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

1177 Alakea St., #402, Honolulu, HI 96813 Phone: 587-0788 Fax: 587-0783 www.shpda.org

March 21, 2025

TO: HOUSE COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Representative Scot Z. Matayoshi, Chair
Representative Cory M. Chun, Vice Chair; and
Honorable Members

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

RE: **SB1449 SD1 HD1 – RELATING TO PRIOR AUTHORIZATION (of healthcare insurance)**

HEARING: Tuesday, March 25, 2025 @ 2:00 pm; Conference Room 329

POSITION: SUPPORT, WITH COMMENTS

TESTIMONY:

SB1449 SD1 HD1 requires utilization review entities (health insurers) to submit data relating to the prior authorization (PA) of health care services to the State Health Planning and Development Agency (SHPDA), and also includes creation of the Healthcare Appropriateness and Necessity working group. .

Prior authorization (PA), 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. The first step in moving in a direction to improve and streamline the PA process is to understand its current uses by requiring a reporting process to SHPDA. This will facilitate accurate understanding of the frequency of PA claims by insurer; the top 100 diagnostic and therapeutic triggers of PA; the numbers of PA determinations that are challenged by providers; the numbers of PA determinations that are overturned; and so on. In other words, this required reporting will develop transparency and accuracy around the use of PA in Hawaii.

Based on what is learned by this reporting requirement, SHPDA will develop a strategy to streamline and automate PA determinations to discuss with insurers; physicians, hospitals and other providers; and consumers/employers to collaborate on potential solutions and to present to the next legislative session for action as needed.

We suggest amending the original version of the bill to include “laboratory and diagnostic tests” in the previous testimony.

And we also add a comment that we prefer HB 250 HD2 to this bill in its original form because, in addition to requiring the same PA reporting requirements to SHPDA as does this bill, HB 250 HD2 suggests a solution to this problem by forming a work group of insurers, provider and consumers to agree upon PA peer-reviewed national and professional standards to be applied statewide to claims determinations to allow the process to be automated.

The **SB1449 SD1 HD1** also adds additional language to HRS §323D- to create the Health Care Appropriateness and Necessity working group convened by SHPDA as follows:

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

(1) Determine by research and consensus:

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

(B) Clinical guidelines; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 4. New statutory material is underscored.

SECTION 5. This Act shall take effect on_____.

Mahalo for the opportunity to testify.

-- Jack Lewin MD, Administrator, SHPDA

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SB-1449-HD-1
Submitted on: 3/22/2025 1:43:25 PM
Testimony for CPC on 3/25/2025 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Martha Wiedman, M.D.	Hawaii Radiological Society	Support	Written Testimony Only

Comments:

HOUSE COMMITTEE ON HEALTH

Representative Gregg Takayama, Chair

Representative Sue Keohokapu-Lee Loy, Vice Chair

Date: March 22, 2025

From: Marti Wiedman, MD, HRS Legislative Liaison, Hawai'i Radiological Society, HRS

Re: SB1449 SD1 HD1 RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES- SHPDA; Prior Authorization; Utilization Review Entities; Reporting; Health Care Appropriateness and Necessity Working Group; State Health Planning and Development Agency

Position: Support

This measure requires utilization review entities to submit data relating to the prior authorization of health care services to the State Health Planning and Development Agency. Establishes the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency. Effective 7/1/3000.

The American Medical Association Survey reveals that 93% of physicians say prior authorization sometimes, often or always results in care delays for their patients and that 29% of physicians report that prior authorization has led to a serious adverse event for a patient in their care. The survey reveals that 89-95% of physicians report that prior authorization somewhat or significantly increases physician burnout.

Prolonged waits for insurance approval can delay the start of patient care and negatively affect patient health. Prior authorizatin can result in treatment abandonment and serious patient outcomes including hospitalization, disabilitiy or death. In Hawai'i, even routine procedures now require prior authorization. Each insurance company may use different standards to determine which medical services and medications require prior authorization. The lack of standardization, amount of paperwork and number of telephone conversations required to review each case limit physicians' patient interactions and exhaust providers.

