UNIVERSITY OF HAWAIʻI SYSTEM ANNUAL REPORT

REPORT TO THE 2026 LEGISLATURE

Annual Report on Findings from the
Hawaiʻi Physician Workforce Assessment
Project

Act 18, SSLH 2009 (Section 5)
Act 186, SLH 2012
Act 40, SLH 2017

December 2025

Hawai‘i Physician Workforce Report 2025

Of the 12,688 licensed physicians in Hawai‘i only 3,647 are currently providing patient care to Hawai‘i's population. Further, of those practicing, not all physicians practice full-time, thus these 3,647 individuals provide approximately 3,044 Full-Time Equivalents (FTEs) of active patient care in Hawai‘i. These numbers are **25 individual providers and 31 FTEs LESS than in 2024**. The demand model used to estimate how many physicians are needed is based on the average US utilization of physician services by specialty as applied to the demographic characteristics and health risk factors of each of Hawai‘i's four counties. Adaptations for geographic barriers and time-sensitive coverage needs were made for practitioners of Emergency Medicine, Critical Care, Orthopedic Surgery, Urologic Surgery, Cardiothoracic Surgery, Vascular Surgery, Neurologic Surgery, Intensive Care and Psychiatry. The demand model indicates the State of Hawai‘i needs 3,688 FTEs of practicing physicians, indicating a **statewide shortage of 644 FTEs** of physician services**.** However, when the geographic realities of specialty coverage on different islands are addressed, the **unmet need for physicians equals 833 FTEs** statewide. The greatest statewide shortage of physicians by specialty remains in primary care, with **178 FTEs** needed in total across all islands. The greatest subspecialty statewide shortages include Pediatric Gastroenterology, Pediatric and Adult Endocrinology, Pediatric and Adult Pulmonology, Cardiothoracic and Colorectal Surgery and Pediatric Critical Care.

Activities pursued by the Physician Workforce team coordinated by University of Hawai‘i John A. Burns School of Medicine Area Health Education Center (AHEC) to increase the physician population include: 1) conducting the research to maintain the workforce database and providing presentations as requested throughout the state; 2) ongoing recruitment of physicians to Hawai‘i through collaboration with all Hawai‘i physician recruiters and sponsoring recruitment booths at national conferences; 3) providing continuing education including the Hawai‘i Health Workforce Summit (600 participants in 2025) and Project ECHO (4,897 people-hours of case-based education in 2024); 4) supporting lobbying efforts in Washington DC to increase Medicare reimbursement rates; 5) administering the Hawai‘i Healthcare Education Loan Repayment Program (HELP) that has provided loan repayment for 928 individuals; 5) working to simplify prior authorization; 6) supporting recruitment to health careers, clinical teaching, travel, lodging, community activities; 7) co-administering the Hawai'i Preceptor Tax Credit; and 8) matching retiring physicians with physicians interested in practice for smooth practice transition. Activities introduced in 2025 include the creation of a statewide physician recruiting platform DocJobsHawaii.org, promotion of a new discounted physician mortgage program and creating a one-stop-shop for teachers and counselors needing field trips or in-school health career awareness visits statewide: hawaiihealthcareers@gmail.com.

Background

Recent national estimates of physician supply indicate a current shortage of between 40,000 and almost 60,000 practicing physicians in the United States, and this shortage is expected to grow to 139,000 physicians by the year 2033.[1] Much of this projected shortage is attributed to an aging population which will require more medical care, and an aging physician workforce which is increasingly considering retirement.[1] The American Association of Medical Colleges found that in 2023, 22.3% of physicians in the US were already 65 years old.[1] Furthermore, COVID has negatively affected practicing physicians, both physically and psychologically, as have the Maui wildfires. The Physician Foundation found that as many as 61% of physicians are suffering from moral distress and burnout and that physicians have three to five times the suicide rates of the general population.[2] Thus, many challenges face the physician workforce. The current study of Hawai'i's physician workforce began in 2010 to measure the number and distribution of physicians by specialty in order to help the state understand and work toward building the ideal health workforce.

Project Methodology

Supply

The supply of physicians in Hawaiʻi is estimated based on a combination of four research activities: 1) a voluntary survey administered with the online physician state re-licensure process (see Appendix 1); 2) queries of local community contacts; 3) extensive internet searches for current practice location and phone number; and 4) direct calling of physician offices to confirm hours of active patient care. The phone calls were performed by staff from the Area Health Education Center (AHEC) office at the University of Hawaiʻi John A. Burns School of Medicine and trained pre-health interns working with the AHEC. The script used is included in Appendix 2. It includes confirming whether the physician works at the office, his/her specialty, how many hours s/he works each week on average, if s/he has other office locations or has partners working in the office. The information collected is converted to Full Time Equivalent (FTE) based on a 40-hour week representing 1.0 FTE. Although many physicians work more than 40 hours a week, this number is used as a baseline for full-time effort and 1.0 is the maximum allocation given to a physician.

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[1] https://www.aamc.org/data-reports/data/2023-key-findings-and-definitions#:~:text=In%202022%2C%2023.2%25%20of%20active,Data%20by%20Specialty%20and%20Location).

[2] https://physiciansfoundation.org/new-survey-reveals-55-of-physicians-know-a-physician-who-considered-attempted-or-died-by-suicide/

Demand

There is no perfect estimate of the ideal number of physicians per population or physician mix for an island population such as that needed in Hawaiʻi. Therefore, a demand model was purchased from a well-known healthcare workforce modeling organization IHS Markit[3] which performs demand estimates for the federal government and other large organizations. The model was purchased from IHS Global in 2021. The major components of the demand model include:

1. A population database that contains characteristics and health risk factors for a representative sample of the population in each Hawaiʻi county,
2. Predictive equations based on national data that associate a person's demographic, socioeconomic, and health risk factor characteristics to his or her demand for healthcare services by care delivery setting, and
3. National healthcare delivery patterns that convert demand for healthcare services to demand for FTE of physicians.

For purposes of physician workforce modeling, the relevant settings are physician offices, outpatient clinics, hospital emergency departments, and hospital inpatient settings. While the forecasting equations and staffing patterns are based on national data, a population database was constructed for Hawaiʻi that was representative of the population in each county of Hawaiʻi. This was done using county-level population information (e.g., age-gender-race/ethnicity), data on whether a county was considered metropolitan or non-metropolitan, and information from the Behavioral Risk Factor Surveillance System (BRFSS) for the population, including summary statistics by county for factors such as the prevalence of obesity, diabetes, current smoking status, and other risk factors used in the model. The current model includes estimates of pediatric subspecialty demand that were not available previously and are still being studied for local accuracy.

Applying the IHS Markit model to Hawaiʻi produced estimates of physician demand by specialty representing the demand for service if the people in each county were to receive a level of care consistent with the national average while adjusting for differences across counties in demographics, health, and economic factors that affect demand for health care services. To adapt to the island geography of Hawaiʻi, three changes were made to the model in collaboration with the model's creators:

1. Tourist use of emergency care: Emergency physician demand was increased to cover the percentage of Emergency Department (ED) visits which were made by non-residents in each county. The hospital ED visit numbers were obtained for 2016-2019[4] and ED and inpatient demand was

[3] IHS Markit, https://ihsmarkit.com/index.html

[4] Hospital billing data archive of the Laulima Data Alliance. Analyzed by Hawai'i Department of Health in 2023.

increased by the percentage of non-residents receiving emergency care in that county.

2. Emergent surgical and intensive care services: Based on current research of best practices,[5,6] the research team believes that every patient should be within half an hour of a hospital with available emergency surgical capabilities to provide orthopedic, urologic, cardiothoracic, neurologic and vascular care. However, this is not possible on all islands of Hawaiʻi. Therefore, to create a best-case, but reasonable scenario, each island with a Level III or higher trauma center (Kauaʻi, Oʻahu, Maui, and Hawaiʻi Island) was estimated to need at least 2.0 FTE of surgeons from the specialties noted above (orthopedic, urologic, cardiothoracic, neurologic and vascular care). Hawaiʻi Island was estimated to need twice that due to its geographic size (4.0 FTE). Of course, a group of only two providers per discipline in a community is challenging to maintain due to on-call responsibilities. Unfortunately, it would be difficult to support much larger practices in rural areas, and, given low physician reimbursement levels compared to cost of living in Hawaiʻi, the market may not be able to support what is recommended here. Furthermore, during discussion with local physicians, it became clear that it requires at least 5.0 FTE to staff a full time Intensive Care Unit (ICU) due to the 24/7 nature of the work. Therefore, all non-military eight level I (Queens) to III (Wilcox, Castle, Pali Momi, Maui Memorial, Hilo, Kona and Queens Waimea) adult trauma centers and the one pediatric trauma Center (Kapiolani) were counted as requiring 5 ICU physicians each (to cover 24/7). This influenced the demand number compared to past years because it added an additional 30 Critical Care physicians to statewide demand.
3. Psychiatry demand: The most recent assessment of Psychiatry demand in Hawaiʻi is 20.5/100,000 population.[7] This number is between the range of numbers estimated in different national publications of 3.9[8] to 25.9[9] per 100,000 population. To find the number of adult and child psychiatrists needed per county, the above ratio was multiplied by the population of

[5] McCrum, M. L., Wan, N., Lizotte, S. L., Han, J., Varghese, T., & Nirula, R. (2021). Use of the spatial access ratio to measure geospatial access to emergency general surgery services in California. *The journal of trauma and acute care surgery*, *90*(5), 853–860.

