I strongly urge lawmakers to support HB250 and take meaningful action to remove these unnecessary obstacles. Passing this bill will help ensure that patients in Hawaii receive timely, appropriate care without being subjected to harmful delays, ultimately strengthening healthcare access and outcomes across our state.

HB-250
Submitted on: 1/30/2025 8:18:44 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Jasmine Kelly	Individual	Support	Written Testimony Only

Comments:

As a physician, I have seen firsthand how prior authorization requirements create unnecessary obstacles to patient care. These bureaucratic processes are often confusing, inconsistent, and time-consuming, forcing me to spend hours navigating approvals instead of focusing on my patients. The delays caused by prior authorizations can prevent timely access to essential treatments, leading to worsening conditions and frustration for both patients and providers. HB250 is a step toward addressing these inefficiencies by increasing transparency and accountability in utilization review. Reform is needed to ensure that medical decisions are driven by clinical necessity, not administrative red tape.

HB-250
Submitted on: 1/30/2025 8:43:48 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Kristine Uramoto, MD	Individual	Support	Written Testimony Only

Comments:

As a Hawaii physician, I can testify that we need more transparency in the prior authorization (PA) process. Prior authorizations place a huge burden on physicians and their staff and hinder the prompt, appropriate medical care of patients. I can personally testify to the harm that the prior authorization process has caused patients - I deal with patients with arthritis. With delays of coverage, many patients have suffered for weeks or even months before receiving the appropriate medication necessary to treat their arthritis. Please help Hawaii's patients receive the necessary medical care they require. Also, please help Hawaii's shrinking physician work force in dealing with unnecessary administrative burdens.

HB-250
Submitted on: 1/30/2025 8:45:43 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Ross Simafranca	Individual	Support	Written Testimony Only

Comments:

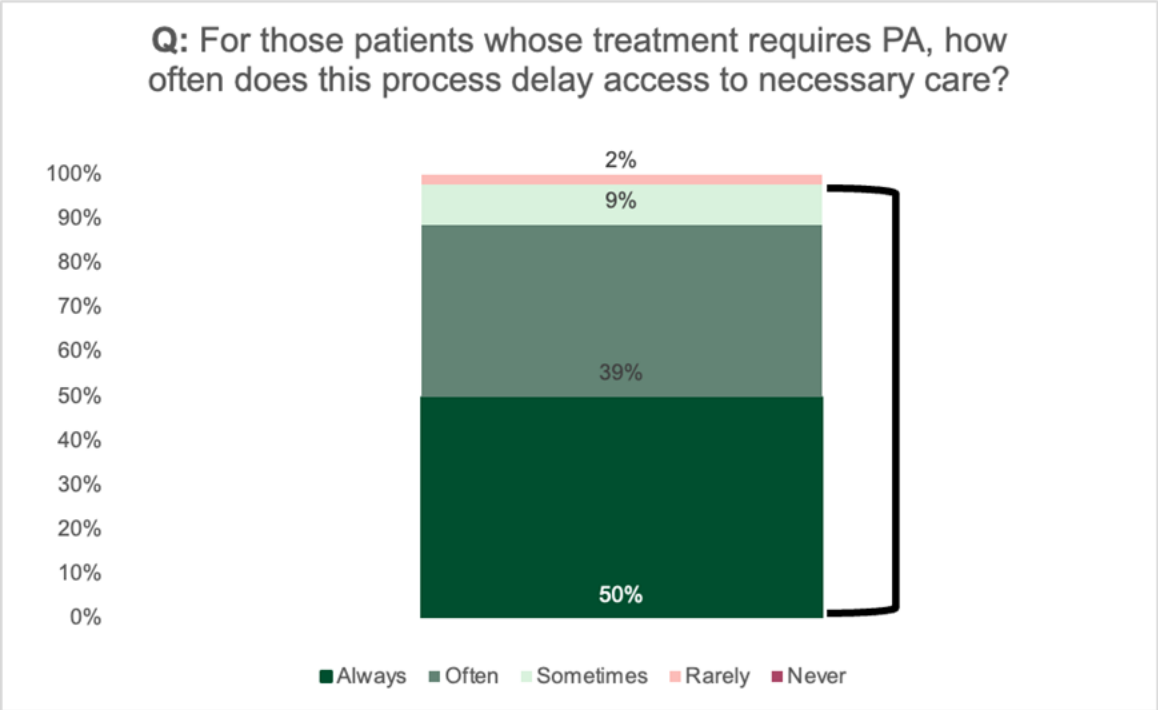
Hello. I'm a general surgeon in private practice located in Ewa Beach, Oahu since 2007. I support HB 250 which would help my patients receive adequate health care in a more timely fashion.

Mahalo,

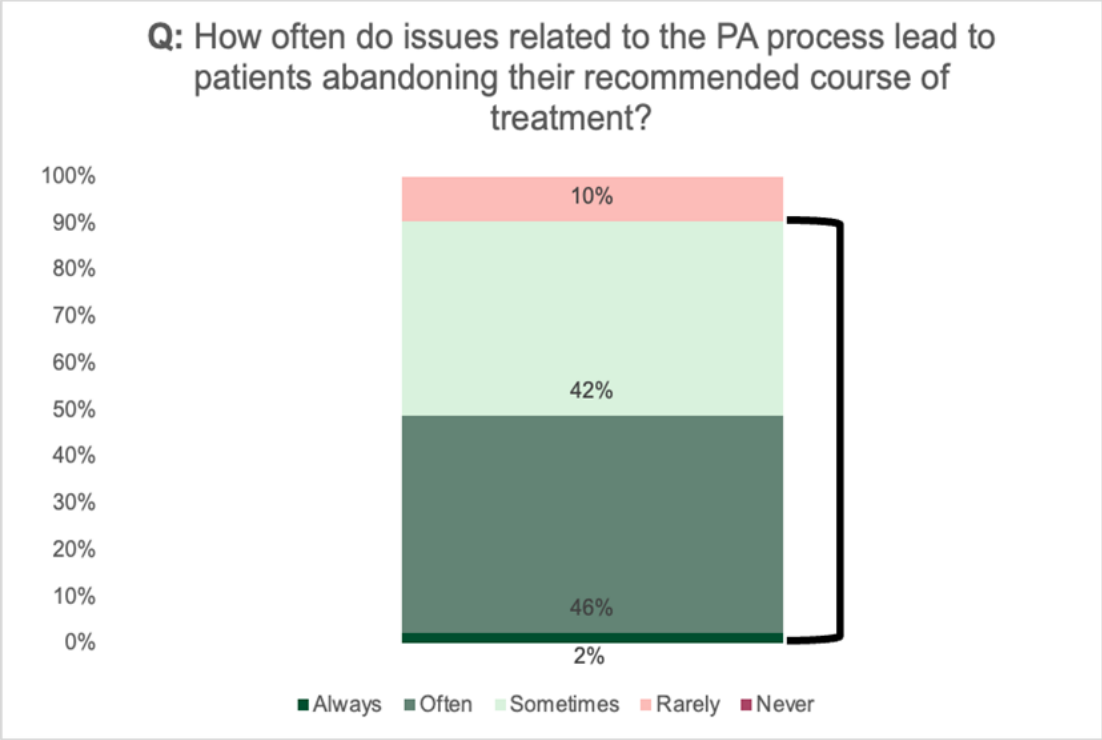
Ross Simafranca, MD, FACS

Please SUPPORT HB250!!