Physicians' duty and desire is to preserve their patients' health and access to care.

Prior authorization is a key issue in Hawai'i. Emily Carroll, the senior legislative attorney to the AMA, notes that data recording on insurance rates of approvals and denials, appeal rates and time to decision making are important to transmit to insurance commissioners, who can then report the data to the legislature and the public.

Each level of data information can then be evaluated for accuracy, transparency and efficiency, which improves timely and quality health care delivery to the patient. This measure establishing the Health Care Appropriateness and Necessity Working Group addresses these needs and streamlines Prior Authorization reform policies.

Thank you for allowing the Hawai'i Radiological Society to testify in support of this measure.

References:

1. American Medical Association Advocacy Insights Webinar, "How Prior Authorization Disrupts Patient Care and How We Can Fix It", U Tube Video, 7-26-24.

2. Hawai'i Public Radio, "Doctors Call for Reform on Insurance Practice They Say Impacts Care and Leads to Burnout", by Ashley Mizuo, 3-20-2025.

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

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

Date: March 25, 2025
From: Hawaii Medical Association (HMA)
Jerald Garcia MD - Chair, HMA Public Policy Committee

Re: SB 1449 SD1HD1 RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES -SHPDA; Prior Authorization; Utilization Review Entity; Reporting
Position: Support

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

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

The disclosure and reporting of the relevant payor utilization data of PA is imperative for meaningful analyses of challenges. Not only will this data help inform patient consumers and employers as they make health plan choices, but also update health systems and provider practices in order to improve administrative efficiencies of service delivery. **HMA strongly supports the reporting provisions of this measure.**

HMA also strongly supports the establishment of a Health Care Appropriateness and Necessity Working Group in this version SD1HD1. Given the complexities of PA, purposeful modifications will require collaboration of advocates and stakeholders. The group work to eliminate PA barriers may include recommendations for 1) specific consensus of clinical guidelines and evidence based appropriate use criteria that reduce time delays and volumes of PA for common medical diagnostic tests and treatments, 2) transparency on PA determinations including detailed denials, and 3) high quality review of care delivery that allows for automation and mitigates disruption of patient care for common chronic or long term conditions in the appropriate clinical setting.

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

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

REFERENCES AND QUICK LINKS

Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). CMS Interoperability and Prior Authorization Final Rule (CMS-0057-Fhttps://www.cms.gov/files/document/cms-0057-f.pdf Accessed Jan 28 2025.

American Medical Association. Issue Brief: Federal Changes to Prior Authorization Rules and their Impact on State Legislative Efforts. https://cdn.ymaws.com/hawaiimedicalassociation.org/resource/resmgr/advocacy/prior_auth_issue_brief_on_fe.pdf Accessed Jan 28 2025.