[6] https://www.facs.org/-/media/files/quality-programs/trauma/vrc-resources/resources-for-optimal-care.ashx

[7] Aaronson A, Withy K. Does Hawai'i Have Enough Psychiatrists? Assessing Mental Health Workforce Versus Demand in the Aloha State. Hawaii J Med Public Health. 2017 Mar;76(3 Suppl 1):15-17. PMID: 28435753; PMCID: PMC5375008.

[8] https://openminds.com/store/the-2018-open-minds-state-by-state-guide-to-estimating-the-number-of-psychiatrists-an-open-minds-market-intelligence-report/

[9] Satiani, A., Niedermier, J., Satiani, B., & Svendsen, D. P. (2018). Projected Workforce of Psychiatrists in the United States: A Population Analysis. *Psychiatric services (Washington, D.C.)*, *69*(6), 710–713. https://doi.org/10.1176/appi.ps.201700344

each county (https://census.hawaii.gov/main/2024-county-population-estimates/) and then divided into the percentage of adult to child psychiatrists estimated in the IHS Markit demand model. Use of this ratio greatly increased psychiatrist demand estimations and, the authors believe, more accurately reflects the need in Hawaiʻi.

These changes are incorporated into the tables in Appendix 3.

Shortage

The shortage of physicians is calculated by subtracting supply from demand. This number is further refined to consider geographic restrictions caused in an island state by eliminating overages of subspecialists on each island. This means that for all specialties other than primary care, the overage of FTEs (i.e., when physician supply is more than demand in a county) is zeroed out, as it is unlikely a specialty physician can fill in for a physician of another specialty. Since the excess of physicians in a discipline is of no advantage to an island, it is eliminated from the calculation. The exception to this practice is primary care, as the four professions in primary care (Internal Medicine, Pediatrics, Family Medicine, and Geriatrics) can usually cover each other to some extent and thus an overage in one area of primary care was not zeroed out. This number appears in Appendix 3 as “Shortage (without overage)”. The percentage of shortage is then calculated by dividing the total “Shortage (without overage)” number by the “Demand” number (Demand minus Shortage without overage)/(Demand).

Other Data Collection

Physician age, gender, ethnicity, practice size and employment status are obtained as available from internet searches and the licensure survey. Retirement, death, and moved out of state status were obtained from community contacts, internet searches, or the physician's office upon phone call.

Project Results

Workforce statistics obtained from re-licensure survey, internet searches, public records, community contacts, and calling of physician offices indicate that in 2025, Hawaiʻi has approximately 3,044 FTEs of physicians caring for patients.

Table 1: Hawaiʻi Physician Supply Trend (in Full Time Equivalents)

Year	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
FTE	2894	2802	2806	2903	2978	2927	2974	2812	2857	2962	3022	3075	3044

The demand model based on US average physician use when applied to Hawaiʻi’s four counties indicates the State of Hawaiʻi needs 3,688 FTEs of practicing physicians. This indicates a shortage of 644 FTE of physician services. However,

when island geography is considered (i.e., eliminating specialty overage), the estimated unmet need for physicians increases to 833 FTEs. County-level differences are listed below.

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

	Hawai'i County	Honolulu County	Kauai County	Maui County	Statewide
Shortage	224 (201)	379 (328)	50 (43)	179 (174)	833 (768)
Percent	43% (40%)	15% (13)	28% (24)	41% (41)	23% (21)

Table 3: Primary Care Physician Shortage by County (Prior year numbers in blue)

	Hawai'i County	Honolulu County	Kauai County	Maui County	Statewide
Shortage	21 (20)	109 (86)	4 (6)	45 (41)	178 (152)
Percent	14% (13%)	13% (11)	8% (12)	35% (32)	16% (13)

Additional facts about the active physician workforce in Hawai'i

- Our practicing physicians range from age 29 to age 91 in age. The average age is 55.4 years old (compared to 54.4 US average[10]) up slightly from 54.7 in 2024.
- Currently 25% of our physicians are already age 65 years or over, constituting 804 practicing physicians (up slightly from 24% in 2024)
- Women make up 39% of the physician workforce (same as 2024).
- In 2025, 69% of physicians were employed compared to 56% in 2016 and 58% in 2020.

Table 4: Percent of Physicians Employed

2016	2020	2025
56%	58%	69%

- Practice size has also shifted to a greater proportion of large groups. In 2014 54% of physicians were in groups of less than six. Now only 42% are.

Table 5: Physician Practice Size 2025

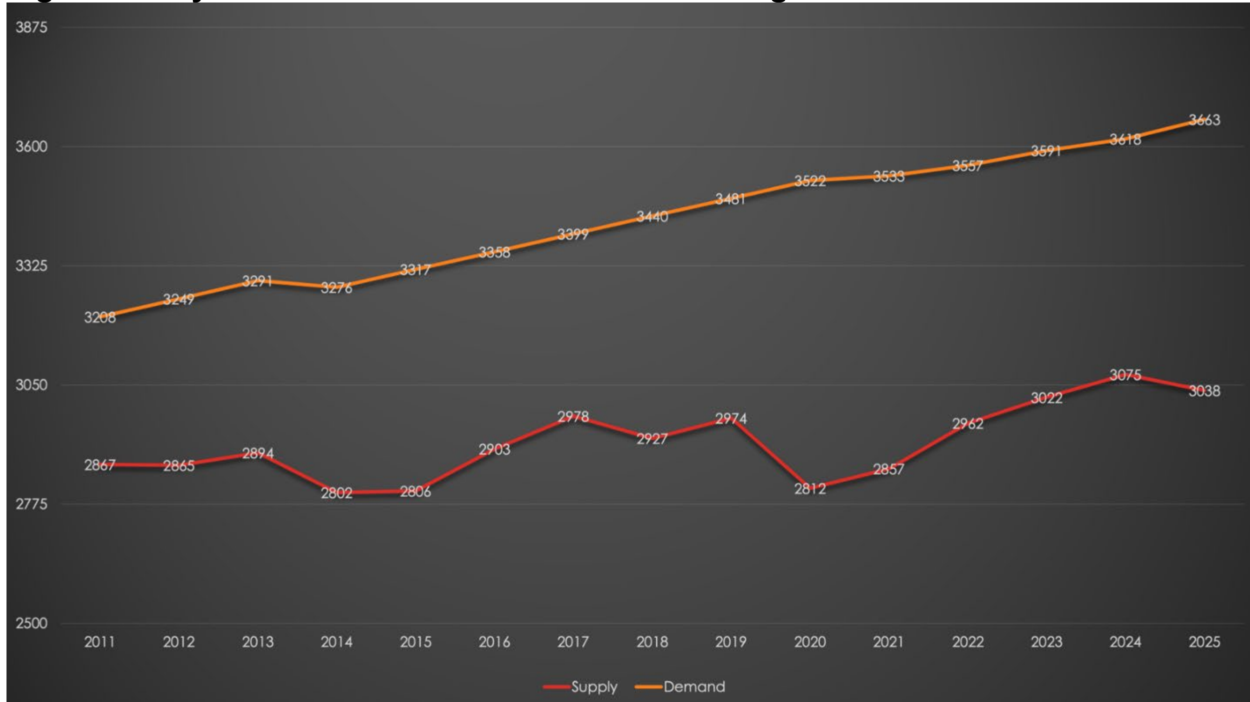
Solo (1-2)	Small (3-5)	Medium (6-9)	Large (10+)
28%	14%	12%	46%

[10] https://www.definitivehc.com/resources/healthcare-insights/average-provider-age-medical-specialty#:~:text=What%20is%20the%20average%20age,more%20than%20110%20medical%20specialties.

► In 2025, at least 81 physicians retired, 14 passed away, and more than 88 moved away.

The documented physician workforce changes since the Hawai‘i Physician Workforce Assessment began are outlined in Figure 1 below.

Figure 1: Physician Workforce Assessment Findings from 2010 to Present



The greatest shortage category is primary care where we need 178 additional Full Time Equivalents (FTEs). The greatest subspecialty shortages by percent are outlined in Table 6 below. The Individual Specialty Shortages by County Estimates tables are included in Appendix 3.

Table 6: Subspecialty Shortages over 50% by Percentage, Statewide

Specialty	FTE Shortage	Percent Short
Child Gastroenterology	6.8	81%
Child Pulmonology	3.7	64.9%
Child Endocrinology	5	62.5%
Cardiothoracic Surgery	12.7	60.5%
Colorectal Surgery	6.4	57%
Adult Endocrinology	16.8	58%
Adult Pulmonology	33.6	56.0%
Child Critical Care	3	51.7%

Future Trends
The demand model predicts our demand will increase by at least 30 FTEs a year. If we hope to meet the demand for physician services, we must increase our workforce by at least 100 physicians a year more than we lose, or find alternatives to meet the need.