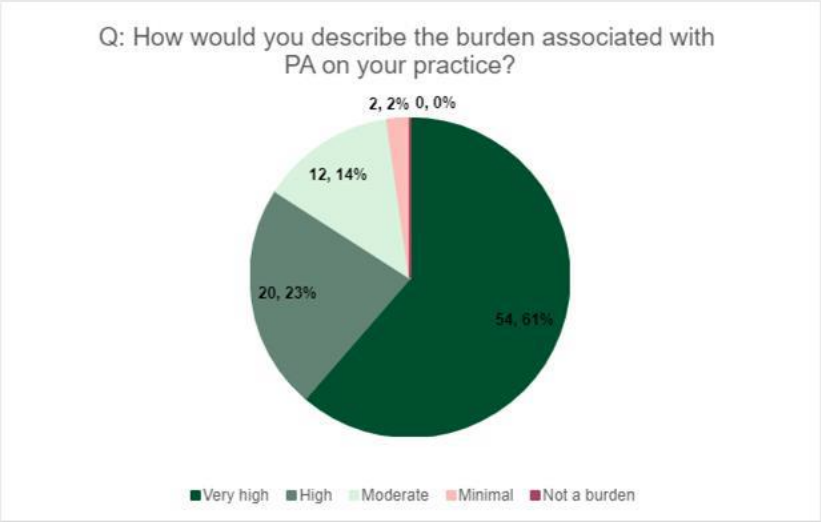
Prior authorization (PA) practices in Hawaii are hurting patients. UH research shows:



In fact, patients often give up on getting recommended treatments because of prior authorization. I know I have!



Plus, it takes doctor, nurse and staff time away from patients!!



In fact, physicians and their staff in Hawaii spend 19.8 hrs per week processing PAs, wait 8 business days for a PA decision, and wait 13.8 business days for a decision after an appeal.

HB250 will help improve this by creating transparency and teamwork to make things better!!

HB-250
Submitted on: 1/30/2025 9:57:32 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Wells Weymouth	Individual	Support	Written Testimony Only

Comments:

As an emergency medicine physician practicing in Hawaii, I am writing to express my strong support for House Bill 250 (HB250), which aims to reform prior authorization processes by requiring utilization review entities to submit relevant data to the State Health Planning and Development Agency and establishing the Health Care Appropriateness and Necessity Commission.

In the fast-paced environment of emergency medicine, timely decision-making is crucial. However, the current prior authorization requirements often lead to significant delays in patient care. A 2023 survey by the American Medical Association found that 94% of physicians reported that prior authorization processes always, often, or sometimes delay patient care, and 19% noted that these delays have led to serious adverse events, including hospitalizations.

Moreover, the administrative burden associated with prior authorizations contributes to physician burnout. The same survey indicated that 95% of physicians believe prior authorization increases burnout, with more than one-third employing staff solely to manage these requirements.

HB250 addresses these concerns by promoting transparency and accountability among utilization review entities. By mandating the submission of prior authorization data and establishing a commission to evaluate and streamline these processes, the bill seeks to reduce unnecessary delays and administrative burdens, ultimately improving patient outcomes.

In the emergency department, every moment counts. Reforming prior authorization procedures as proposed in HB250 will enable healthcare providers to deliver timely and effective care, enhancing the health and well-being of our community.

I urge the legislature to pass HB250 to ensure that emergency medical services in Hawaii can operate more efficiently and provide the highest standard of care to our patients.

Thank you for considering my testimony.

Wells Weymouth, MD

HB-250
Submitted on: 1/30/2025 10:07:59 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Michael Jaffe	Individual	Support	Written Testimony Only

Comments:

Yes Please support HB250

The insurance Prior Authorization (PA) system is essentially the insurance company practicing medicine and overriding the physician-patient treatment plan. The capricious nature of the PA process is inefficient, to say the least. My biggest problem is; as a specialist, the PA requirements are the same as for a primary care doctor. My clinical decision-making should have more flexibility.

More data and transparency - may help the efficiency of the PA process so patients can get the expedited care they need.

Michael Jaffe DO

Hawaii Brain & Spine

Kailua

HB-250
Submitted on: 1/30/2025 10:10:29 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Paul Heese	Individual	Support	Written Testimony Only

Comments:

As a voter, resident, and licensed physician in Hawaii, I am writing to support HB250 and the increase in transparency of the utilization of Prior Authorizations by heath care payees. Intended to curb insurance payee costs by requiring extra review for expensive, experimental, or off label treatments and medications. Unfortunately, throughout my career, I've seen insurance companies use PAs to create barriers to care.

They utilize a byzantine system of forms, faxes, portals, and hold-lines on the phone. They obscure reasons for denial. And otherwise use bureaucratic red tape to gum up efficient health care delivery; to save investors money at the cost of the patients.

At the very least, Hawaii health care payees should know their practices are being monitored and released to the public for review. Information that would allow Hawaii residents to better evaluate which insurance companies they wish to purchase services from.

As a voter, resident, and licensed physician in Hawaii, I am writing to support HB250 and the increase in transparency of the utilization of Prior Authorizations by heath care payees. Intended to curb insurance payee costs by requiring extra review for expensive, experimental, or off label treatments and medications. Unfortunately, throughout my career, I've seen insurance companies use PAs to create barriers to care.

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At the very least, Hawaii health care payees should know their practices are being monitored and released to the public for review. Information that would allow Hawaii residents to better evaluate which insurance companies they wish to purchase services from.

HB-250
Submitted on: 1/30/2025 10:15:30 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Kaohimanu L K Dang Akiona MD	Individual	Support	Written Testimony Only

Comments:

Aloha esteemed Representatives,

I am writing in strong support of HB250.
As a physician serving primarily rural, underserved and vulnerable populations in Hawaii, I have witnessed firsthand how prior authorization delays prevent patients from receiving necessary care. The lack of transparency in these processes creates undue administrative burdens on providers like me and unnecessary roadblocks for patients. This has directly interfered with necessary care, contributed to preventable health complications and death and has caused the closure of many independent practices, disproportionately moreso in the rural areas I serve. HB250 is a crucial step forward—it holds utilization review entities accountable, ensures oversight through the newly established Health Care Appropriateness and Necessity Commission, and prioritizes patient care over bureaucratic inefficiencies. I strongly urge lawmakers to support this bill to improve healthcare access and outcomes in our state.

Mahalo for your time and consideration of this very important aspect of healthcare in Hawai`i,

`O au iho no,

Ka`ohimanu Dang Akiona, MD- Physician/Owner Kohala Coast Urgent & Mobile Health, Moloka`i Family & Urgent Care

HB-250
Submitted on: 1/30/2025 10:19:57 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
arieh levine	Individual	Support	Written Testimony Only

Comments:

Please support prior authorization oversight and transparency. Significant delays in care, waste time and resources that are too valuable to be spent on such delays.