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

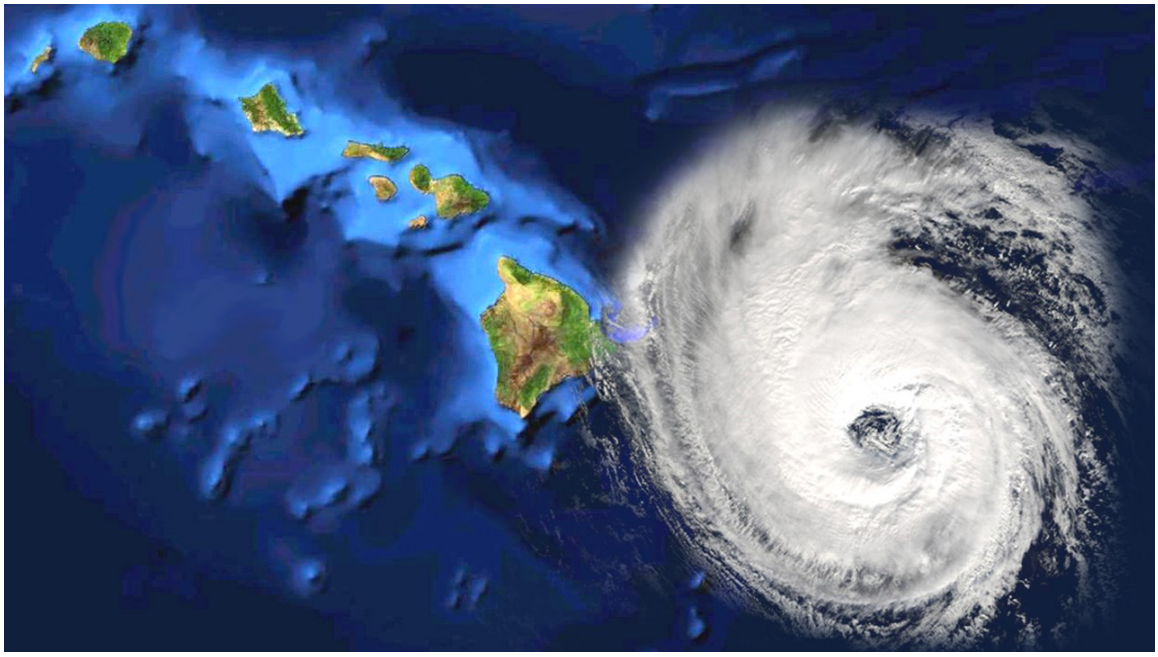
American Medical Association. 2023 AMA Prior Authorization (PA) Physician Survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf Accessed Jan 28 2025.

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

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.

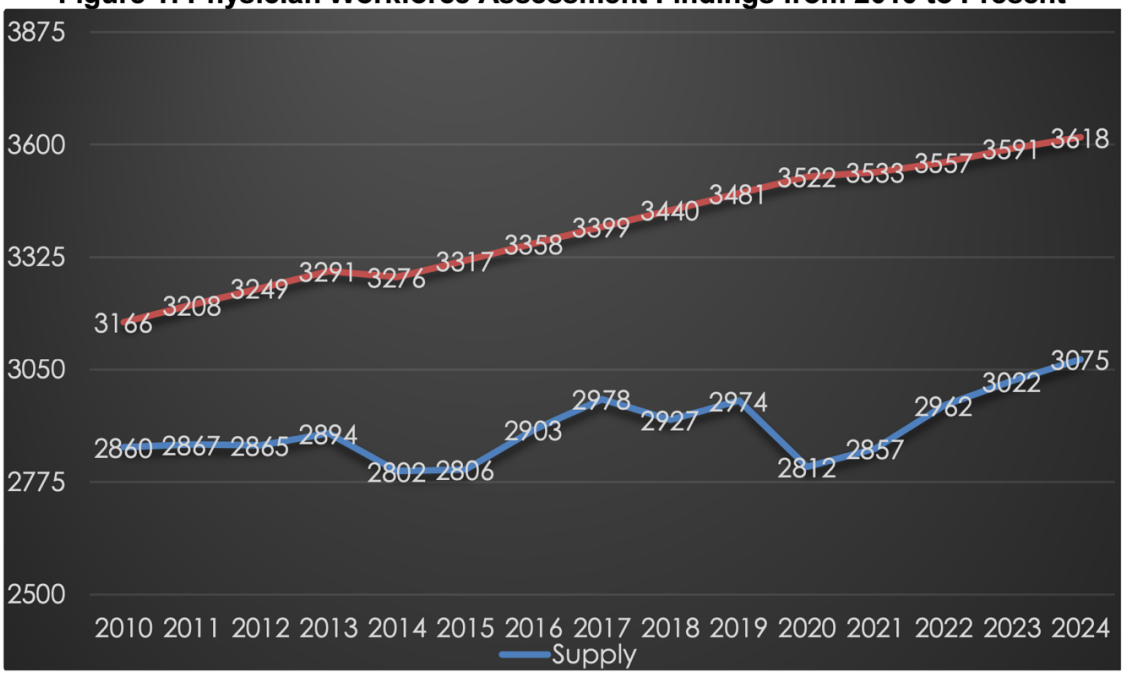
For 15 years, the HI Physician Workforce Assessment Project has studied the ongoing Physician Workforce Shortage.