Limitations of the Research
This research is intended only to track the size and distribution of the physician workforce in Hawai‘i. The purpose of this activity is to assist in guiding the development of the right-sized physician workforce in Hawai‘i so that everyone in Hawai‘i has access to services where they need them and when they need them. The data are imperfect due to many challenges. Every workforce is fluid, and the physician workforce is no exception. An unofficial estimate of number of physicians who move or change their work setting annually is 20%. Thus, the data collected is an estimate as of September 2025 but is ever-changing.

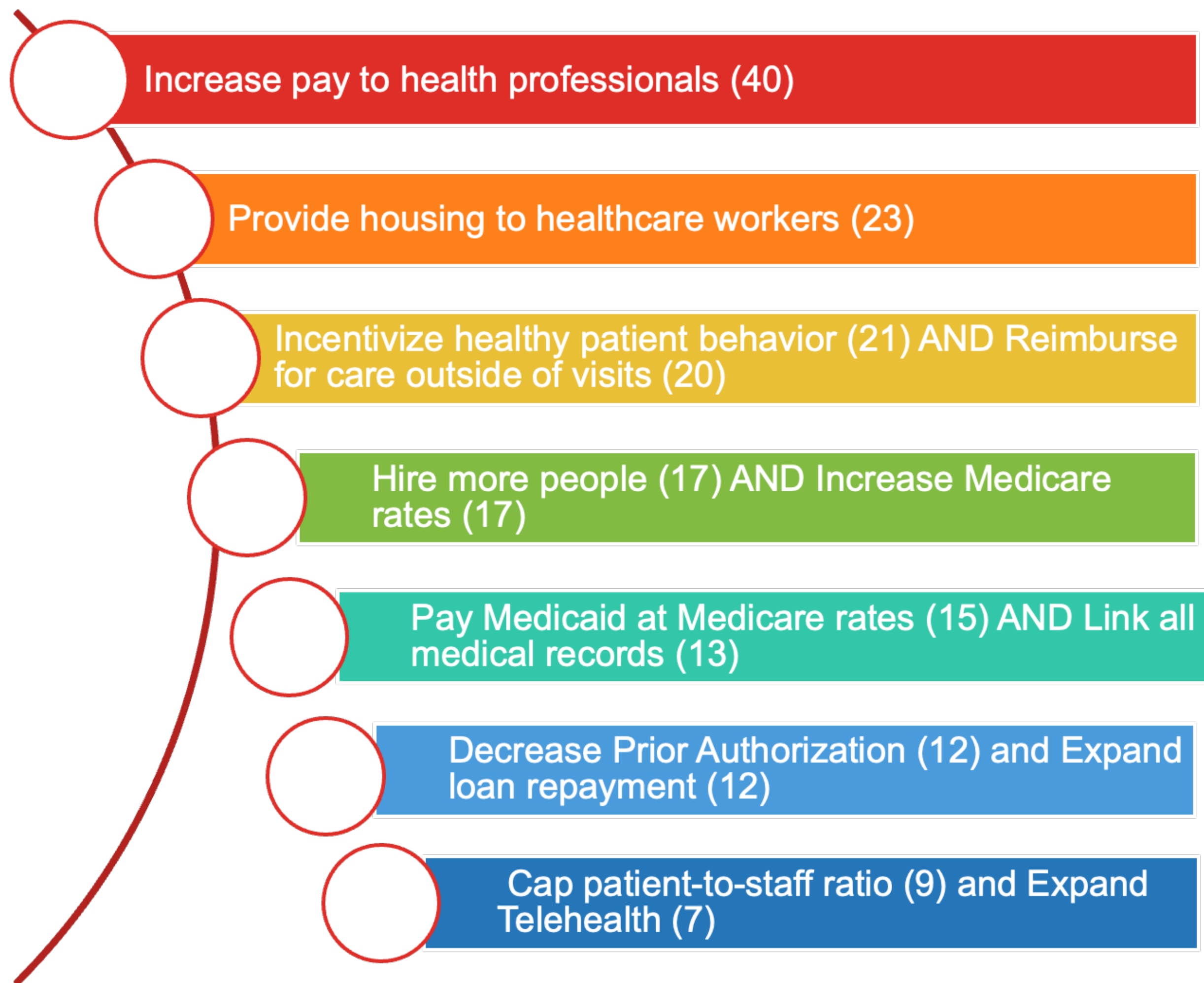
Furthermore, we encountered difficulty identifying time spent in each specialty for physicians who have multiple specialties. For example, medical subspecialists usually complete an Internal Medicine residency before completing a fellowship in a subspecialty. Therefore, they are skilled at both primary care and their subspecialty. It is difficult to allocate the amount of time they commit to each activity, and it is estimated based on the answers to the licensure survey and interaction with their staff during annual phone calls. This is even more challenging with providers who serve both adults and children. There is a severe shortage of pediatric subspecialists, so in the past, adult providers sometimes also served pediatric patients, although this is less likely now as subspecialization is increasing. However, this is often difficult to disentangle when quantifying services to pediatric versus adult patients, especially in surgical care. Furthermore, 36 locums were found working in Hawai’i temporarily. These doctors are not included in the analysis because of the short-term nature of locum’s contracts, but may impact the supply numbers.

Finally, the Maui wildfires exacerbated an already significant shortage of providers and eliminated multiple healthcare facilities which have not been rebuilt. Providers and patients moved location or out of state as a result. For this reason, the Maui landscape is even more fluid than previously and the numbers are likely even worse than estimated in this document.

Interventions to Recruit and Retain Physicians to/in Hawai‘i
At the Hawai‘i Health Workforce Summit on September 6, 2025, participants were asked to identify the most important interventions to improve Hawai‘i’s health workforce. The audience of 600 people was a mixture of healthcare workers from across the state. A total of 151 individuals answered the question and the results are below in Figure 2. The clear winner with almost a third of the votes was “Increase pay to health professionals” and was accompanied by three other payment responses

("Reimburse for care outside of visits", "Increase Medicare rates", and "Pay Medicaid at Medicare rates"), indicating that pay must increase in order to solve our healthcare workforce shortages. Other solutions include providing housing, incentivizing healthy patient behavior, hiring more people, linking all medical records, decreasing prior authorization, expanding loan repayment, capping patient-to-staff ratio and expanding telehealth.

Figure 2: 2025 Top Solutions for Improving Hawai'i's Health Workforce



<u>Proposed solutions to identified challenges</u>

<u>Increasing healthcare pay</u> will depend on both local and federal interventions, as there are both federal and local (private) health insurance plans for individuals in Hawai'i. The federal interventions include increasing Medicare rates and continued support for Medicaid. The Physician Workforce Assessment fund is supporting a lobbyist in Washington DC to work on increasing Medicare rates. There is a vehicle introduced titled the **PROTECTING ACCESS TO CARE IN HAWAII (PATCH) ACT**, however there is limited support for the PATCH ACT at this time. Furthermore,

federal funds for Medicaid are expected to decrease, which will most likely decrease payments to local physicians, and not allow the state government to continue to support Medicaid/Quest payments at the level of Medicare payments.

More positive local changes include the new law exempting medical and dental practices from paying the Hawaiʻi State General Excise Tax on visits for Medicare, Medicaid/Quest and Tricare patients starting 1/1/2026. This law will relieve private practices from paying the cost of the excise tax on visits for their patients out of practice income. This single change may save practices 10-15% of revenue. In addition, the Hawaiʻi Prior Authorization Act 17 Working Group began meeting October 2026 to collect and review prior authorization data from all Hawaiʻi health insurance companies and make recommendations. Both Laws mentioned in this paragraph are included in the appendix.

The above changes are beneficial; however two additional changes could make an even larger impact on the healthcare workforce landscape. If health insurance companies are able to **increase reimbursement rates** for medical services, this would increase the state's chance of recruiting physicians. Furthermore, clinicians need to take the lead in healthcare spending and embrace **alternative payment systems** such as provider owned and led Accountable Care Organizations that empower providers to work directly with patients to improve health and decrease medical expenditures associated with complex hospitalizations, thus improving reimbursements to medical practices.

Housing is of course the largest expense to anyone living in Hawaiʻi. The Physician Workforce Research fund is not able to purchase houses for physicians, but we are trying to assist in making it easier for physicians to do so. AHEC is working with economists, donors, and investors to create methods for physicians and other healthcare workers to be able to purchase a home with a manageable mortgage. Four housing resources: MODEA through Hawaiʻi Housing Finance and Development Corporation, Maui Medical housing for healthcare workers on Maui, a loan discount program that allows physicians to purchase with 5% down payment (Medproadvantage through CMGhomeloans) and https://landed.com/ have been identified. In addition, research into the possibility of receiving donated or leasehold land for physicians to build on is ongoing.

Furthermore, recent research performed by OmniTrack Group showed that hundreds of doctors would consider moving to Hawaiʻi if they received four things:

- A 4 day work week
- A salary of 110% of their current salary
- A 50% tax credit for 3 years
- A quarter point lower interest rate for home mortgages

Of these four possibilities, Central Pacific Bank has agreed to provide the last item through their White Coat Program. They will loan physicians funds for a quarter point lower than the going mortgage rate, thus improving the chance of physicians being able to afford homes, and improving the chance of Hawaiʻi recruiting physicians.