Arieh Levine MD

HB-250
Submitted on: 1/30/2025 10:23:04 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Robert Shapiro	Individual	Support	Written Testimony Only

Comments:

Doctors waste a lot of time with prior authorization. It's a huge headache and very costly for overhead. Much of the money is taken up by the PBM's. It does not lead to cost savings, it increases costs for the whole system including the patients.

HB-250
Submitted on: 1/30/2025 10:27:51 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Vishal Goyal	Individual	Support	Written Testimony Only

Comments:

As a physician who takes care of seriously ill patients, I often prescribe medications that provide comfort and reduce suffering. Even common medications such as morphine are often flagged for prior authorization. This causes stress amongst my patient and their caregivers, as well as requires me (and our RN) to spend unnecessary time on the phone or on the computer justifying medication regimen. I am a double-board certified physician and I take my work very seriously. To constantly be questioned "if I am sure" that I want my patient to have the medication I've prescribed is frustrating. Please consider making prior authorizations less prevalent in care and less burdensome on the providers who are trying to take care of the citizens of Hawaii.

Mahalo,

Vishal Goyal, MD, MPH

HB-250
Submitted on: 1/30/2025 11:07:17 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Komal Soin	Individual	Support	Written Testimony Only

Comments:

Aloha

As a Family Physician on Oahu that faces the burden of Prior Auths atleast once a week, I'm in support of this bill for prior auth reform. Prior auth requirements in its current state are very cumbersome and take away from proper patient care including medications that are necessary, and imaging that may be required for evaluation. I have had MULTIPLE patients who have been established on a medication for over a year with good results that come January 1 need a prior auth for the medication because the formulary for the insurance company has changed. It is very frustrating for the patient to not have their medications that work. Additionally, we have had severe injuries that need an MRI for evaluation but are denied as they have to go through Physical therapy and Xray prior to MRI, even if they cannot tolerate Physical therapy due to severe pain.

Thank you for introducing this bill to improve our patient care in Hawaii and unnecessary burden to physicians.

Mahalo

Komal Soin

HB-250
Submitted on: 1/30/2025 11:17:42 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

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

Comments:

I support HB250

HB-250
Submitted on: 1/30/2025 11:25:56 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Robert Wong	Individual	Support	Written Testimony Only

Comments:

I support HB250. As a gastroenterologist in Aiea/Pearl City, I often need to obtain prior authorizations for diagnostic tests and medications. This is a resource intensive process and undoubtedly results in delays in care. Often the priour authorizations are unnecessary or redundant. For example, some insurance companies require (and may even deny) annual authroizations for patients that are on a stable medication regiment that has worked for them.

Please support HB250.

Aloha,

Robert Wong, MD

HB-250
Submitted on: 1/30/2025 11:43:30 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Catherine Rault	Individual	Support	Written Testimony Only

Comments:

As a doctor and healthcare provider, I wholeheartedly support this bill. Prior authorizations are often slow and burdensome, delaying the treatment of patients and allowing them to access medications they need.

LATE *Testimony submitted late may not be considered by the Committee for decision making purposes.

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

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

This bill HB250 is a good start, necessary but not sufficient,

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

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

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

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

warmest aloha

Edward Gutteling, MD

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

Opinion I Health insurance:

Prior authorization is a scam

I know, because I helped design it

January 28, 2025

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

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

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

So what is?

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

deny care to patients by taking three actions:

They should

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

They don't.

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

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

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

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

In fact, they cause harm.

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

Some things are too broken to be fixed or reformed.

Prior authorization is one of them.

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

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

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

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

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

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

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

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

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

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

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

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

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

HB-250
Submitted on: 1/30/2025 12:17:50 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Angel Willey	Individual	Support	Written Testimony Only

Comments:

I support transparency and oversight with prior authorizations.

Respectfully submitted,

Angel M. Willey, MD

OBGYN Honolulu, HI

HB-250
Submitted on: 1/30/2025 12:50:14 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Scott Kuwada, MD	Individual	Support	Written Testimony Only

Comments:

Please help us decrease delays in care for our patients by promoting transparency and oversight in onerous preauthorizations for tests, procedures and medications.

Mahalo!

HB-250
Submitted on: 1/30/2025 12:59:18 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Celina Hayashi	Individual	Support	Written Testimony Only

Comments:

Aloha,

I am a medical doctor writing in strong support of HB250. As a Board Certified Family Medicine Physician, serving our local community, it is imperative that you support this bill for the health of our state. The current prior authorization process is untenable and directly results in delays in patient care, resulting in harm to our community members.

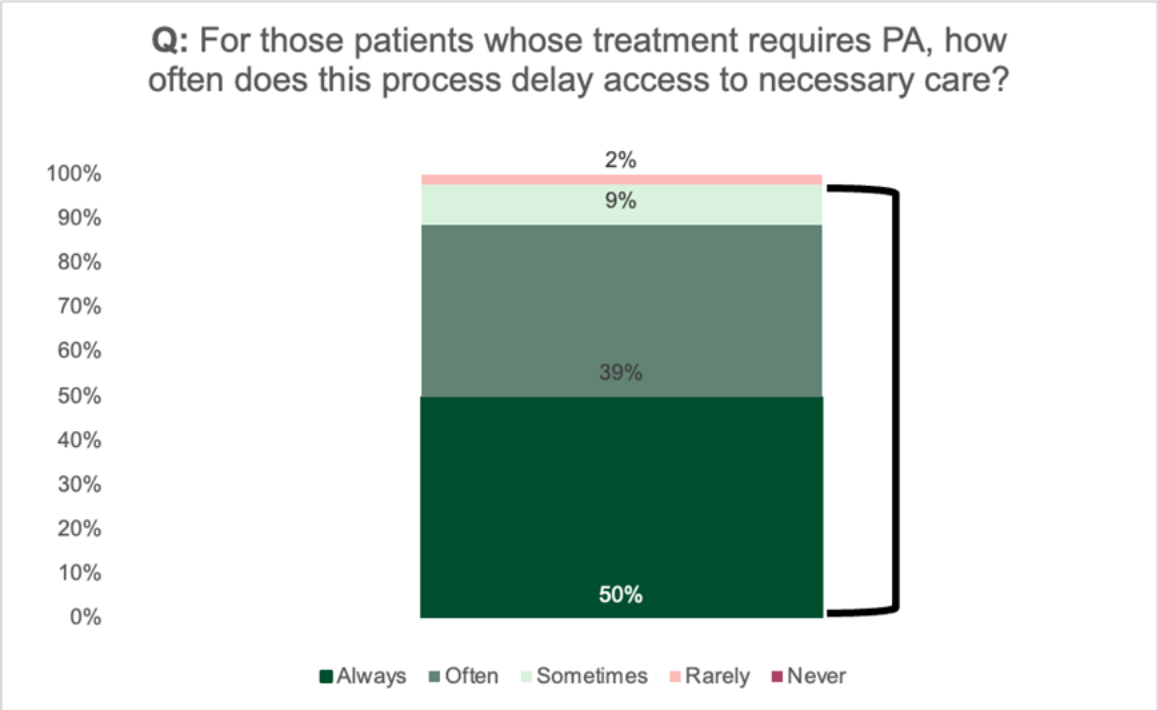
The support of this bill will support transparency and oversight of prior authorizations.