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.

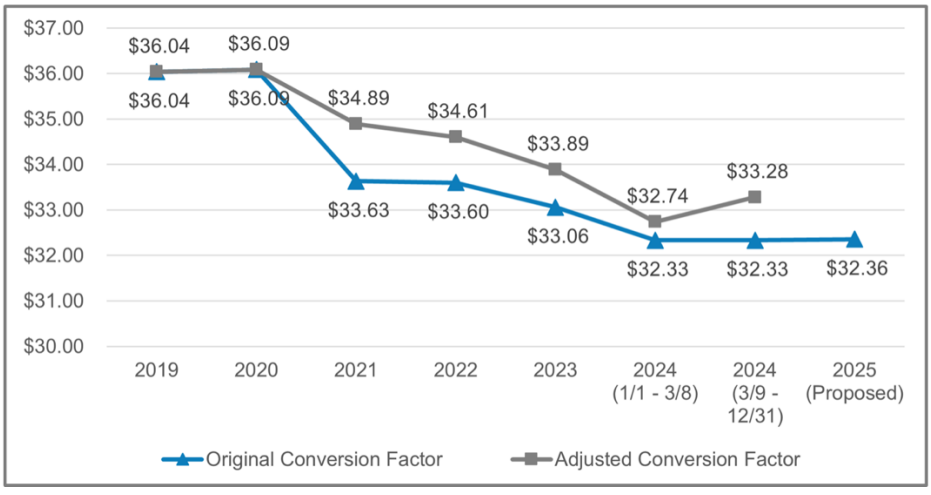
The HI Medicare issue could be addressed by requesting an amendment to the Social Security Act adding Hawaii to Section 42 U.S.C. 1395w–4(e)(1)(G)) which reads….

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.

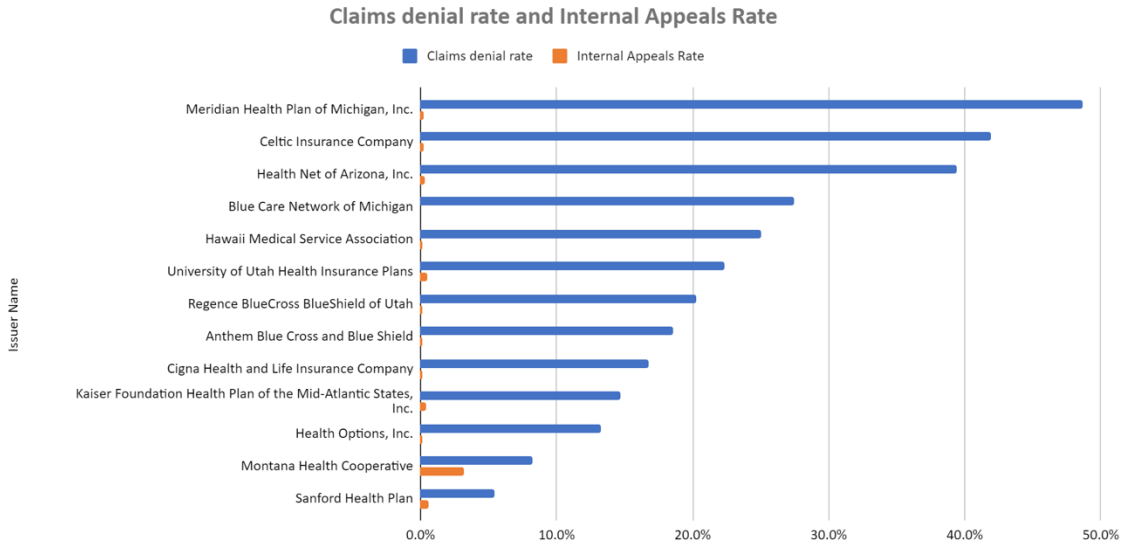
Over the last six years, the HMSA Claim Denial Rate for patients who have purchased their insurance on the HealthCare.gov and obtained care In Network is a stunning 25.1%.