Incentivizing Healthy Patient Behavior is a very challenging task that AHEC has been researching and supporting in the form of Walk With a Doc groups for all interested providers, but more needs to be done. Activities for incentivizing health in rural areas may receive funding through Hawaiʻi's Rural Health Transformation Program application to Medicare, if funded in 2026.

Loan Repayment is active and ongoing in Hawaiʻi. With the addition of Governor Green's Hawai'i State Legislature supported $15,000,000 a year Hawaiʻi Health Education Loan rePayment Program to the Hawaiʻi State Loan Repayment program, 928 physicians have had loans paid down or and of those, 431 have had their loans fully paid off in the last two years!

Table 7: HELP Award Update October 2025

State: Total $60M *FY 24 $10M; FY 25 $20M* *FY 26 $15M, FY 27 $15M*	**Phase 1 2023-2025**	**Phase 2 2024-2026**	**Phase 3 2025-2027**
Funds Allocated for Loan Repayments (i.e., EXCLUDES costs to administer program)	$10M [9M + 1M (Benioff)]	$21.7M [18M + 3.7M (Benioff)]	$13.5M
Funds Disbursed or Scheduled to be disbursed	$35.1M [31.3M + 3.8M (Benioff)]	$6.5M [5.6M + 0.9M (Benioff)]	$9.1M
Total # Apps Received, by phase	810	1,590	2,035
# of Physician Apps / (%)	230 (28.4%)	164 (8.9%)	462 (24.5%)
Total Apps Funded (2 years of payment)	623 (96 Benioff)	146 (18 Benioff)	159
# of Physician Apps Funded (%)	**209 (33.5%)**	**24 (16.4%)**	**92 (60.9%)**
Total Loans Paid Off (all providers)	$9.1M (N=258)	$2.1M (N=67)	$3.3M (N=86)

Table 8: HELP Awards by Island as of October, 2025

# Applicants Awarded 928	By Disci-pline	Oahu Urban	Oahu Rural	Hawaii Island (inc Benioff)	Maui Island	Kauai	Molokai	Lanai	Other (resi-dents return-ing to HI
MD/DO	**325 (35%)**	**205**	**7**	**50**	**33**	**12**	**2**	**0**	**16**
APRN/PA	**160 (17%)**	80	7	43	25	4	0	0	1
Nurses	**104 (11%)**	40	3	31	18	10	2	0	0
Others	**339 (37%)**	166	21	88	52	11	1	0	1
Total by Island (% of total)	**928**	491 (52%)	38 (4%)	212 (23%)	128 (14%)	37 (4%)	5 (1%)	0	18 (2%)
Waitlisted (preliminarily approved)	**1,885**	1,286 (68%)	66 (4%)	239 (13%)	199 (11%)	84 (4%)	7 (0.4%)	2 (0.1%)	2 (0.1%)

Other Solutions Being Implemented

Physician Recruitment

❖ AHEC actively works to recruit physicians by attending national meetings such as the American Academy of Family Physicians, the American College of Physicians Annual Clinical and Scientific Meeting, Pediatric Academic Societies meeting and the Western Section American Urological Association meeting and staffing a recruiting booth. In addition, AHEC posts all Hawai'i physician job openings online through collaboration with the Hawaiʻi Physician Recruiters Group. The AHEC website advertises job opportunities and resources for physicians at https://ahec.hawaii.edu/ahecsite-forhealthcareprofessionals/practice-in-hawaii.html, but is building an improved website for physician recruitment. Direct assistance has been provided for 4 practices during the current year to connect to five new providers.

Figure 3: Dr. Withy at Western Section American Urological Association meeting 2025

- ❖ In addition, JABSOM Alumni Association regularly spreads the word about opportunities in Hawaiʻi to JABSOM graduates and assists with sending recruitment information to graduates. AHEC is also collaborating with Hawai'i Residency Program on their Annual Physician Career Pathways Event and supporting regular get togethers of the Hawai'i Young Healthcare Professionals group.

- ❖ Free dinner! A new idea is when physicians who go to educational conferences on the Continent, they are encouraged to talk to colleagues about moving to Hawaiʻi. **If a Hawaiʻi physician takes another doctor out to dinner to recruit them to Hawaiʻi, AHEC will reimburse for dinner** up to $50 per person with itemized receipt and meeting participant list (although we cannot reimburse for alcohol).

- ❖ Incentives: The Physician Workforce Assessment team is working with the Hawaiʻi State Rural Health Association and the Hawaiʻi Physician Recruiter's Group to expand rural incentives, community welcoming of providers, and increase the ability for spouses to find jobs. This is an area that the new Federal Rural Health Transformation Program (RHTP) grant, that will be applied for by the State of Hawaiʻi, may be able to expand in rural areas by supporting provider incentives in exchange for a five-year commitment to work in rural Hawaii.

- The Bridge to Practice initiative encourages residents in primary care graduate medical education programs to be mentored by and explore work opportunities in independent practices across Hawaiʻi. It is hoped that this program will encourage physician residents and fellows to practice in healthcare need areas upon graduation and assist physicians who want to retire.

- Scholarships: The AHEC Office has agreed to oversee the repayment responsibilities for new JABSOM scholarships which require recipients to practice in Hawaiʻi after graduation. AHEC anticipates creating a medical school scholarship for a student who has excelled in the AHEC program through their pursuit of medical school and training. Most exciting is that RHTP funding may become available for providing scholarships to students who commit to practice in rural areas.

Physician Retention

- Preceptor Tax Credit: AHEC is instrumental in implementing the Hawaiʻi Preceptor Tax Credit for preceptors offering professional instruction, training, and supervision to students and residents in medicine, advanced practice nursing, and pharmacy. The program began in 2019 and continues to grow in number of individuals who receive tax credit of up to $5,000 a year for teaching medical, nurse practitioner and pharmacy students, with physicians receiving approximately 75% of the tax credits.

Table 9: Hawaiʻi Preceptor Tax Credits Awarded by Year

Year	2019	2020	2021	2022	2023	2024	Total
Preceptors	181	190	261	301	310	311	1554
Tax Credits Awarded	371	378	587	645	676	664	3321

From 2019 to 2024, the program gained 102 providers who had never engaged in precepting in the past and who completed some level of clinical rotation education in the calendar year. More information is available at: http://preceptortaxcredit.hawaii.edu/.

- Physician Resiliency: Dr. Withy has held a monthly Balint group for providers interested in sharing about work stress in a safe environment. While individual organizations provide support groups, we are searching for additional resources for wellness support such that providers have access to free anonymous counseling support if needed through hawaiiutelehealth.org and other sources.

- Continuing Education: The 2025 Hawaiʻi Health Workforce Summit offered six and a half hours of Continuing Education Credit to 600 participants at the Hawaiʻi

Health Workforce Summit. The Summit addressed topics including Provider Well-Being, Interprofessional Team-Based Care Ideas, Geriatric Practice Expertise, Recognition and Treatment of Substance Use Disorder, Pediatric Mental Health and Rural Health Practice. The participant evaluation demonstrated a high level of satisfaction with the event. Project ECHO case based training provided 522 people with 4,897 people-hours of case-based distance education in 2024. The ongoing ECHO distance learning clinics cover behavioral health, pediatrics, Long COVID and geriatrics and are overseen by Hawaiʻi State Rural Health Association.

Expand the Pathway to Health Careers

❖ Train the Future Physician Workforce: Very exciting things are happening in the recruitment of students into healthcare careers. The Health Sector Partnership is working with Hawai'i Pacific Health, Healthcare Association of Hawai'i and Hawai'i Department of Education, bringing together the industry to work with academia and has created the capability for training certifications to be provided in high school so that students enter health careers as soon as they graduate high school. The areas of training are shown below.