Mahalo,

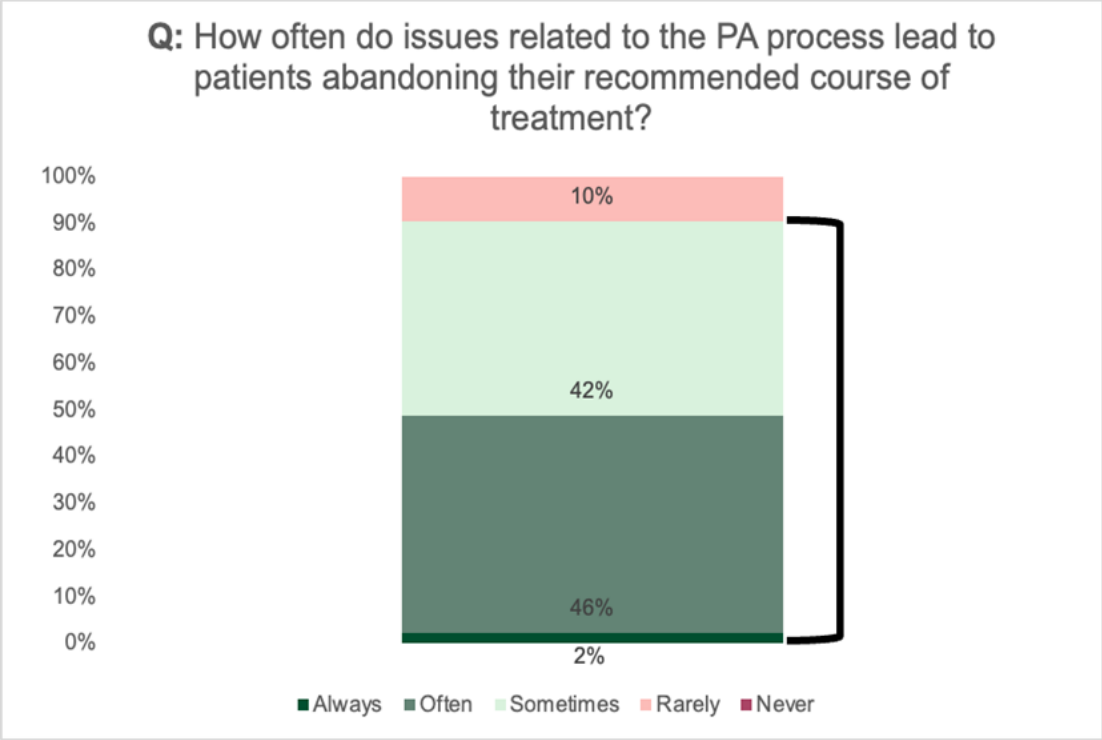
Dr. Celina Macadangdang Hayashi

Please SUPPORT HB250!!

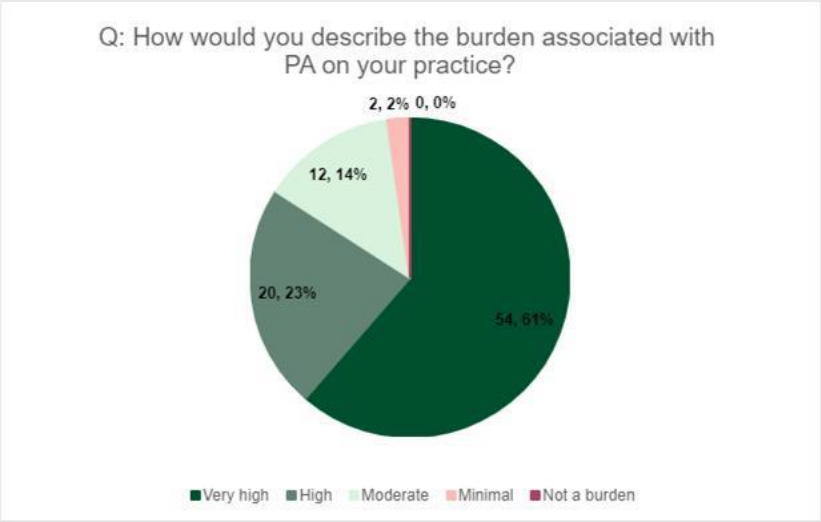
Prior authorization (PA) practices in Hawaii are hurting patients. UH research shows:



In fact, patients often give up on getting recommended treatments because of prior authorization. I know I have!



Plus, it takes doctor, nurse and staff time away from patients!!



In fact, physicians and their staff in Hawaii spend 19.8 hrs per week processing PAs, wait 8 business days for a PA decision, and wait 13.8 business days for a decision after an appeal.

HB250 will help improve this by creating transparency and teamwork to make things better!!

HB-250
Submitted on: 1/30/2025 1:22:37 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Lori Kamemoto, MD, MPH	Individual	Support	Written Testimony Only

Comments:

January 30, 2025

To: House Committee on Health

From: Lori Kamemoto, MD, MPH

Re; HB250

Position: Strong Support

Dear Chair Takayama and Health Committee Members:

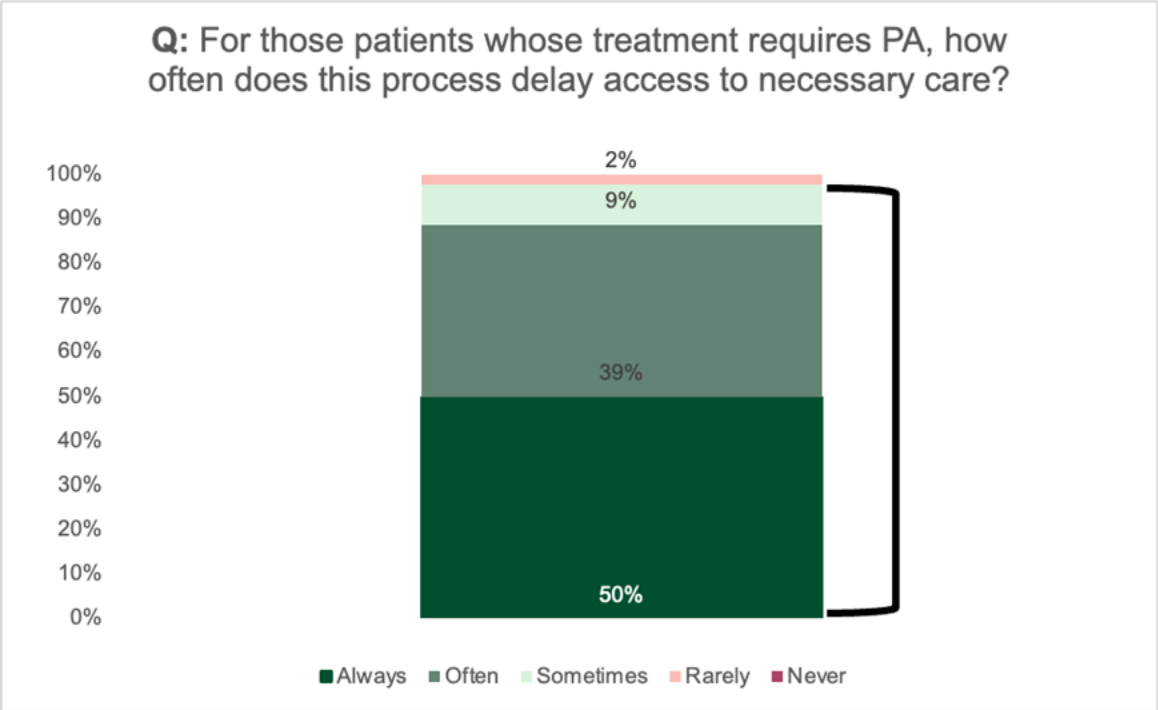
Over my 30-plus years as a Hawaii physician, I have spent a lot of time on health insurance prior authorizations and repeal of denials. Time that would have been better spent caring for my patients rather than on long phone calls with insurance companies, writing letters to insurance companies explaining why particular procedures are necessary (to persons who are not necessarily physicians or to physicians not in my specialty field) and other insurance paperwork.