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

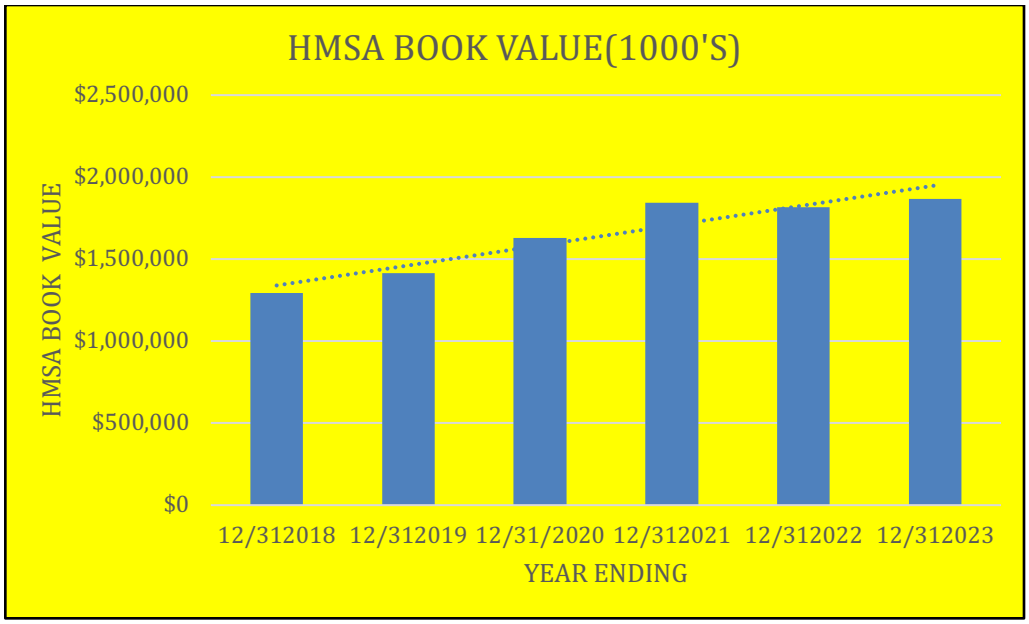
An investment company is a financial institution principally engaged in holding, managing, and investing securities. Think Blackrock, Vanguard, Fidelity.
Insurance companies are essentially investment vehicles driven by the principal of float. No one explains this better than Warren Buffett.

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

SB-1449-HD-1
Submitted on: 3/24/2025 8:14:35 AM
Testimony for CPC on 3/25/2025 2:00:00 PM

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

Comments:

Please refer to Written Testimony for the Hawaii Medical Association.

Hawaii Association of Health Plans

March 25, 2025

To: Chair Matayoshi, Vice Chair Chun, and Members of the House Committee on Consumer Protection and Commerce

From: Hawaii Association of Health Plans Public Policy Committee
Date/Location: March 25, 2025; 2:00 pm/Conference Room 329 & Videoconference

Re: Testimony with comments on SB1449 SD1 HD1 – Relating to Prior Authorization of Health Care Services

The Hawaii Association of Health Plans (HAHP) appreciates the opportunity to offer comments on SB 1449 SD1 HD1. HAHP is a statewide partnership that unifies Hawaii's health plans to improve the health of Hawaii's communities together. A majority of Hawaii residents receive their health coverage through a plan associated with one of our organizations.