Table 10: Schools Providing Certificate Training

School	HPH Programs	HAH Programs
ʻAiea HS	Phlebotomy	
Campbell HS	Nurse Aide, Medical Assistant	
Castle HS	Medical Assistant	
Farrington HS	Medical Assistant	
Farrington HS (HAH includes Kaimuki HS & McKinley HS)	Nurse Aide	Certified Nurse Aide
Hilo HS		Certified Nurse Aide
Honokaʻa High & Intermediate		Medical Assistant
Kailua HS (HAH includes Castle HS)		Phlebotomy
Kalani HS	Medical Assistant	
Kamaile Academy PCS	Medical Assistant	
Kapaʻa HS	Nurse Aide	
Kapolei HS	Nurse Aide, Medical Assistant	
Kauaʻi HS		Certified Nurse Aide
Kealakehe HS (HAH includes WHEA)		Certified Nurse Aide
McKinley HS	Medical Assistant	
Mililani HS (HAH includes Leilehua HS)		Certified Nurse Aide
Myron B. Thompson Academy	Medical Assistant	
Pearl City HS	Nurse Aide, Medical Assistant	
Roosevelt HS	Medical Assistant	
Summer Honolulu District (HAH includes Farrington HS, McKinley HS, Kaimuki HS, Kailua HS, & Castle HS)		Certified Nurse Aide
Summer Maui (HAH includes Maui HS & Baldwin)		Certified Nurse Aide
Summer West Hawaiʻi (HAH includes Kealakehe HS, Konawaena HS, Kohala HS, & WHEA)		Certified Nurse Aide
Waiākea HS		Certified Nurse Aide
Waiʻanae HS		Patient Service Representative
Waimea HS	Nurse Aide	
Waipahu HS	Medical Assistant	

The AHEC team has engaged over 4,000 health professions students in activities during 2024. Health career activities have been expanded to reach students on all neighboring islands. Through federal grant funding, AHEC provides mentoring, counseling support, and activities so that students from throughout Hawaiʻi can

successfully pursue careers in the health professions. Participating AHEC students receive certification and training in Cardio Pulmonary Resuscitation (CPR), First Aid, Stop the Bleed; Youth Mental Health First Aid, and Occupational Safety Administration procedures, Health Information Portability and Accountability Act (HIPPA) procedures, as well as training in science, technology, engineering, and mathematics through real-life data acquisition, public speaking, leadership, research literacy, teamwork abilities, interview skills, professionalism, time management, and financial planning methods. The free PreHealth Career Corps program for students pursuing health careers now has over 4,500 students. More information is available at https://ahec.hawaii.edu/students/phcc.html. AHEC is also working with the Healthcare Association of Hawaiʻi to bolster non-physician health professions to lighten the load on the physicians by maximizing teamwork and collaboration and assisting with other University of Hawaiʻi programs and the Health Sector Partnership activities which increase students pursuing health careers.

- Teen Health Camps are day-long events held on each island where students can learn about different health careers, talk to local health professions students and engage in hands-on activities such as casting and suturing. The annual goal for student involvement is 500 students from across Hawai'i .

- Support for upskilling: AHEC makes a promise to any student in Hawaiʻi who wants to pursue a career or upskill in health careers to assist them. Through our PreHealth Career Corps and non-traditional student programs, we will help every step of the way. More info at: https://www.ahec.hawaii.edu/programs-for-students/

- Annual Teacher and Counselor Training Conferences are being introduced through a collaboration between AHEC and Maui Economic Development Board. Annual conferences on every island are being planned to alert teachers and counselors to all available resources and develop additional resources as needed.

- Expand Rural Training Opportunities: AHEC works with neighbor island communities to recruit additional preceptors to teach health professions students, recruit and support students interested in health careers, work with community members to host students, support travel and lodging for students to perform rural experiences and document the impact of rural activities on health professions training. The Chan-Zuckerburg Initiative is an exciting JABSOM program for six medical students a year to maximize training time on Kauaʻi, receive full scholarships, and spend at least 4 years working on Kauaʻi after residency. AHEC is working to expand resources on all islands by providing travel and housing for medical students and residents to train throughout Hawai'i. A new residency program is being planned on Kauai, as well as one in Waimea, Big Island. It is

possible that RHTP funds can assist in this area as well by supporting additional training and residency programs.

Next Steps

Exciting introductions in 2025 include two statewide efforts, the first for recruiting our youth to health professions, the second for stronger recruitment of physicians to Hawai'i.

1. Any teacher, counselor, principal or HOSA mentor who would like to obtain resources for students such as visits to local colleges or healthcare sites, or healthcare visits to their schools can email healthcareershawaii@gmail.com or call 808-692-1060 for a one-stop-shop and AHEC will reach out to resources across the state to meet all requests.

2. AHEC is creating a new physician recruiting website for all recruiters in Hawai'i. They can post positions easily, and resources such as the White Coat Program, a reduced mortgage program for doctors. In addition, doctors can sign up to get information when jobs open up and recruiters can post simple job descriptions. The website is: DocJobsHawaii.org

Finally, the Physician Workforce Research Team will continue to conduct the research and implement the solutions described above and will explore additional methods for healthcare reform that will improve work/life balance for physicians in Hawaiʻi. We look forward to YOUR input on ideas for expanding support for Hawai'i's current and future physician workforce.

More information on ongoing and upcoming activities is available at the AHEC website: https://www.ahec.hawaii.edu or call (808) 692-1060. Dr. Kelley Withy may be reached at (808) 692-1070 or via email withy@hawaii.edu.

Appendix 1: Online Hawaii Physician Re-licensure Survey

The following questions ask for essential information needed by the University of Hawaii John A. Burns School of Medicine to help Hawaii better understand and address the need for physicians. Answering these questions is not required for license renewal but your assistance and cooperation is greatly appreciated. Your individual responses will be strictly confidential. For inquiries, please contact Dr. Kelley Withy, at the John A. Burns School of Medicine: 808-692-1070 or withy@hawaii.edu.

Do you provide direct healthcare services to individual patients in Hawaii

○ Yes

○ No

Conditional

Please select the primary zip codes in which you work and enter hours per week.

Zip Code | Hours/Week

Add another response

Conditional

Do you primarily serve an active duty military population

○ Yes

○ No

Are you currently in training (internship, residency or fellowship)

○ Yes

○ No

What specialty/specialties do you practice and what percent of time in that specialty? (round to nearest)

Primary Specialty: Please select...

Primary Specialty Percentage: Please select...

Conditional

Primary Specialty (if Other) *

Secondary Specialty: Please select...

Secondary Specialty Percentage: Please select...

Conditional

Secondary Specialty (if Other) *

Conditional

Is a majority of your income a result of being employed by a medical group, hospital, school (faculty) or other entity?

- Yes
- No

Conditional

Name of entity?

Please select...

Conditional

Name of entity (if Other) *

What is the size of your practice group (how many partners do you have including yourself)?

- 1-2
- 3-5
- 6-10
- 11 or more

What year were you born?

What ethnicity do you primarily identify with? Please include all others under "Other Ethnicities" below.

Please select...

Other Ethnicities

Do you have any other comments/ideas/input on the physician workforce in Hawaii? Also feel free to contact Dr. Kelley Withy at withy@hawaii.edu if you have additional questions/ideas/suggestions:

Previous Page **Submit**

Appendix 2: Physician Research Telephone Script

Please review each entry before calling. Physician offices may be busy, especially under current circumstances. You want to be prepared for any changes to data or sudden disruptions during the call. Among the various details we're confirming and updating, the most important are FTE, physician specialty, and zip code.

"Hi, I'm______________with the UH Medical School Area Health Education Center doing physician workforce research."

(If they ask about our research: The purpose of this research is to identify where the largest shortages are so we can develop programs to recruit providers such as loan repayment.)

"I'm calling to see if Dr. _____________works here."

"Does Dr.________ work full time?" (If they ask, full time is 40+ hours per week) (If NO) "How many hours at this office?"

"I wanted to confirm Dr._________'s specialty. Is it **[insert found specialty]**?"

"I have the office/hospital **zip code** as ______________. Is this correct?"

"Does s/he work at any **other clinic locations**?" (If YES) "Would you happen to have the location and/or phone number?" You'll call this second location to confirm FTE and other practice details. Some physicians may have more than two locations. Add any additional information to the 'Notes' column. Be sure to confirm FTE at every location you find.

"How many **other physicians** work at this location?" This is group size.

"Thank you very much for your time and for supporting our work!"

ALWAYS BE POLITE AND THANK THEM FOR THEIR TIME. If they have any further questions that you don't know the answers to, you can direct them to me. My email is withy@hawaii.edu, or they may call at 808-692-1070.

"I'm not sure, but I can give you the contact of my supervisor! The Area Health Education Center's Director is Kelley Withy, and you can reach her at **withy@hawaii.edu.**

If busy:

1. Would I be able to send an email or fax our survey?

2. Is there a better time to call back, or someone else available I can talk to?

3. Leave a voicemail with your name, the reason for your call, the best time to reach you, and your contact number. Repeat this a second time in case they didn't hear the first time. You may want to create your own voicemail script to help with leaving messages.

If the health professional doesn't work there anymore: Would you happen to know if they moved practice locations, moved out of state, or retired? (obtain new address if moved).

