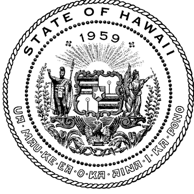

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

DEPARTMENT OF HEALTH - *KA ʻOIHANA OLAKINO*

JOSH GREEN, MD
GOVERNOR OF HAWAIʻI
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

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ADMINISTRATOR

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April 2, 2026

TO: SENATE COMMITTEE ON WAYS AND MEANS
Senator Donovan M. Dela Cruz, Chair
Senator Sharon Y. Moriwaki, Vice Chair

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

RE: **HB 2319-HD2-SD1 -- RELATING TO STATE HEALTH PLANNING AND DEVELOPMENT AGENCY**

HEARING: Monday, April 6, 2026 @ 10:32 am; Conference Room 211

POSITION: SUPPORT with COMMENTS

Testimony:

SHPDA strongly supports HB 2319-HD2-SD1, which is in the Governor's package. The bill first adds to our statute a modernized definition of healthcare: "Health care" means the improvement of a person's health through the prevention, diagnosis, treatment, and amelioration or cure of disease, illness, injury, or other physical and mental impairment, regardless of the setting in which those services are delivered. Health care includes oral health, behavioral health, and long-term care."

Second, it modernizes SHPDA functions as promoting "universal access to high-quality, equitable, and affordable health care for ALL the people of the State and a shared vision Hawaii's healthcare future". This very broad clarified definition of healthcare and of our powerful primary function are critically important for various reasons. The "shared vision" term is important as well. There are large State healthcare programs and/or responsibilities in the Departments of Health (DOH), Department of Human Services (DHS), Corrections and Rehabilitation, Education, Commerce and Consumer Affairs, the Hawai`i Health System Corporation, the University of Hawai`i, and many other state agencies. Most of these have historically been operating in silos. One important aspect of SHPDA's mission is, by collaboration and persuasion, to help the entire state government achieve a shared vision of the ideal future of healthcare here. Similarly, SHPDA interacts with virtually all stakeholders in the larger non-state health sector. A shared vision is sorely needed, there also, considering the federal underfunding issue and the seemingly cataclysmic changes occurring in the private healthcare sector and insurance industry here. With a physician Governor, there is an opportunity for real progress in this regard.

HMSA objected to language in the new version that involves assessing impacts of elements of healthcare impacting access, quality, and cost on behalf of consumers, including *insurance* impacts. However, this bill adds no new regulatory powers to SHPDA. DCCA regulates insurers. We will responsibly report, however, impacts like the fact that one insurer has abruptly left the state in the past month; and that all insurers, like hospitals and providers, are hurting financially under the very low per capital reimbursement in Medicare. After the impacts of the Big (Not So) Beautiful Bill (HR1) are felt after 2027, insurers providing Medicaid coverage will also suffer from lower reimbursement there.

The state spends between $15-20 billion a year for healthcare services annually; and the more precise accounting of total costs of care (TCOC) will emerge from our implementation of the 10-year AHEAD grant, which SHPDA and DHS Med-QUEST Division successfully applied for in 2024. Importantly, healthcare is by far the largest sector of our state economy. For us and all states, reining in healthcare cost inflation, which is growing faster than general inflation, is necessary to maintain access and affordability of care. SHPDA will take on this tracking function and suggest solutions to maintain affordability.

On the other hand, our federal government is severely underfunding Medicare, putting all hospitals and independent physicians and clinicians in financial jeopardy. With the highest cost of living and housing of states, we have among the lowest per capita spending in Medicare. We are also working with our energetic physician Governor, our Congressional Delegation, and all health sector participants on remedying this, which is a necessary but monumental task since it involves Congressional approval. All said, SHPDA must track access to care, costs of care, quality of care, and healthcare equity on behalf of both the public and private sectors and our population. The mission therefore necessarily includes working in collaboration with all public and private health sector participants and the federal government to foster a Hawai`i-specific shared vision of the future of healthcare.