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

We would like to ensure that the reporting noted in this bill aligns with current CMS regulations set to be implemented in 2026 and note that we would be willing to participate in further conversations with lawmakers and stakeholders.

Thank you for the opportunity to testify on SB1449 SD1 HD1.

Sincerely,

HAHP Public Policy Committee
cc: HAHP Board Members

An Independent Licensee of the Blue Cross and Blue Shield Association

March 25, 2025

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

Re: SB 1449 SD1 HD1 - RELATING TO PRIOR AUTHORIZATION OF HEALTH CARE SERVICES

Dear Chair Matayoshi, Vice Chair Chun, and Members of the Committee:

HMSA would like to offer comments on SB 1449 SD1 HD1, which requires utilization review entities to submit data relating to the prior authorization of health care services to the State Health Planning and Development Agency and establishes the Health Care Appropriateness and Necessity Working Group within the State Health Planning and Development Agency.

Acknowledgement and Collaboration

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

HMSA Prior Authorization

HMSA currently meets, and typically exceeds, Centers for Medicare & Medicaid Services and National Committee for Quality Assurance timeliness requirements for PA. We do not require PA for emergency care or care that members receive when hospitalized.

HMSA is committed to forward progress, and we have participated in and convened conversations around solutions to administrative burden, eliminated PA requirements for certain procedures, expanded our Fast Pass Program for qualifying providers, and are moving towards a fully integrated and digitized PA process to further improve accuracy, efficiency, and turnaround time and minimize errors and administrative burden.

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

Sincerely,

Dawn Kurisu
Assistant Vice President
Community and Government Relations

SB-1449-HD-1
Submitted on: 3/21/2025 3:09:19 PM
Testimony for CPC on 3/25/2025 2:00:00 PM

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

Comments:

I fully support SB1449 SD1 HD1. Mahalo

SB-1449-HD-1
Submitted on: 3/22/2025 10:44:14 AM
Testimony for CPC on 3/25/2025 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Jennifer K Camp	Individual	Support	Written Testimony Only

Comments:

Dear Hawai'i state legislators,

I work in healthcare and see the negative effects of the prior authorization process on our community health. It also severely decreases patient satisfaction and makes patients leery of seeking care at all. Creating a work group to analyze insurance data is the first step to seeing what can be standardized, which PAs are ineffective and evaluate correlations with misuse of emergency services. Please support Bill SB1449.
Jennifer Kiko Camp

Kamuela, HI 96743

SB-1449-HD-1
Submitted on: 3/24/2025 9:47:42 AM
Testimony for CPC on 3/25/2025 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Victor Brock	Individual	Support	Written Testimony Only

Comments:

I support this bill and any effort to reign in this prior authorization madness.

SB-1449-HD-1
Submitted on: 3/24/2025 10:48:25 AM
Testimony for CPC on 3/25/2025 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Marcia Kemble	Individual	Support	Written Testimony Only

Comments:

Greetings Committee Chair and Committee Members,

I strongly support SB 1449 SD1 HD1, which would increase transparency regarding prior authorization.
Prior authorization delays prevent patients from receiving necessary care, and prior authorization denials of care that physicians have prescribed have become a very serious problem for doctors and patients alike.
Healthcare providers have been 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.
Data are critical to evaluating the effectiveness, impact, and costs of prior authorization on both patients and clinicians. Though barriers imposed by prior authorization will not be resolved solely by increasing transparency, having access to relevant data can serve as a first step to improving timely access to care.
I would prefer the HB250 version to SB 1449 because it contains the same language on prior authorization reporting and transparency to SHPDA, but also presents a solution with the goal of having the process be automated in the near future, with PA decisions made while the patient is still in the office or while being admitted to the hospital.

Mahalo for your consideration.
Marcia Kemble
Makiki