Appendix 3: Supply and Demand Tables Statewide and by County

Table 13: Hawaiʻi County Physician Supply/Demand Estimates by Primary Care

Specialty (Primary Care)	Demand	Supply	Shortage (without overages)	%Shortage
Family Medicine	71.2	77.3		
General Internal Medicine	45.7	24.4		
Geriatric Medicine	2.6	2.7		
Pediatrics	28.8	23.3		
Primary Care Total	148.3	127.7	20.6	14%

Table 14: Hawaiʻi County Physician Supply/Demand Estimates Medical Specialties

Specialty (Medical Specialties)	Demand	Supply	Shortage (without overages)	%Shortage
Allergy & Immunology	2.2	0.9	1.3	59.0%
Dermatology	4.9	5.7	0	0.0%
Infectious Disease	5.7	1.2	4.5	79.0%
Neonatology	4.1	0	4.1	100.0%
Nephrology+	6.9	2.5	4.4	64.0%
Adult Cardiology	14.5	9.6	4.9	34.0%
Pediatric Cardiology	0.7	0.5	0.2	29.0%
Adult Critical Care+	15	0	15	100.0%
Pediatric Critical Care	0.4	0	0.4	100.0%
Adult Endocrinology	3.2	0	3.2	100.0%
Pediatric Endocrinology	1.2	0	1.2	100.0%
Adult Gastroenterology	7.2	2.6	4.6	64.0%
Pediatric gastroenterology	0.5	0	0.5	100.0%
Adult Hematology & Oncology	6.3	0.2	6.1	97.0%
Pediatric Hematology & Oncology	0.9	0	0.9	100.0%
Adult Pulmonary	6.9	0.3	6.6	96.0%
Pediatric Pulmonary	0.5	0	0.5	100.0%
Adult Rheumatology	3	1.1	1.9	63.0%
Pediatric Rheumatology	0.2	0	0.2	100.0%
Medical Specialties Total	84.3	24.6	60.5	72.0%

Table 15: Hawai'i County Physician Supply/Demand Estimates Surgical Specialties

Specialty (Surgery)	Demand	Supply	Shortage (without overages)	%Shortage
Colorectal Surgery	1.8	0.4	1.4	78.0%
General Surgery	17.9	13.4	4.5	25.0%
Neurological Surgery+	4	0.2	3.8	95.0%
Obstetrics & Gynecology	21.5	20	1.5	7.0%
Ophthalmology	13.4	4.6	8.8	66.0%
Orthopedic Surgery+	14.8	11.2	3.6	24.0%
Otolaryngology	5.3	1	4.3	81.0%
Plastic Surgery	4.1	1.6	2.5	61.0%
Thoracic Surgery+	4	0	4	100.0%
Urology+	5.4	2.8	2.6	48.0%
Vascular Surgery+	4	2.7	1.3	33.0%
Surgery Total	96.2	57.9	38.3	40.0%

Table 16: Hawai'i County Physician Supply and Demand Estimates-Other Specialties

Specialty (Other)	Demand	Supply	Shortage (without overages)	%Shortage
Anesthesiology	26.7	6	20.7	78.0%
Emergency Medicine*	38.9	32.8	6.1	16.0%
Other Specialties***	21.1	15.4	5.7	27.0%
Pathology	9.8	3	6.8	69.0%
Physical Medicine & Rehabilitation	7.6	1.7	5.9	78.0%
Radiation Oncology	2.5	2.9	0	0.0%
Radiology	18.1	5.3	12.8	71.0%
Adult Neurology	6.4	1.7	4.7	73.0%
Pediatric Neurology	0.9	0	0.9	100.0%
Adult Psychiatry**	37	12.1	24.9	67.0%
Child/Adolescent Psychiatry**	5.9	2.1	3.8	64.0%
Other Specialties Total	174.9	83	92.3	52.8%
Hospital Medicine	20.9	9	11.9	57.0%
Grand Total (Hawai'i County)	524.6	302.2	223.6	42.6%

*Increase in ED demand to reflect non-resident increase in utilization on each island.
**Calculated 20.5 per 100,000 population divided between adult & pediatric specialists as indicated by the population-based IHS model.
***Other Specialties include: Concierge, Complimentary/Alternative Medicine, Medical Genetics, Occupational Medicine, Palliative Care, Pain Medicine, Preventive Medicine, Sleep Medicine, Urgent Care, and Wound Care.
+All residents should be within 60 minutes of care, so each island has at least 2 providers, and Hawai'i Island has a minimum of 4 providers. Each Level I-III Trauma Center has 5 ICU providers.
++Not calculated, as primary care can cover other primary care in most cases.

Table 17: Honolulu County Supply and Demand Estimates by Primary Care

Specialty (Primary Care)	Demand	Supply	Shortage (without overages)	%Shortage ++
Family Medicine	295.7	217.4		
General Internal Medicine		320	274.8	
Geriatric Medicine	22.8	40.9		
Pediatrics	170.9	167.8		
Primary Care Total	809.4	700.9	108.5	13.4%

Table 18: Honolulu County Supply and Demand Estimates by Medical Specialties

Specialty (Medical Specialties)	Demand	Supply	Shortage (without overages)	%Shortage
Allergy & Immunology	15.1	10.3	4.8	31.8%
Dermatology	24.3	48.5	0	0.0%
Infectious Disease	27.9	18.3	9.6	34.4%
Neonatology	17.8	19.6	0	0.0%
Nephrology+	35.2	26.3	8.9	25.3%
Adult Cardiology	76.5	61.8	14.7	19.2%
Pediatric Cardiology	5.6	4.9	0.7	12.5%
Adult Critical Care+	15	31.5	0	0.0%
Pediatric Critical Care	5	2.8	2.2	44.0%
Adult Endocrinology	21.3	11.6	9.7	45.5%
Pediatric Endocrinology	5.3	2.9	2.4	45.3%
Adult Gastroenterology	47.8	48.6	0	0.0%
Pediatric Gastroenterology	6.8	1.6	5.2	76.5%
Adult Hematology & Oncology	30.2	27	3.2	10.6%
Pediatric Hematology & Oncology	5.6	5.3	0.3	5.4%
Adult Pulmonary	43.1	23.9	19.2	44.5%
Pediatric Pulmonary	4.4	2	2.4	54.5%
Adult Rheumatology	16.4	14.4	2	12.2%
Pediatric Rheumatology	0.9	2	0	0.0%
Medical Specialties Total	404.2	363.3	85.3	21.1%

Table 19: Honolulu County Supply and Demand Estimates by Surgical Specialties

Specialty (Surgery)	Demand	Supply	Shortage (without overages)	%Shortage
Colorectal Surgery	7.4	4.4	3	40.5%
General Surgery	61.1	68.6	0	0.0%
Neurological Surgery+	9.1	13.8	0	0.0%
Obstetrics & Gynecology	117	124.9	0	0.0%
Ophthalmology	59.3	75.7	0	0.0%
Orthopedic Surgery+	60.6	59.2	1.4	2.3%
Otolaryngology	25.6	21.1	4.5	17.6%
Plastic Surgery	19.7	21.4	0	0.0%
Thoracic Surgery+	12.6	7	5.6	44.4%
Urology+	25.8	24.1	1.7	6.6%
Vascular Surgery+	13.8	14.8	0	0.0%
Surgery Total	412	435	16.2	3.9%

Table 20: Honolulu County Supply and Demand Estimates by Other Specialties

Specialty (Other)	Demand	Supply	Shortage (without overages)	%Shortage
Anesthesiology	120.7	121.8	0	0.0%
Emergency Medicine*	199.2	139.4	59.8	30.0%
Other Specialties***	105.4	80.1	25.3	24.0%
Pathology	45.7	30.7	15	32.8%
Physical Medicine & Rehabilitation	25.1	22.1	3	12.0%
Radiation Oncology	12.3	15.2	0	0.0%
Radiology	63.1	70.8	0	0.0%
Adult Neurology	38.9	43.9	0	0.0%
Pediatric Neurology	4.3	4	0.3	7.0%
Adult Psychiatry**	152.9	109.6	43.3	28.3%
Child/Adolescent Psychiatry**	51.9	29.2	22.7	43.7%
Other Specialties Total	819.5	666.8	169.4	20.7%
Hospital Medicine#	97.5	173.4	0	0.0%
Grand Total (Statewide)	2542.6	2339.4	379.4	14.9%

*Increase in ED demand to reflect non-resident increase in utilization on each island.
**Calculated 20.5 per 100,000 population divided between adult & pediatric specialists as indicated by the population-based IHS model.
***Other Specialties include: Concierge, Complimentary/Alternative Medicine, Medical Genetics, Occupational Medicine, Palliative Care, Pain Medicine, Preventive Medicine, Sleep Medicine, Urgent Care, and Wound Care.
+All residents should be within 60 minutes of care, so each island has at least 2 providers, and Hawaiʻi Island has a minimum of 4 providers. Each Level I-III Trauma Center has 5 ICU providers.
++Not calculated, as primary care can cover other primary care in most cases.

