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

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April 8, 2025

To: HOUSE COMMITTEE ON HEALTH
Representative Gregg Takayama, Chair
Representative Sue L. Keohokapu-Lee Loy, Vice Chair, and
Honorable Members

From: John C (Jack) Lewin, MD, Administrator, SHPDA

Re: **SCR 10, SD2 – Urging the Director of Health to Establish a Working Group on Health Insurance Reform to Provide Recommendations for Reducing the Impact of Prior Authorization Requirement on the Timely Delivery of Healthcare in the State**

Hearing: Friday, April 11, 2025 at 10:00 am; Conference Room 329

Position: SUPPORT the INTENT, with COMMENTS

Testimony:

SHPDA supports the intent of SCR 10, SD1 to establish a working group regarding streamlining of the prior authorization (PA) process.

In terms of state background on this issue, SHPDA worked with the Department of Health to propose in legislation during this session a means to accomplish two parallel and important improvements to the controversial prior authorization (PA) issue: mandatory reporting to SHPDA on prior authorization practices (frequency of claims denials by condition, appeals, reversals of denials), which can be easily accomplished if such reporting parallels for insurers what they are already required to report to the federal government. The second improvement involves forming a work group defined in SCR10 to attempt to standardize and use the most widely accepted national peer-reviewed scientific and medical standards, guidelines, and appropriate use criteria for prior authorization determinations. This could de-mystify the process for physicians, providers, and hospitals and allow Hawaiʻi to become the first state to largely automate the PA process, and relieve all parties -- including the insurers -- from the burdensome nature of the PA process for all.

Please also note that HB250 and SB1449 both contain these goals and identical language for both the reporting process and the work group. Both bills, assign SHPDA to be the convenor of the work group, which we are ready and able to do, with the Director of Health, the Med-QUEST Administrator, and the Insurance Commissioner as ex-officio

participants. We firmly believe this process can lead to constructive results and satisfy the intent of this concurrent resolution.

We note that PA dissatisfaction among providers and consumers of healthcare services nationally has resulted in the tragic murder of an insurance executive, and has further resulted in numerous state bills to accelerate PA adjudications and to make the process more transparent to physicians, hospitals, other providers, and patients. The PA process also often delays essential healthcare. It is time to build trust regarding this PA process in our state among all involved parties, (providers (physicians, clinicians, and hospitals); insurers, and purchasers of health insurance (patients, employers like EUTF, and concerned consumer groups).

Additional important federal background is that the Centers for Medicare and Medicaid services (CMS) published in 2023 a new Final Rule, CMS-0057-F to expedite PA processes and interoperability standards in federal programs (Medicare, Medicaid, CHIP, and ACA Exchanges). The Rule takes full effect in 2027 but does not cover private commercial insurance. It also creates timeline for PA determinations, that while expedited, are not fast enough to satisfy physicians, hospitals, other providers, and consumers. Hence, the many state legislative bills and American Medical Association recommendations to further shorten PA determination timelines, to include all insurers, and to accelerate implementation. The workgroup could also work on voluntary improvements to the process, including timelines, which are not included in the latest versions of either HB250 or SB1449.

SHPDA did not request new staff or resources to manage the required reporting or to convene and staff the "health care appropriateness and necessity work group." While medical conditions are complex, associated with personal and genetic individualities, and with many possible co-morbidities and/or social factors attached to any medical diagnosis or recommended treatment, we live in the information age.

National academic, federal, and professional organizations have created sophisticated peer-reviewed guidelines and standards that reflect this complexity already. For the working group proposed to succeed, SHPDA believes no special consulting services or scientific consultants will be needed for determining scientific and clinical consensus on best standards to apply to unique PA determinations. We have the scientific and clinical expertise to do this among our providers, insurers, and employers/consumer groups now to achieve consensus of best standards. And SHPDA has staff capable of convening the working group.

We therefore recommend that this SCR10 be amended to be consistent with the language SB1449 regarding the work group to be convened by SHPDA as follows:

1. The §323D- Health care appropriateness and necessity working group; appointment process shall appear as in SB1449 (or HB250) as:

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STATE OF HAWAII
KA MOKU'ĀINA O HAWAI'I
DEPARTMENT OF HUMAN SERVICES
KA 'OIHANA MĀLAMA LAWELAWE KANAKA
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April 10, 2025

TO: The Honorable Representative Gregg Takayama, Chair
House Committee on Health

FROM: Ryan I. Yamane, Director

SUBJECT: **SCR 10 SD2 – URGING THE ADMINISTRATOR OF THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY TO ESTABLISH A WORKING GROUP ON HEALTH INSURANCE REFORM TO PROVIDE RECOMMENDATIONS FOR REDUCING THE IMPACT OF PRIOR AUTHORIZATION REQUIREMENTS ON THE TIMELY DELIVERY OF HEALTH CARE IN THE STATE.**

Hearing: Friday, April 11, 2025, Time 10:00 a.m.
Conference Room 329 & Via Videoconference, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) appreciates the intent of this resolution, defers to the Department of Health, and provides comments.