Although as a physician, it has been frustrating dealing with health insurance company prior authorizations, delays and denials - it's effect on our patients and patient care is what is most disturbing. The undue stress and worry placed on our patients over whether a medically recommended visit/procedure/medication will be covered by insurance and how long the delay will be while awaiting insurance decisions is unacceptable and unnecessary.

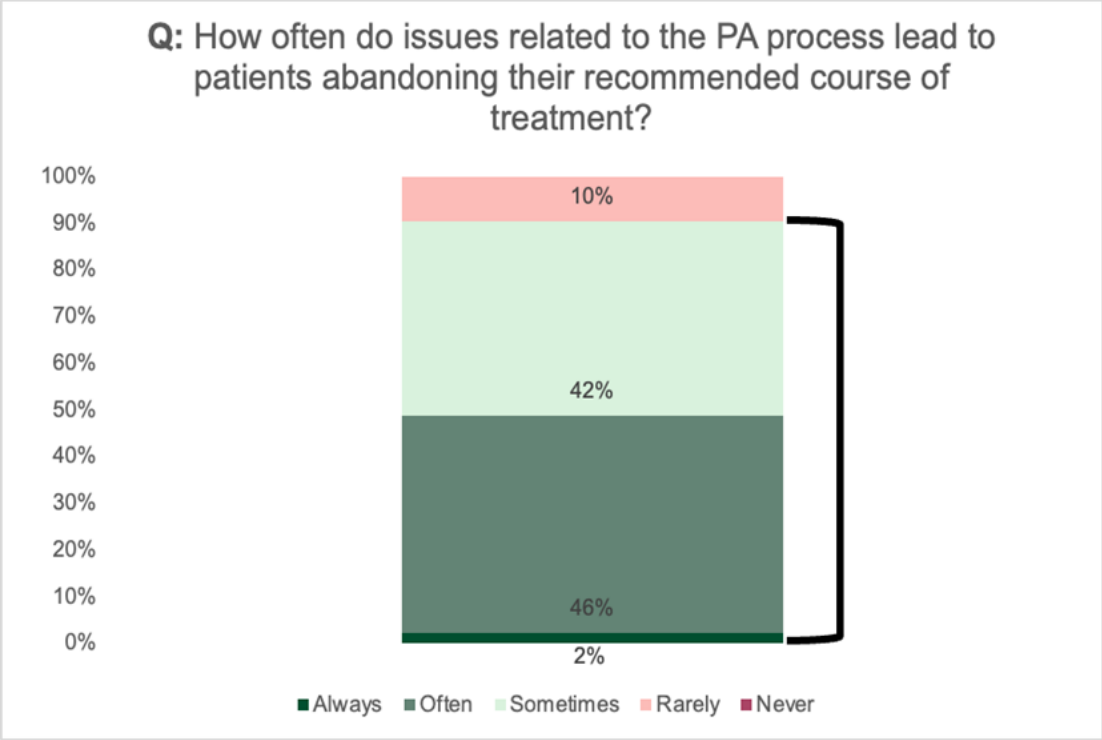
HB250 is a step in the right direction towards alleviating some of these issues. Mahalo for your support of Hawaii patients through HB250.

Please SUPPORT HB250!!

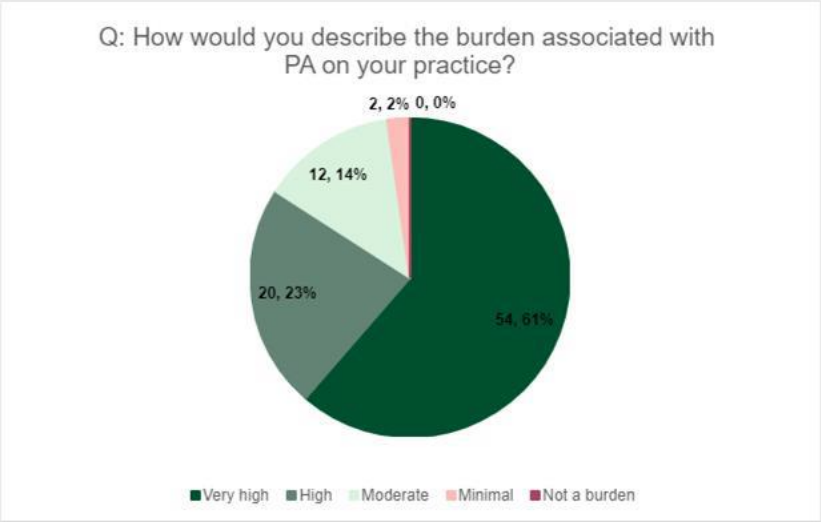
Prior authorization (PA) practices in Hawaii are hurting patients. UH research shows:



In fact, patients often give up on getting recommended treatments because of prior authorization. I know I have!



Plus, it takes doctor, nurse and staff time away from patients!!



In fact, physicians and their staff in Hawaii spend 19.8 hrs per week processing PAs, wait 8 business days for a PA decision, and wait 13.8 business days for a decision after an appeal.

HB250 will help improve this by creating transparency and teamwork to make things better!!

HB-250
Submitted on: 1/30/2025 1:42:29 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Eric Murray MD	Individual	Support	Written Testimony Only

Comments:

I write today in strong support of HB250, which would require insurance companies to use published, evidence-based standard of care guidelines for prior authorization decisions, rather than proprietary criteria designed to limit access to care.

Currently, many insurance companies and the utilization management firms they hire use internal, unpublished guidelines that are not based on the standard of care recognized by the medical community. These proprietary rules prioritize cost savings over patient well-being, often overriding the clinical judgment of treating physicians. Unlike peer-reviewed medical guidelines, these insurer-created rules lack transparency, are not subject to independent scientific scrutiny, and are developed with an inherent financial conflict of interest.