Table 21: Kauaʻi County Supply and Demand Estimates by Primary Care

Specialty (Primary Care)	Demand	Supply	Shortage (without overages)	%Shortage ++
Family Medicine	24.5	21.7		
General Internal Medicine	15.8	12.4		
Geriatric Medicine	0.9	3		
Pediatrics	9.9	10		
Primary Care Total	51.1	47.1	4	7.8%

Table 22: Kauaʻi County Supply and Demand Estimates by Medical Specialties

Specialty (Medical Specialties)	Demand	Supply	Shortage (without overages)	%Shortage
Allergy & Immunology	0.7	0.1	0.6	85.7%
Dermatology	1.6	1	0.6	37.5%
Infectious Disease	1.9	1	0.9	47.4%
Neonatology	1.4	0	1.4	100.0%
Nephrology+	2.4	0	2.4	100.0%
Adult Cardiology	4.9	2	2.9	59.2%
Pediatric Cardiology	0.2	0	0.2	100.0%
Adult Critical Care+	5	0	5	100.0%
Pediatric Critical Care	0.1	0	0.1	100.0%
Adult Endocrinology	1.1	0	1.1	100.0%
Pediatric Endocrinology	0.4	0	0.4	100.0%
Adult Gastroenterology	2.5	2	0.5	20.0%
Pediatric Gastroenterology	0.2	0	0.2	100.0%
Adult Hematology & Oncology	2	2.6	0	0.0%
Pediatric Hematology & Oncology	0.3	0	0.3	100.0%
Adult Pulmonary	2.3	0.5	1.8	78.3%
Pediatric Pulmonary	0.2	0	0.2	100.0%
Adult Rheumatology	1.1	0	1.1	100.0%
Pediatric Rheumatology	0.1	0	0.1	100.0%
Medical Specialties Total	28.4	9.2	19.8	69.7%

Table 23: Kaua'i County Supply and Demand Estimates by Surgical Specialties

Specialty (Surgery)	Demand	Supply	Shortage (without overages)	%Shortage
Colorectal Surgery	0.6	0	0.6	100.0%
General Surgery	6	5.5	0.5	8.3%
Neurological Surgery+	2	0	2	100.0%
Obstetrics & Gynecology	7.5	7.1	0.4	5.3%
Ophthalmology	4.6	5.3	0	0.0%
Orthopedic Surgery+	5.1	4	1.1	21.6%
Otolaryngology	1.8	2	0	0.0%
Plastic Surgery	1.4	0	1.4	100.0%
Thoracic Surgery+	2	0	2	100.0%
Urology+	2	4	0	0.0%
Vascular Surgery+	2	0.3	1.7	85.0%
Surgery Total	35	28.2	9.7	27.7%

Table 24: Kaua'i County Supply and Demand Estimates by Other Specialties

Specialty (Other)	Demand	Supply	Shortage (without overages)	%Shortage
Anesthesiology	9.1	12.5	0	0.0%
Emergency Medicine*	14.1	17.1	0	0.0%
Other Specialties***	7.2	7.7	0	0.0%
Pathology	3.3	1	2.3	69.7%
Physical Medicine & Rehabilitation	2.6	1	1.6	61.5%
Radiation Oncology	0.8	1.3	0	0.0%
Radiology	6	4.4	1.6	26.7%
Adult Neurology	2.2	1	1.2	54.5%
Pediatric Neurology	0.3	0	0.3	100.0%
Adult Psychiatry**	13	4	9	69.2%
Child/Adolescent Psychiatry**	2	1.1	0.9	45.0%
Other Specialties Total	60.6	51.1	16.9	27.9%
Hospital Medicine	7.1	8	0	0.0%
Grand Total (Kauai County)	182.2	143.6	50.4	27.7%

*Increase in ED demand to reflect non-resident increase in utilization on each island.
**Calculated 20.5 per 100,000 population divided between adult & pediatric specialists as indicated by the population-based IHS model.
***Other Specialties include: Concierge, Complimentary/Alternative Medicine, Medical Genetics, Occupational Medicine, Palliative Care, Pain Medicine, Preventive Medicine, Sleep Medicine, Urgent Care, and Wound Care.
+All residents should be within 60 minutes of care, so each island has at least 2 providers, and Hawai'i Island has a minimum of 4 providers. Each Level I-III Trauma Center has 5 ICU providers.
++ Not calculated, as primary care can cover other primary care in most cases.

Table 25: Maui County Supply and Demand Estimates by Primary Care

Specialty (Primary Care)	Demand	Supply	Shortage (without overages)	%Shortage++
Family Medicine	54.6	34.5		
General Internal Medicine	41.7	26.3		
Geriatric Medicine	6.1	0.1		
Pediatrics	26.1	22.6		
Primary Care Total	128.5	83.5	45	35.0%

Table 26: Maui County Supply and Demand Estimates by Medical Specialties

Specialty (Medical Specialties)	Demand	Supply	Shortage (without overages)	%Shortage
Allergy & Immunology	2.8	0	2.8	100.0%
Dermatology	5.4	5.5	0	0.0%
Infectious Disease	4.8	1	3.8	79.2%
Neonatology	2.8	0	2.8	100.0%
Nephrology+	5.4	2.3	3.1	57.4%
Adult Cardiology	13.5	7.4	6.1	45.2%
Pediatric Cardiology	0.8	0.2	0.6	75.0%
Adult Critical Care+	5	5	0	0.0%
Pediatric Critical Care	0.3	0	0.3	100.0%
Adult Endocrinology	3.4	0.6	2.8	82.4%
Pediatric Endocrinology	1.1	0.1	1	90.9%
Adult Gastroenterology	8	2.1	5.9	73.8%
Pediatric Gastroenterology	0.9	0	0.9	100.0%
Adult Hematology & Oncology	7.9	3.1	4.8	60.8%
Pediatric Hematology & Oncology	0.6	0	0.6	100.0%
Adult Pulmonary	7.7	1.8	5.9	76.6%
Pediatric Pulmonary	0.6	0	0.6	100.0%
Adult Rheumatology	2.8	0.3	2.5	89.3%
Pediatric Rheumatology	0.1	0	0.1	100.0%
Medical Specialties Total	73.9	29.4	44.6	60.4%

Table 27: Maui County Supply and Demand Estimates by Surgical Specialties

Specialty (Surgery)	**Demand**	**Supply**	**Shortage (without overages)**	**%Shortage**
Colorectal Surgery	1.4	0	1.4	100.0%
General Surgery	12.1	10	2.1	17.4%
Neurological Surgery+	2	0.6	1.4	70.0%
Obstetrics & Gynecology	19.7	19.9	0	0.0%
Ophthalmology	9.7	4.8	4.9	50.5%
Orthopedic Surgery+	12.6	9.5	3.1	24.6%
Otolaryngology	6.2	3.3	2.9	46.8%
Plastic Surgery	5.8	3.3	2.5	43.1%
Thoracic Surgery+	2.4	1.3	1.1	45.8%
Urology+	4.9	2	2.9	59.2%
Vascular Surgery+	2.4	2	0.4	16.7%
Surgery Total	79.2	56.7	22.7	28.7%

Table 28: Maui County Supply and Demand Estimates by Other Specialties

Specialty (Other)	**Demand**	**Supply**	**Shortage (without overages)**	**%Shortage**
Anesthesiology	22.9	15.5	7.4	32.3%
Emergency Medicine*	30.3	16.5	13.8	45.5%
Other Specialties***	18	10	8	44.4%
Pathology	7.9	3	4.9	62.0%
Physical Medicine & Rehabilitation	3.2	2	1.2	37.5%
Radiation Oncology	2.9	2	0.9	31.0%
Radiology	13.6	5.1	8.5	62.5%
Adult Neurology	6.1	2.9	3.2	52.5%
Pediatric Neurology	1.2	0.2	1	83.3%
Adult Psychiatry**	23.9	13.1	10.8	45.2%
Child/Adolescent Psychiatry**	9.7	3.8	5.9	60.8%
Other Specialties Total	139.7	74.1	65.6	47.0%
Hospital Medicine	16.8	15.5	1.3	7.7%
Grand Total (Maui County)	438.1	259.2	179.2	40.9%

*Increase in ED demand to reflect non-resident increase in utilization on each island.
**Calculated 20.5 per 100,000 population divided between adult & pediatric specialists as indicated by the population-based IHS model.
***Other Specialties include: Concierge, Complimentary/Alternative Medicine, Medical Genetics, Occupational Medicine, Palliative Care, Pain Medicine, Preventive Medicine, Sleep Medicine, Urgent Care, and Wound Care.
+All residents should be within 60 minutes of care, so each island has at least 2 providers, and Hawaiʻi Island has a minimum of 4 providers. Each Level I-III Trauma Center has 5 ICU providers.
++ Not calculated, as primary care can cover other primary care in most cases.

Table 9: Statewide Supply and Demand Estimates by Primary Care

Specialty (Primary Care)	Demand	Supply	Shortage (without overage)	%Shortage++
Family Medicine	446	350.9		
General Internal Medicine	423.2	337.9		
Geriatric Medicine	32.4	46.7		
Pediatrics	235.7	223.7		
Primary Care Total	1137.3	959.2	178.1	15.7%

Table 10: Statewide Supply and Demand Estimates by Medical Specialties

Specialty (Medical Specialties)	Demand	Supply	Shortage (without overage)	%Shortage
Allergy & Immunology	20.8	11.3	9.5	45.7%
Dermatology	36.2	60.7	0.6	1.7%
Infectious Disease	40.3	21.5	18.8	46.7%
Neonatology	26.1	19.6	8.3	31.8%
Nephrology+	49.9	31.1	18.8	37.7%
Adult Cardiology	109.4	80.8	28.6	26.1%
Pediatric Cardiology	7.3	5.6	1.7	23.3%
Adult Critical Care+	40	36.5	20	50.0%
Pediatric Critical Care+	5.8	2.8	3	51.7%
Adult Endocrinology	29	12.2	16.8	57.9%
Pediatric Endocrinology	8	3	5	62.5%
Adult Gastroenterology	65.5	55.3	11	16.8%
Pediatric Gastroenterology	8.4	1.6	6.8	81.0%
Adult Hematology & Oncology	46.4	32.9	14.1	30.4%
Pediatric Hematology & Oncology	7.4	5.3	2.1	28.4%
Adult Pulmonary	60	26.5	33.5	56.0%
Pediatric Pulmonary	5.7	2	3.7	64.9%
Adult Rheumatology	23.3	15.8	7.5	32.2%
Pediatric Rheumatology	1.3	2	0.4	30.8%
Medical Specialties Total	590.8	426.5	210.2	35.6%