PURPOSE: Requesting that the Administrator of the State Health Planning and Development Agency establish a working group on health insurance reform to provide recommendations for reducing the impact of prior authorization requirements on the timely delivery of health care in the State; the DHS Med-QUEST Administrator or delegate is requested to serve as an ex-officio member of the working group. The working group is requested to consider all relevant federal law, Hawaii law, and law in other states to determine whether there are statutes and regulations that establish: (1) Reasonable and appropriate prior authorization response times, including whether a response time of twenty-four hours for urgent care and forty-eight hours for non-urgent care is feasible; (2) Valid prior authorizations for medications for a period of at least one year, regardless of dosage changes; (3) Valid prior

authorizations for the length of treatment for patients having chronic conditions; (4) That adverse determinations should only be conducted by providers licensed in the State and of the same specialty that typically manages the patient's conditions; (5) The manner in which retroactive denials may be avoided if care is preauthorized; (6) Procedures whereby private insurers may publicly release prior authorization data, disaggregated by drug or service, as it relates to approvals, denials, appeals, wait times, and other categories; (7) Reasonable and appropriate periods of time for a new health plan to honor a patient's prior authorization for a transitional period of time; and (8) Criteria or factors that would allow for a reduction in the total volume of prior authorization requests, such as exemptions or gold-carding programs.

The topic of ensuring the timely provision of health care services while also ensuring the necessary, cost-effective, clinically appropriate, and eligible coverage using prior authorizations is very timely. There is robust dialogue nationally and locally in Hawaii on access to care. Centers for Medicare and Medicaid Services also have new rules regarding prior authorizations and timing coming into effect within the year. DHS Med-QUEST administration is interested in participating in such a workgroup as it impacts the Medicaid members, the health care providers, and the Medicaid managed care plans.

Thank you for the opportunity to provide comments on this resolution.

HPCA
HAWAI'I PRIMARY CARE ASSOCIATION

Testimony to the House Committee on Health
Friday, April 11, 2025; 10:00 a.m.
State Capitol, Conference Room 329
Via Videoconference

RE: SENATE CONCURRENT RESOLUTION NO. 010, SENATE DRAFT 2, URGING THE ADMINISTRATOR OF THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY TO ESTABLISH A WORKING GROUP ON HEALTH INSURANCE REFORM TO PROVIDE RECOMMENDATIONS FOR REDUCING THE IMPACT OF PRIOR AUTHORIZATION REQUIREMENTS ON THE TIMELY DELIVERY OF HEALTHCARE IN THE STATE. [AMENDED TITLE.]

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

The Hawaii Primary Care Association (HPCA) is a 501(c)(3) organization established to advocate for, expand access to, and sustain high quality care through the statewide network of Community Health Centers throughout the State of Hawaii. The HPCA **SUPPORTS** Senate Concurrent Resolution No. 010, Senate Draft 2, URGING THE ADMINISTRATOR OF THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY TO ESTABLISH A WORKING GROUP ON HEALTH INSURANCE REFORM TO PROVIDE RECOMMENDATIONS FOR REDUCING THE IMPACT OF PRIOR AUTHORIZATION REQUIREMENTS ON THE TIMELY DELIVERY OF HEALTHCARE IN THE STATE. [AMENDED TITLE.]

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

This resolution, as received by your Committee, would establish a working group on health insurance reform to provide recommendations for reducing the impact of prior authorization requirements on the timely delivery of health care in the State. As presently drafted, this resolution is intended to coincide with the substantive provisions of Senate Bill No. 1449, and House Bill No. 0250, to make recommendations regarding the prior authorization process.

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

We greatly appreciate the amendment made by the Senate Committee on Health and Human Services that would specify that one of the members representing consumers of health care or employers be selected by the HPCA. This would allow the HPCA to fully participate in the working group.

The HPCA urges your favorable consideration of this resolution.

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

ALOHACARE

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

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

Hearing: Friday, April 11, 2025, 10:00 AM, Conference Room 329

RE: **SCR10 SD2 Urging the Administrator of the State Health Planning and Development Agency to Establish a Working Group on Health Insurance Reform to Provide Recommendations for Reducing the Impact of Prior Authorization Requirements on the Timely Delivery of Health Care in the State**

AlohaCare appreciates the opportunity to provide testimony in **support** of **SCR10 SD2.** This measure urges the administrator of the State Health Planning and Development Agency to establish a working group on health insurance reform to provide recommendations for reducing the impact of prior authorization requirements on the timely delivery of health care in the state.