Alarmingly, even the insurance companies themselves acknowledge in their disclaimers that their internal guidelines "do not constitute medical advice." Yet, these same guidelines are used to deny care recommended by physicians who are following well-established, evidence-based protocols. This creates unnecessary delays, imposes administrative burdens on healthcare providers, and, most importantly, jeopardizes patient health by restricting access to medically necessary treatments.

By requiring insurance companies to align their prior authorization policies with published and peer-reviewed standard of care guidelines, this legislation ensures that decisions about patient care are based on medical necessity rather than corporate profit margins. Patients deserve access to treatments that are grounded in science and best practices, not dictated by opaque, non-clinical cost-containment strategies.

I urge you to pass HB250 to restore fairness, transparency, and integrity to the prior authorization process. Patients' health should be guided by medical expertise—not insurance company financial models.

Thank you for your time and consideration.

HB-250
Submitted on: 1/30/2025 1:46:26 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Joji Kohjima	Individual	Support	Remotely Via Zoom

Comments:

Prior authorizations by corporations such as uha are killing primary care offices. We are understaffed and underpaid, and we cannot provide care in Hawaii unless something changes.

HB-250
Submitted on: 1/30/2025 2:14:22 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Veronica J Rooks	Individual	Support	Written Testimony Only

Comments:

I support oversight !

HB-250
Submitted on: 1/30/2025 2:32:28 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Lauren Ing, MD	Individual	Support	Written Testimony Only

Comments:

As a physician, me and my staff spend countless hours on prior authorizations and appeals for denials that greatly impact patient care and staff well-being. I hope for a better system or way to evaluate how neccesary it is.

HB-250
Submitted on: 1/30/2025 4:07:20 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Ronnie Texeira	Individual	Support	Written Testimony Only

Comments:

January 30, 2025

To: House Committee on Health

From: Ronnie Texeira, MD

Re; HB250

Position: Strong Support

Dear Chair Takayama and Health Committee Members:

I have spent a lot of time on health insurance prior authorizations and repeal of denials. Time that would have been better spent caring for my patients rather than on long phone calls with insurance companies, writing letters to insurance companies explaining why particular procedures are necessary

Although as a physician, it has been frustrating dealing with health insurance company prior authorizations, delays and denials - it's effect on our patients and patient care is what is most disturbing. The undue stress and worry placed on our patients over whether a medically recommended visit/procedure/medication will be covered by insurance and how long the delay will be while awaiting insurance decisions is unacceptable and unnecessary.

HB250 is a step in the right direction towards alleviating some of these issues. Mahalo for your support of Hawaii patients through HB250.

HB-250
Submitted on: 1/30/2025 4:09:28 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

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

Comments:

Thank you for the chance to provide testimony in support of HB250.

This bill aims to bring reform to the prior authorization process.

As an individual affected by the access to healthcare problem. I support making prior authorizations fairer and accountable for the benefit of consumers. Concern for fairness in healthcare insurance has become a national issue and Hawai'i is no exception. It is clear that prior authorization has become a tool for insurers to limit expense. However, there is an incentive for the insurer to deny services at every opportunity. Although the insurers claim that prior authorization functions to keep the cost of healthcare down, the enormous compensation (financial and other) of insurance company executives is never mentioned.

HB250 is a part of fixing the prior authorization processes which is a barrier to consumers receiving the treatment assessed to be necessary by the healthcare provider who has had a chance to directly examine and asses the needs of the patient..

Please support HP250

HB-250
Submitted on: 1/30/2025 4:10:11 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Miki Miura	Individual	Support	Written Testimony Only

Comments:

Aloha Chair Takayama, Vice Chair Keohokapu-Lee Loy and Members of the House Committee on Health,

My name is Miki Miura, and I am a family nurse practitioner (NP) at the Waianae Coast Comprehensive Health Center and St. Luke's Clinic Ala Moana. I strongly support the bill HB 250 and would like to offer comments.

As an NP, I have provided women's healthcare services in two clinical settings on Oahu. I have witnessed the devastating effects of delayed care due to denial or prolonged approval processes for prior authorizations for healthcare services on patients.

For example, some pregnant women need genetic testing for alpha thalassemia disorder, which is an inherited blood disorder that can cause anemia, during their pregnancies. However, insurance companies often delay the approval of the test, and some of my patients couldn't get the test done for weeks and months because of the delayed process for the prior authorization. Though it is rare, when both parents have alpha thalassemia, their children can have severe forms of thalassemia, Hb Bart syndrome, which presents with hydrops fetalis (U.S. Department of Health and Human Services National Institutes of Health, 2022). Without proper treatment, the majority of fetuses with hydrops fatalis are stillbirth or die shortly after birth due to complications from the condition. Therefore, promptly identifying the disorder's presence is critical to increase the chances of survival for these babies. Some patients got approval for prior authorization for the test without problem or didn't need prior authorization, while others in similar situations couldn't get the tests done. This was primarily because of their insurance plan. I firmly believe that sharing data relating to prior authorization of healthcare services to the State Health Planning and Development Agency contributes to a big step forward to bringing the prior authorization process to national standard and diminishing the discrimination in access to care among patients with different health insurance.

Thank you for the opportunity to testify on this bill.

Respectfully,

Miki Miura, DNP, APRN, FNP-C

Reference list:

U.S. Department of Health and Human Services National Institutes of Health. (2022, December 2). Alpha thalassemia. MedlinePlus. https://medlineplus.gov/genetics/condition/alpha-thalassemia/

HB-250
Submitted on: 1/30/2025 4:30:49 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Robin Rohr	Individual	Support	Written Testimony Only

Comments:

As a patient and as a representative for extended family members who have endured the unfairness of requests for prior authorization being denied denied denied, and the ensuring workload on doctors having to resubmit resubmit resubmit,

I ask that you work with our advocates to help make this bill a reality.
Medical specialists know what tests are needed on behalf off their patients.

To have admin personnel assume they know what is needed for a patient is nonsensical. They are not medical doctors and they do not know these patients. They have not been trained and to override a physicians knowledge and wisdom has proven to be dangerous to the health and well-being of patients.

It is unfortunate that many of our Hawaii's citizens have died or been irreparably harmed through these bureaucratic decisions.

It makes no sense, it makes no sense at all, except for the obvious conclusion that it adds to the financial bottom line of the insurance companies to deny.

The foolishness of it is that after multiple submissions for pre-authorization, sometimes they are finally approved and by that time the patient has been greatly harmed by that delay.

In the name of fairness, in the name of common sense, please meet with physicians, hear the stories and know that they represent thousands of patients who are shocked and angry at the unjust decisions they have received by the denial of pre-authorizations.
In the name of humanity, this situation needs to be solved.

Do the right thing and pass this bill. And please, know that the spotlight is on the Legislature in these days.

To have bills unanimously approved in the legislative process and then have them blow up when they get to the Finance Chair’s desk, has become absolutely unacceptable.

The death of the CEO of United Healthcare was shocking and horrific. The perpetrator needs to be punished to the full exten of the law.

However, the conversations that came out of that tragedy ignited a national conversation- a conversation that brought forth stories related to denials and delays on prior authorizations. Delays that caused deaths of family members and denial that caused permanent harm to loved ones.

I know the legislators are also family men and women. Certainly they have the courage to address this critical issue at this time.