We expect huge opportunities in these regards from the AHEAD grant, and we have a significant role in the Rural Health Transformation Program. We will be managing the deployment of a significant portion of these new resources. SHPDA's regional and topic-focused advisory councils are named in both federal grants by the Centers for Medicare and Medicaid Services (CMS) as the consumer advocate resource for assuring these programs unfold in the best interest of Hawaii's patient community. We are a 50-year-old agency. Ironically, we are only now beginning to be in a position to fulfill our longstanding legislative mandate and responsibility. Through this authority, and in partnership with DHS/MQD and UH, we are building the state's All-Payer Claims Database. SHPDA will need this and other sources of data from federal and all state sources to fulfill our mission and to monitor the health status of the population. We are building that capacity as well.

SHPDA is working with the governor to raise Hawaii's distressingly low per capita Medicare reimbursement to at least the national average. It is important for the legislature to recognize that this federal under reimbursement in Medicare is in fact the destabilizing factor that is causing the current proposals for major change in the healthcare marketplace.

We need this bill as is. Originally, DOH and SHPDA, in consultation with WAM and FIN, discussed the staffing needed for SHPDA to adequately fulfil this mission of accurately monitoring the status of healthcare in Hawai'i for all involved. We initially proposed adding 6-8 staff and related funds. However, in the interim, SHPDA has received federal funding through the AHEAD grant with two additional staff and federal funding through RHTP for an additional two staff. We note these are temporary staff.

Though this may not be the right timing, ideally an epidemiologist data analyst and a qualified health economist would greatly accelerate our ability to fulfil the tasks ahead. These positions could possibly be partnerships with the University of Hawai'i, John A. Burns School of Medicine.

The Certificate of Need (CON) modest housekeeping changes proposed in this bill are ones we fully support. Thank for the opportunity to testify and to serve the State as a kind of healthcare-focused authority and resource for our future.

Lastly, SHPDA supports the below amendments from the Senate HHS committee's report to bring the two versions in conformity:

(1) Deleting language that would have specified that the health planning activities of the State Health Planning and Development Agency includes health insurance coverage and rates, health insurance benefits and affordability, and workforce development and reimbursement;
(2) Inserting language to require the State Health Planning and Development Agency to establish a state health services and facilities plan, rather than a state health services, workforce, and facilities plan;
(3) Inserting an effective date of January 30, 2050, to encourage further discussion; and
(4) Making technical, non-substantive amendments for the purposes of clarity and consistency.

Thank you for hearing HB 2319-HD2-SD1. Mahalo for the opportunity to testify.

■ -- Jack Lewin, MD, Administrator, SHPDA

HB-2319-SD-1
Submitted on: 4/2/2026 7:58:46 AM
Testimony for WAM on 4/6/2026 10:32:00 AM

Submitted By	Organization	Testifier Position	Testify
Speedy Bailey	Testifying for AMR	Support	Written Testimony Only

Comments:

In support.

West Virginia University
JOHN CHAMBERS COLLEGE OF BUSINESS AND ECONOMICS
KNEE REGULATORY RESEARCH CENTER

April 2, 2026
Senate Committee on Ways and Means
Re: Testimony on HB 2319

Chair Dela Cruz, Vice Chair Moriwaki, and members of the Senate Committee on Ways and Means:

I am a research analyst at the Knee Regulatory Research Center at West Virginia University. I appreciate this opportunity to comment on HB 2319. This comment is not submitted on behalf of any party or interest group.

Under Hawaii's certificate-of-need law, certain types of proposed projects to build or expand health care facilities or equipment must be reviewed and authorized by the State Health Planning and Development Agency. This bill would make two important changes to the certificate-of-need process: 1) grant existing healthcare facilities more flexibility to add additional beds, and 2) exempt health care facilities and services operated by the State Department of Health from certificate-of-need review.

While evidence suggests that these changes would improve access to care and lower costs, the committee may wish to consider broader reforms to Hawaii's certificate-of-need requirements.