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

AlohaCare is committed to partnering with community healthcare providers to advance the goals of the triple aim: improving the patient experience of care including quality and satisfaction, improving the health of the population, and reducing per capita cost of care. While we support efforts to reduce administrative burdens on providers, we would note that prior authorization is one tool in a broad strategy to ensure delivery of safe and necessary care consistent with evidence-based guidelines and best practices. At AlohaCare, we use prior authorization on a limited basis to maintain high standards of care and gauge medical necessity or appropriateness, directing care to cost-effective, higher-quality, and in-network settings and avoiding potentially harmful care. For example, prior authorization allows AlohaCare to prevent harmful drug interactions and to ensure that prescribed services are the right fit for members, such as confirming that

wheelchairs can fit through the door of a member's home. Further, we utilize prior authorization data internally to allow care managers to better understand a member's needs and care, and we share data with network providers to enhance the provision of care and to assist with discharges and transitions in care settings. Prior authorization may also shield families from unnecessary health care bills, protect patients from bad actors in the health care provider community, and help ensure that limited health care dollars are wisely spent.

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

We would note that we also use prior authorization data to understand where the plan-provider relationship can be enhanced, how provider education can be improved, and how provider burden can be reduced. For example, linking prior authorization processes and data with claims systems ensures claims are paid quickly and accurately. Prior authorization can also help to ensure access to payment, avoid backend disputes, and can even encourage some providers to accept patients because they can be assured of payment in advance.

Finally, recognizing the importance of addressing providers' concerns, we are committed to working with our provider partners and other stakeholders to improve this process. Given the complexity of this issue, we support convening a working group toward developing multi-stakeholder consensus solutions. AlohaCare would appreciate being included in this working group, and we look forward to the opportunity to collaborate with policymakers and stakeholders to ensure quality, appropriate and cost-effective care for our state's residents.

Mahalo for this opportunity to provide testimony in **support** of **SCR10 SD2.** Below we offer additional background and context.

Government Oversight for Medicaid Managed Care. State Medicaid agencies are required by federal rules to collect and review data on appeals of denials and state fair hearings, conduct external quality reviews of Medicaid health plans, and assess

timeliness requirements, plus have discretion to conduct additional oversight activities. Accordingly, Medicaid health plans submit prior authorization policies and data for review to state Medicaid agencies when required, complying with state and federal laws on utilization management and prior authorization and following state contracts and guidelines.[1]

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

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

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

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

Re: SCR 10 SD2/ SR 6 SD2 URGING THE DIRECTOR OF HEALTH TO ESTABLISH A WORKING GROUP ON HEALTH INSURANCE REFORM TO PROVIDE RECOMMENDATIONS FOR REDUCING THE IMPACT OF PRIOR AUTHORIZATION REQUIREMENTS ON THE TIMELY DELIVERY OF HEALTHCARE IN THE STATE-DHS; Health Insurance Reform; Prior Authorization; Working Group; Report
Position: Support

In this resolution, the Director of Health is urged to establish a working group on health insurance reform to provide recommendations for reducing the impact of Prior Authorization requirements on the timely delivery of healthcare in the State.

Prior Authorization (PA) is the upfront bottleneck to the delivery of many common necessary diagnostic tests and medical treatments. PA further compounds the increased costs and administrative demands on Hawaii medical providers and staff, made worse by the healthcare workforce shortages in our state. According to a report published by the Council for Affordable Quality Healthcare (CAQH), PA is the most expensive manual administrative transaction in healthcare, costing the plan $3 and the physician $11 for each transaction per patient.

Recent changes to CMS rules on PA will greatly improve the prior authorization process for patients in federal programs. However much more work is needed at the state level to ensure broader relief from the problems associated with harmful PA processes. Hawaii has an opportunity to build on federal requirements, and ensure greater patient protections, filling in many of the policy gaps that continue to exist.

The disclosure and reporting of the relevant payor utilization data of PA is imperative for meaningful analyses of challenges, and a body for oversight as described in this

resolution is necessary to address deficiencies as well as monitor progress.

HMA strongly supports the formation of the Work Group with the State Health Planning and Development Agency (SHPDA).

Given the complexities of PA and healthcare delivery, modifications and revisal will require ongoing assessment and review over time. The work to eliminate PA barriers should also include specific provisions to reduce time delays and volumes of PA, ensure continuity of care, improve transparency and ensure high quality review of care delivery for Hawaii patients, bridging PA policy gaps that worsen Hawaii healthcare disparities.

Thank you for allowing the Hawaii Medical Association to testify in support of this resolution.

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-F) https://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.

2019 Council for Affordable Quality Healthcare (CAQH) Index. Conducting Electronic Business Transactions: Why Greater Harmonization Across the Industry is Needed. CAQH.org 2020. Accessed Feb 24 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.