My prayers are with you that you do the right thing and that you at the Legislature, stop these pre-authorization decisions that play Russian roulette with the lives and health of Hawai'i citizens.

My thoughts and prayers are with you as you make ongoing decisions to "do no harm" to the people of Hawai'i that you have committed to serve.

Respectfully,
Robin Rohr

HB-250
Submitted on: 1/30/2025 4:52:57 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Alexander Silvert	Individual	Support	Written Testimony Only

Comments:

Dear Chair and Committee Members:

My name is Alexander Silvert and I write in support of HB250. State oversight of prior authorization proceedures is essential for the safety of all Hawaii citizens given that it appears that private health care organizations are, naturally, looking out for their bottom line more than for the health and well being of patients. It is particularly troubling that while the state requires that doctors must receive years of training and be certified by the state before they can practice medicine in Hawaii, private health agencies can deny treatment either through an algorithm or by someone who may not even have a college degree, much less any medical training. Oversight is absolutely necessary to safeguard our citizens.

Mahalo.

Alexander Silvert

HB-250
Submitted on: 1/30/2025 5:10:36 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Christina Speirs	Individual	Support	Written Testimony Only

Comments:

I support this bill. Thank you.

HB-250
Submitted on: 1/30/2025 5:11:14 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Richard Lee	Individual	Support	Written Testimony Only

Comments:

I'm writing in support of HB250 which aims to bring much-needed reform and openness to the prior authorization process. As someone deeply invested in the health of our community, I want to express my support for this bill's intent and provisions to make prior authorizations more fair and accountable. At the same time, I encourage you to consider requiring full disclosure of prior authorization data to the public.

Support for HB250

HB250 is an important step toward fixing the frustrating and confusing prior authorization processes that delay care for people in Hawai‘i. By requiring annual reporting from utilization review entities and creating a Health Care Appropriateness and Necessity Commission, this bill helps create transparency and drives meaningful change. These measures are crucial for:

1. Spotting Barriers to Care: Detailed reporting will help everyone understand where delays and denials are happening, so we can work on solutions.

2. Promoting Accountability: Requiring these reports will push entities to make their processes more efficient and reduce unnecessary headaches for providers and patients.

3. Improving Patient Outcomes: Streamlining the system means people can get care faster, which leads to better health and happier patients.

4. Decreasing Provider Administrative Burden: Reducing paperwork makes more time for patient care and reduces burnout in our healthcare community.

I fully support HB250 as a critical measure to reform prior authorization practices in Hawai‘i. Thank you for considering my testimony and for your efforts to make healthcare better for everyone in Hawai‘i. I am happy to answer any questions or provide more information if needed.

HB-250
Submitted on: 1/30/2025 5:27:51 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Leah Shama-Brown	Individual	Support	Written Testimony Only

Comments:

I support transparency and oversight of prior authorization.

HB-250
Submitted on: 1/30/2025 6:50:23 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Anna Maisu	Individual	Support	Written Testimony Only

Comments:

I support transparency and oversight of prior authorization. Please consider the recommendations for remediation.

HB-250
Submitted on: 1/30/2025 7:14:23 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Eric Wyatt	Individual	Support	Written Testimony Only

Comments:

Please vote in favor of this bill. Not only is there an excessive financial burden taking time away from from patient care and running a business but patients suffer by delaying care. Numerous studies have shown prior authorizations do little to decrease the cost of medicine.

HB-250
Submitted on: 1/30/2025 8:01:23 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Ashley Rapoza	Individual	Support	Written Testimony Only

Comments:

Dear Chair and Committee Members,

I am writing to express my strong support for **HB250,** which seeks to enhance transparency and accountability in the prior authorization process by requiring utilization review entities to submit data on prior authorizations to the **State Health Planning and Development Agency** and establishing the **Health Care Appropriateness and Necessity Commission**.

As a healthcare professional, I have witnessed firsthand how **delays in prior authorization approvals can negatively impact patient care**, particularly when it comes to obtaining necessary prescriptions and treatments. The administrative burden placed on providers and the uncertainty faced by patients often lead to **delayed treatments, worsened health outcomes, and increased healthcare costs** due to complications that could have been prevented with timely care.

By implementing the provisions outlined in HB250, Hawai‘i will take a significant step toward:

1. **Improving Patient Access to Timely Care** – Ensuring that patients receive medically necessary treatments without unnecessary delays.
2. **Enhancing Transparency** – Providing data that will help policymakers and healthcare stakeholders assess the impact of prior authorization requirements.
3. **Reducing Administrative Burden on Providers** – Allowing healthcare professionals to focus on patient care rather than excessive paperwork and appeals.

I urge you to pass **HB250** to support a **more efficient, patient-centered healthcare system** that prioritizes timely access to medically necessary services and prescriptions. Thank you for your time and consideration.

Respectfully,

Ashley Rapoza

HB-250
Submitted on: 1/30/2025 8:25:37 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Aaron Morita	Aaron H. Morita, MD, FACP, Inc.	Support	Written Testimony Only

Comments:

Please support HB250 !!!

HB-250
Submitted on: 1/30/2025 8:37:14 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Paul N Morton	Individual	Support	Written Testimony Only

Comments:

Dear Chair Takayama, Vice Chair Keohokapu-Lee Loy, and Members of the Committee,

I am writing to submit testimony in strong support of HB 250, which aims to improve transparency and efficiency in the prior authorization process by requiring utilization review entities to submit relevant data and establishing the Health Care Appropriateness and Necessity Commission. As a board-certified orthopedic surgeon practicing in Honolulu and Kailua-Kona, I have seen firsthand how prior authorization requirements can delay necessary medical care, increasing administrative burdens on healthcare providers and negatively impacting patient outcomes.

The findings outlined in HB 250 highlight the significant obstacles physicians face due to prior authorization policies, including treatment delays, increased burnout, and adverse patient outcomes. The establishment of a commission to assess and streamline these processes is a critical step toward reducing unnecessary administrative barriers and ensuring timely access to care for patients in Hawaii.

I urge the committee to pass HB 250 to support healthcare providers and improve patient care across the state. Thank you for the opportunity to provide testimony. I am available for any further discussion or clarification regarding this matter.

Respectfully submitted,
Paul Norio Morton, MD

HB-250
Submitted on: 1/30/2025 9:08:09 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Matthew Dykema	Individual	Support	Written Testimony Only

Comments:

Please pass this bill as an important step to ensure your constituants have proper access to health care.

Thank you

Dr. Matthew Dykema

QUEEN'S HEART INSTITUTE | THE QUEEN'S HEALTH SYSTEMS

GENERAL CARDIOLOGY NETWORK
Physicians Office Building 3 ▪ 550 South Beretania Street, Suite 601 ▪ Honolulu, HI 96813
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January 31, 2025

USCIS/DHS

Re: HB 250

Dear Sir or Madam,

I am writing as a private citizen in support of HB 520, which is designed to reduce the administrative burden associated with healthcare delivery. Even though I write to you as a private individual, I use Queen's letterhead because it is in my experience at the Queen's Health Systems that I understand how critical is it for initiatives like these to be supported.