Certificate-of-need laws originated in the US more than 60 years ago; they were intended to control health care costs by preventing over-investment in facilities and equipment. The effects of these laws on a variety of outcomes have been extensively studied. Overwhelmingly, research finds that these laws have not achieved their goals.[1] In 2016, the Federal Trade Commission and the Antitrust Division of the US Department of Justice released a joint statement on the impact of certificate-of-need laws on the health care system. The agencies wrote:

> "...after considerable experience, it is now apparent that [certificate-of-need] laws can prevent the efficient functioning of health care markets in several ways that may undermine those goals. First, [certificate-of-need] laws create barriers to entry and expansion, limit consumer choice, and stifle innovation. Second, incumbent firms seeking to thwart or delay entry or expansion by new or existing competitors may use [certificate-of-need] laws to achieve that end. Third, …[certificate-of-need] laws can deny consumers the benefit of an effective remedy following the consummation of an anticompetitive merger. Finally, the evidence to date does not suggest that [certificate-of-need] laws have generally succeeded in controlling costs or improving quality."[2]

Recent studies have found that certificate-of-need laws undermine access to psychiatric and mental health treatment[3] and have helped fuel the opioid crisis.[4]

Informed by decades of research and practical experience, many states have rolled back their certificate-of-need laws, and more than a dozen states have eliminated their certificate-of-need programs entirely. The evidence strongly indicates that repealing Hawaii's certificate-of-need program would benefit patients.

Thank you for your kind consideration.

Liam Sigaud

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[1] Mitchell, M. D. (2024). Certificate of Need Laws in Health Care: Past, Present, and Future. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 61, 00469580241251937.
[2] Federal Trade Commission and U.S. Department of Justice. "Joint Statement of the Federal Trade Commission and the Antitrust Divisionof the U.S. Department of Justice on Certificate-of-Need Laws and South Carolina House Bill 3250," January 11, 2016. Available at: https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-certificate-need-laws-south-carolina-house-bill-3250/160111ftc-doj-sclaw.pdf
[3] Bailey, J., & Lewin, E. (2021). Certificate of Need and Inpatient Psychiatric Services. *The Journal of Mental Health Policy and Economics, 24*(4), 117-124.
[4] Plemmons, A., Deyo, D., & Drain, S. (2024). The effect of Certificate-of-Need laws on substance use disorder care for vulnerable populations. *Southern Economic Journal*.

GRASSROOT
INSTITUTE OF HAWAII

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Removing barriers to Hawaii's prosperity

April 6, 2026, 10:32 a.m.
Hawaii State Capitol
Conference Room 211 and Videoconference

To: Senate Committee on Ways and Means
Sen. Donovan M. Dela Cruz, Chair
Sen. Sharon Y. Moriwaki, Vice Chair

From: Grassroot Institute of Hawaii
Ted Kefalas, Director of Strategic Campaigns

TESTIMONY IN SUPPORT OF HB2319 HD2 SD1 — RELATING TO STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

Aloha Chair, Vice Chair and other Committee Members,

The Grassroot Institute of Hawaii **supports —** and **proposes amendments** to **—** HB2319 HD2 SD1, which would increase the certificate of need exemption threshold for bed changes to 30% of a facility's total existing licensed beds within a two year period, up from 10%. The bill would also exempt state Department of Health facilities and services from CON requirements.

This bill has potential to expand healthcare access. However, it would be more effective if it included additional certificate of need exemptions, such as those proposed in SB2289 SD1. Therefore, we suggest the Committee amend the bill to add the following exemptions to those listed under section 323D-54:

(16)Facilities offering substance abuse treatment programs that employ health care providers or certified substance abuse counselors;
(17) Intermediate care facilities for persons having intellectual disabilities as referenced in section 1905(c) of the Social Security Act, as amended;
(18) Home care agencies licensed under section 321-14.8;
(19) Kidney disease treatment centers including freestanding hemodialysis units;
(20) Services offered in neonatal intensive care units of hospitals;
(21) Services offered in burn care units of hospitals;(22) Facilities, and services offered at facilities, located in federally designated medically underserved rural areas

As Grassroot explained in a recent white paper, Hawaii's restrictive certificate of need program has become a barrier to affordable and accessible healthcare in our state, especially in rural areas and for vulnerable populations.[1]

Required in Hawaii since the mid-1970s, medical certificates of need allegedly prove to state officials that proposed healthcare facilities, services or equipment updates are "needed" in the community. Even the state Department of Health must comply with CON requirements, which seems highly redundant and bureaucratic.