SCR-10-SD-2
Submitted on: 4/10/2025 3:26:03 PM
Testimony for HLT on 4/11/2025 10:00:00 AM

Submitted By	Organization	Testifier Position	Testify
Cathy Wilson	WIMAH - Work Injury Medical Association of Hawaii	Support	Written Testimony Only

Comments:

Re: Strong Support for SRC 10 SD2

Dear Chair Takayama, Members of the Committee:

I am submitting this testimony in **strong support of SRC10 SD2** urging the Administrator of the State Health Planning and Development Agency to establish a working group on health insurance reform. This resolution is critical to addressing the significant challenges posed by prior authorization requirements, which delay timely access to healthcare, burden providers, and disproportionately harm underserved communities.

The Problem with Prior Authorization

1. Delays in Patient Care: Prior authorization processes often result in unnecessary delays for essential medical treatments and diagnostic tests. Studies and testimony from Hawaii's medical community reveal that even routine procedures, such as joint injections or diabetes medications, are subjected to cumbersome approval processes. These delays can lead to adverse patient outcomes, including untreated pain, emergency room visits, or abandonment of care altogether.

2. Impact on Underserved Communities: Rural and medically underserved populations face heightened barriers due to prior authorization delays. For example, patients on neighbor islands may need to travel for specialized care but are often forced to wait weeks for approvals. This exacerbates existing health disparities and undermines trust in the healthcare system.

3. Administrative Burdens on Providers: Physicians and healthcare staff spend an excessive amount of time navigating complex and inconsistent prior authorization requirements across insurers. This administrative burden detracts from direct patient care and contributes significantly to physician burnout—a concern echoed by 95% of doctors nationwide.

Why This Resolution is Necessary

While federal reforms by the Centers for Medicare and Medicaid Services (CMS) have improved prior authorization processes for some patients, these changes do not apply to private insurers operating in Hawaii. Without state-level action, private payers will continue to impose outdated practices that delay care and create inefficiencies.

This resolution proposes a comprehensive approach by convening stakeholders—including insurers, healthcare providers, consumers, and state officials—to develop actionable recommendations. The working group will explore best practices from other states, such as gold-carding programs that exempt high-performing providers from prior authorization requirements, and establish clear timelines for approvals (e.g., 24 hours for urgent care).

Expected Benefits

1. Improved Patient Outcomes: Streamlining prior authorization will ensure timely access to necessary treatments, reducing complications caused by delays.

2. Reduced Administrative Burden: Standardizing processes across insurers will allow healthcare providers to focus on delivering quality care rather than navigating bureaucratic hurdles.

3. Equity in Healthcare Access: Addressing the disproportionate impact on rural and underserved populations will help close gaps in health outcomes.

4. Transparency and Accountability: Requiring insurers to publicly report prior authorization data—such as approval rates and wait times—will foster accountability and allow policymakers to monitor progress.

This resolution is a vital step toward modernizing Hawaii's healthcare system and ensuring that all residents receive timely, equitable access to medical services. By establishing this working group, Hawaii can lead the way in creating patient-centered reforms that balance cost control with quality care.

I urge you to pass this resolution and prioritize the health and well-being of our community. Thank you for your consideration.

Cathy Wilson

Work Injury Medical Association of Hawaii

Co-Founder and Board of Director

SCR-10-SD-2
Submitted on: 4/9/2025 7:26:56 AM
Testimony for HLT on 4/11/2025 10:00:00 AM

Submitted By	Organization	Testifier Position	Testify
Robert Thomas Carlisle, MD, MPH	Individual	Support	Written Testimony Only

Comments:

HOUSE COMMITTEE ON HEALTH

Rep. Gregg Takayama, Chair

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

Date: April 9, 2025

From: Robert Carlisle, MD, MPH

RE: SCR No. 10, SD2; URGING THE ADMINISTRATOR OF THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY TO ESTABLISH A WORKING GROUP ON HEALTH INSURANCE REFORM TO PROVIDE RECOMMENDATIONS FOR REDUCING THE IMPACT OF PRIOR AUTHORIZATION REQUIREMENTS ON THE TIMELY DELIVERY OF HEALTH CARE IN THE STATE

Position: Support

Thank you for allowing testimony on SCR No. 10. I endorse the need to mitigate the adverse impact of prior authorization burden leading to frustration of patients and the unsustainable burden on physicians seeking appropriate health care.

There have been many bills before the legislature this session, and all contain important elements to improve the burden of prior authorization affecting the people of Hawai‘i. SCR No. 10 moves the issue, the health, and the health care of the people of Hawai‘i forward in a meaningful way.

Personally, I have some reservations about any working group that is 15 members in size. And, I would advocate for express inclusion of primary care in the working group.

Thank you for allowing me to testify on this and embracing the need to optimize efficient and effective care for the people of Hawaii. It is greatly appreciated.