Through my multiple roles in healthcare delivery, as a clinical cardiologist, the previous Chief of the Cardiovascular Diseases Clinical Program at The Queen's Health Systems, the previous Division Chief of Cardiovascular Disease at JABSOM, the previous Medical Director of Enterprise Access at The Queen's Health Systems, and the current Chief Medical Officer of Specialty Care & Vice President of Queen's University Medical Group, I have seen how healthcare delivery works from different vantage points. I am extremely concerned about our ability to maintain (let alone expand) our physician workforce in this state and I sincerely believe we are headed towards a worsening crisis in access and healthcare delivery. The administrative burden on physicians is severe and a major contributor to issues with retention. Let me be fully transparent: I am a committed physician and healthcare leader in this community, and I contemplate retiring every day due to how unnecessarily hard it is to practice medicine due to bureaucracy. I have other prominent, young colleagues who think the same. I am 46 years old. I love medicine. Make it easy for me and my colleagues to stay on another 20 years, for your benefit, that of your family, and that of your state.

As a healthcare administrator and a previous Medical Director of Access, I undoubtedly know that prior authorizations delay care, lead to inappropriate care, and worse outcomes. I have experienced this firsthand. My beliefs are not based on numerical data, but the patients in front of me and the moral injury that results from letting them get hurt because of I didn't navigate the paperwork to the liking of a payer in time.

There are ways for healthcare systems, insurance companies, and providers to collaborate effectively in optimizing healthcare delivery for the patients. Initiatives like preauthorization cause an erosion of trust and put us that much further away from collaboration and effective healthcare delivery for our loved ones in the community. Please really think about supporting this bill and understand that it is just a start in decreasing the bureaucratic burden associated with practicing medicine. If you have any questions, please feel free to email me at zkhan@queens.org or call/text at 808-294-4172.

Sincerely,

QUEEN'S HEART INSTITUTE | THE QUEEN'S HEALTH SYSTEMS

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Phone: 808-691-8900 ▪ Fax: 808-691-8919 ▪ www.queens.org

Zia Khan, MD, MPH, FACC
Chief Medical Officer and Vice President of Specialty Care
Queen's University Medical Group

HB-250
Submitted on: 1/30/2025 10:15:42 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Lisa Wong MD	Individual	Support	Written Testimony Only

Comments:

I support transparency and oversight of prior authorization. Prior authorization (PA) practices in Hawaii are hurting patients. Patients often give up on getting recommended treatments because of priorauthorization. it takes doctor, nurse and staff time away from patients. Physicians and their staff in Hawaii spend 19.8 hrs per week processing PAs, wait 8 business days for a PA decision, and wait 13.8 business days for a decision after an appeal.
HB250 will help improve this by creating transparency and teamwork to make things better.

HB-250
Submitted on: 1/31/2025 7:08:44 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Kevin Kern	Individual	Support	Written Testimony Only

Comments:

Prior authorization (PA) practices in Hawaii are delaying essential care and burdening both patients and healthcare providers. Research from UH highlights that many patients abandon recommended treatments due to these hurdles—I know I have! Additionally, doctors, nurses, and staff are forced to spend nearly 20 hours per week navigating PA paperwork instead of caring for patients. On average, it takes eight business days for an initial PA decision and nearly 14 business days for an appeal decision—far too long for those in need of timely care. HB250 will bring much-needed transparency and collaboration to streamline this process, ensuring patients get the care they deserve without unnecessary delays. Let's fix this—support HB250!

HB-250
Submitted on: 1/31/2025 9:40:42 AM
Testimony for HLT on 1/31/2025 9:15:00 AM

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

Comments:

Aloha Committee Members,

I apologize for the late testimony. As a pediatrician who has wasted many hours of my life pursuing prior authorizations that were unnecessary, I strongly support this bill. I look forward to the opportunity to provide more detailed testimony in future hearings.

Mahalo,

Maya Maxym, MD PhD FAAP

HB-250
Submitted on: 1/31/2025 1:47:20 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Laeton J Pang	Individual	Support	Written Testimony Only

Comments:

Thank you for scheduling a hearing on this bill. I'm a practicing radiation oncologist of 30-plus years in Hawai‘i, serving as a former president of the Hawai‘i Society of Radiation Oncology and Immediate Past President of the Hawai‘i Radiological Society. I currently hold appointment as a clinical assistant professor with the John A Burns School of Medicine, clinical member of the UH Cancer Research Center, Radiology Representative to the Hawai‘i Medical Association, and serve as President elect of the Council of Affiliated Regional Radiation Oncology Societies, a non geographic chapter of the American College of Radiology, with additional fellowship designations from the American College of Radiation Oncology, Association of Cancer Care Centers, and American Society of Radiation Oncology.

I'm writing in support of HB250 which aims to bring much-needed reform and openness to the prior authorization process. As someone deeply invested in the health of our community, I want to express my support for this bill's intent and provisions to make prior authorizations more fair and accountable. At the same time, I encourage you to consider requiring full disclosure of prior authorization data to the public.

Support for HB250

HB250 is an important step toward fixing the frustrating and confusing prior authorization processes that delay care for people in Hawai‘i. By requiring annual reporting from utilization review entities and creating a Health Care Appropriateness and Necessity Commission, this bill helps create transparency and drives meaningful change. These measures are crucial for:

1. Spotting Barriers to Care: Detailed reporting will help everyone understand where delays and denials are happening, so we can work on solutions.

2. Promoting Accountability: Requiring these reports will push entities to make their processes more efficient and reduce unnecessary headaches for providers and patients.

3. Improving Patient Outcomes: Streamlining the system means people can get care faster, which leads to better health and happier patients.

4. Decreasing Provider Administrative Burden: Reducing paperwork makes more time for patient care and reduces burnout in our healthcare community.

I fully support HB250 as a critical measure to reform prior authorization practices in Hawai‘i. Thank you for considering my testimony and for your efforts to make healthcare better for everyone in Hawai‘i. I am happy to answer any questions or provide more information if needed.

Laeton J Pang, M.D., M.P.H., FACR, FACRO, FASTRO, FACCC

HB-250
Submitted on: 1/31/2025 3:13:40 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Doede Donaugh, D.O.	Individual	Support	Written Testimony Only

Comments:

As a private practice physician, trying to serve remote and rural community on the Big Island, I would appreciate a reconsideration of the prior authorization process. It makes administrative work even more difficult than it already is. Thank you.

HB-250
Submitted on: 1/31/2025 9:45:42 PM
Testimony for HLT on 1/31/2025 9:15:00 AM

Submitted By	Organization	Testifier Position	Testify
Nancy Chen	Individual	Support	Written Testimony Only

Comments:

To whom it may concern

I highly support HB250 to reduce the burden of managing patient care. We are under staffed and we don't have time and resources to obtain all the pre authorization that is multiplying year after year.

Prior authorization creates unecessary work for our poor physicians and staff that are already overworked and exhausted with paperwork.

Our patients deserve better and faster care. We did not go to medical school to be blocked by an insurance company demands, they should not interfere with a doctor's recommendations.

Thank you for your time.

Sincerely yours,

Nancy Chen, MD