Nationwide, recent studies suggest that CON laws have the counterproductive effect of limiting healthcare quality and access, especially for rural areas and vulnerable populations. For example, consider that:

>> States with certificate-of-need laws have fewer hospitals, substance treatment facilities, psychiatric hospitals, ambulatory surgical centers, dialysis clinics, nursing home beds, open heart surgery programs and hospice care facilities.[2]

>> CON regulations tend to result in fewer hospital beds, decreased access to medical imaging technology and longer wait times.[3]

>> CON regulations are linked to fewer rural hospitals and alternatives, and residents of CON states have to travel farther for care and are more likely to leave their states for care.[4]

This bill deserves praise for liberalizing CON regulations for bed changes, as such CONs contribute to healthcare shortages.

During the COVID-19 crisis, states that required CONs for hospital bed changes were more than twice as likely to experience intensive care unit bed shortages. The average COVID-era ICU bed shortage in states with CON laws was approximately nine beds per 10,000 residents. In states that did not have a CON requirement for hospital bed changes, the ICU bed shortage during the pandemic was significantly smaller at only one bed per 10,000 residents. Moreover, these shortages could not be addressed through the temporary lifting of CON requirements, suggesting that long-term reform is necessary to make an impact in this area.[5]

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[1] Malia Hill, "Improve healthcare access in Hawaii by reforming medical certificates of need," Grassroot Institute of Hawaii, December 2025.
[2] Matthew D. Mitchell, "West Virginia's Certificate of Need Program: Lessons from Research," Mercatus Center at George Mason University, Sept. 22, 2021, p. 5.
[3] Ibid.
[4] Ibid.
[5] Matthew Mitchell, Thomas Stratmann and James Bailey, "Raising the Bar: ICU Beds and Certificates of Need," Mercatus Center at George Mason University, April 29, 2020, p. 3.

Defenders of CON laws claim they are needed to constrain high healthcare costs and guarantee access to higher-quality care. However, research demonstrates that such laws are associated with higher per-person healthcare costs and higher death rates from treatable complications following surgery.[6]

There are numerous benefits to CON reform, which is why it has been gaining in popularity across the country. More than a dozen states have fully repealed their CON programs, and even more have been partially rolling them back.

Hawaii's certificate of need program is badly in need of reform. Amending bed-change requirements and exempting the state Department of Health would be a good first step, but the discussion should not end there. A more comprehensive strategy would encompass broader CON exemptions aimed at helping vulnerable populations.

We hope the Committee will consider expanding the CON exemptions as suggested above, with the goal of improving healthcare access and treatment quality in our state.

Thank you for the opportunity to testify.

Ted Kefalas
Director of Strategic Campaigns
Grassroot Institute of Hawaii

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[6] Matthew D. Mitchell, "West Virginia's Certificate of Need Program: Lessons from Research," Mercatus Center at George Mason University, Sept. 22, 2021, p. 5.

March 6, 2026

The Honorable Donovan M. Dela Cruz, Chair
The Honorable Sharon Moriwaki, Vice Chair

Senate Committee on Ways and Means

Re: HB 2319, HD2 SD1 – RELATING TO THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

Dear Chair Dela Cruz, Vice Chair Moriwaki, and Members of the Committee:

Hawaii Medical Service Association (HMSA) appreciates the opportunity to support HB 2319 HD2 SD1, which amends the functions and responsibilities of the State Health Planning and Development Agency. Adds a new definition of "health care" for chapter 323D, HRS. Amends the exemption threshold for bed changes to up to thirty per cent of existing licensed bed types. Exempts the Department of Health from certificate of need requirements.

HMSA supports the committee's efforts to remove barriers to expanding health care capacity in Hawai'i. We appreciate the work of the State Health Planning and Development Agency (SHPDA) in advancing access to high-quality, equitable, and affordable health care for all residents of our state.

Thank you for the opportunity to offer testimony in support of HB 2319 HD2 SD1.

Sincerely,

Walden Au
Director of Government Relations