Table 11: Statewide Supply and Demand Estimates by Surgical Specialties

Specialty (Surgery)	Demand	Supply	Shortage (without overages)	%Shortage
Colorectal Surgery	11.2	4.8	6.4	57.1%
General Surgery	97.1	97.5	7.1	7.3%
Neurological Surgery+	17.1	14.6	7.2	42.1%
Obstetrics & Gynecology	165.7	171.9	1.9	1.1%
Ophthalmology	87	90.4	13.7	15.7%
Orthopedic Surgery+	93.1	83.9	9.2	9.9%
Otolaryngology	38.9	27.4	11.7	30.1%
Plastic Surgery	31	26.3	6.4	20.6%
Thoracic Surgery+	21	8.3	12.7	60.5%
Urology+	38.1	32.9	7.2	18.9%
Vascular Surgery+	22.2	19.8	3.4	15.3%
Surgery Total	622.4	577.8	86.9	14.0%

Table 12: Statewide Supply and Demand Estimates by Other Specialties

Specialty (Other)	Demand	Supply	Shortage (without overages)	%Shortage
Anesthesiology	179.4	155.8	28.1	15.7%
Emergency Medicine*	282.5	205.8	79.7	28.2%
Other Specialties***	151.7	113.2	39	25.7%
Pathology	66.7	37.7	29	43.5%
Physical Medicine & Rehabilitation	38.5	26.8	11.7	30.4%
Radiation Oncology	18.5	21.4	0.9	4.9%
Radiology	100.8	85.6	22.9	22.7%
Adult Neurology	53.6	49.5	9.1	17.0%
Pediatric Neurology	6.7	4.2	2.5	37.3%
Adult Psychiatry**	226.8	138.8	88	38.8%
Child/Adolescent Psychiatry**	69.5	36.2	33.3	47.9%
Other Specialties Total	1194.7	875	344.2	28.8%
Hospital Medicine	142.3	205.9	13.2	9.3%
Grand Total (Statewide)	3687.6	3044.4	832.6	22.6%

*Increase in ED demand to reflect non-resident increase in utilization on each island.
**Calculated 20.5 per 100,000 population divided between adult & pediatric specialists as indicated by the population-based IHS model.
***Other Specialties include: Concierge, Complimentary/Alternative Medicine, Medical Genetics, Occupational Medicine, Palliative Care, Pain Medicine, Preventive Medicine, Sleep Medicine, Urgent Care, and Wound Care.
+All residents should be within 60 minutes of care, so each island has at least 2 providers, and Hawaiʻi Island has a minimum of 4 providers. Each Level I-III Trauma Center has 5 ICU providers.
++Not calculated, as primary care can cover other primary care in most cases.

Appendix 4: Data Crosswalk

How different specialties are counted is outlined below in the Specialty Crosswalk.

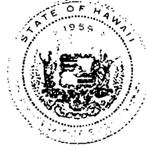
Table 31: Hawai‘i Physician Workforce Specialty Crosswalk

Primary Care	
Family Medicine	General Practice Sports Medicine Family Medicine
General Internal Medicine	
Geriatrics	Geriatrics Geri Hospitalist
Pediatrics	Med-Peds Adolescent med, Pediatrics other
Medical Specialties	
Allergy & Immunology	
Dermatology	
Infectious Diseases	
Neonatology	
Nephrology	Nephrology, peds nephrology
Adult Cardiology	Interventional cardiology
Child Cardiology	
Adult Critical Care	Critical Care Neuro Crit Care
Child Critical Care	Peds Crit Care
Adult Endocrinology	
Child Endocrinology	
Adult Gastroenterology	
Child Gastroenterology	
Adult Hematology & Oncology	
Child Hematology & Oncology	
Adult Pulmonology	
Child Pulmonology	
Adult Rheumatology	
Child Rheumatology	
Surgery	
Colorectal Surgery	
General Surgery	General Surgery Surgical Critical Care Surgery, Other Surgical Oncology
Neurological Surgery	

Obstetrics & Gynecology	Gynecology (only) OB/GYN Perinatology (Maternal-Fetal Med) Reproductive Endo Gyn Oncology
Ophthalmology	
Orthopedic Surgery	Orthopedic Surgery Hand Surgery
Otolaryngology	
Plastic Surgery	
Thoracic Surgery	
Urology	Urology, pediatric urology
Vascular Surgery	
Other	
Anesthesiology	
Emergency Medicine	
Pathology	
Physical Medicine & Rehabilitation	PMR
Radiation Oncology	Rad onc, nuclear med
Radiology	Diagnostic Radiology Interventional (Therapeutic) Radiology Neuroradiology
Other Specialties	Other Concierge Complimentary/Alternative Medicine Occupational Palliative Pain Medicine Preventive Medicine Sleep Urgent Care Medical Genetics Wound Care oral-maxillary surgery
Adult Neurology	
Child Neurology	
Adult Psychiatry	Adult Psych Addiction Psych Psych Geri Psych Psych Hospitalist
Child Psychiatry	Child & Adolescent
Hospitalist	Peds hospitalist, hospitalist

Appendix 5: Two Hawaiʻi Session Laws passed in last two years related to report text

JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA



GOV. MSG. NO. 1251

EXECUTIVE CHAMBERS
KE KE'ENA O KE KIA'ĀINA

June 3, 2025

The Honorable Ronald D. Kouchi
President of the Senate,
and Members of the Senate
Thirty-Third State Legislature
State Capitol, Room 409
Honolulu, Hawai'i 96813

The Honorable Nadine Nakamura
Speaker, and Members of the
House of Representatives
Thirty-Third State Legislature
State Capitol, Room 431
Honolulu, Hawai'i 96813

Aloha President Kouchi, Speaker Nakamura, and Members of the Legislature:

This is to inform you that on June 3, 2025, the following bill was signed into law:

H.B. NO. 250, H.D. 2, S.D. 2, C.D. 1 — RELATING TO HEALTH.
ACT 151

Mahalo,

Josh Green M.D.

Josh Green, M.D.
Governor, State of Hawai'i

Approved by the Governor

on JUN 3 2025

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

ACT 151

H.B. NO. 250 H.D. 2 S.D. 2 C.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH.

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

1 SECTION 1. The legislature finds that prior authorization
2 is a health plan cost-control process that requires physicians,
3 health care professionals, and hospitals to obtain advance
4 approval from a health plan before a specific service to a
5 patient is qualified for payment or coverage. Each health plan
6 has its own policies and procedures that health care providers
7 are required to navigate to have services they prescribe for
8 their patients approved for payment before being provided to the
9 patient. Each health plan uses its own standards and methods,
10 the individual judgment of an employed medical director, or
11 advice from a contracted firm for determining the medical
12 necessity of the services prescribed, which are not transparent
13 or clear to the prescribing clinician or health care provider.
14 The legislature further finds that there is emerging
15 consensus among health care providers that prior authorization
16 increases administrative burdens and costs. In the 2023
17 physician workforce report published by the university of Hawaii

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

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

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

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

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

1 (5) Seven per cent of respondents said prior authorization
2 resulted in a serious adverse event leading to a
3 patient's disability, permanent body damage,
4 congenital anomaly, birth defect, or death.
5 The legislature believes that reducing the burdens of prior
6 authorization will assist health care providers, thereby
7 ensuring the health and safety of their patients.
8 Accordingly, the purpose of this Act is to:
9 (1) Examine prior authorization practices in the State by
10 requiring utilization review entities to report
11 certain prior authorization data to the state health
12 planning and development agency; and
13 (2) Establish the health care appropriateness and
14 necessity working group to make recommendations to
15 improve and expedite the prior authorization process.
16 SECTION 2. Chapter 323D, Hawaii Revised Statutes, is
17 amended by adding two new sections to part II to be
18 appropriately designated and to read as follows:
19 "**§323D- Prior authorization data; reporting.** (a)
20 Utilization review entities doing business in the State shall
21 submit data to the state agency relating to prior authorization

1 of health care services, in a format specified by the state
2 agency. Reporting shall be annual for the preceding calendar
3 year and shall be submitted no later than January 31 of the
4 subsequent calendar year. The state agency shall post the
5 format for reporting on its website no later than three months
6 before the start of the reporting period.
7 (b) Protected health information as defined in title 45
8 Code of Federal Regulations section 160.103 shall not be
9 submitted to the state agency unless:
10 (1) The individual to whom the information relates
11 authorizes the disclosure; or
12 (2) Authorization is not required pursuant to title 45
13 Code of Federal Regulations section 164.512.
14 (c) The state agency shall compile the prior authorization
15 data by provider of health insurance, health care setting, and
16 line of business, and shall post a report of findings, including
17 recommendations, on its website no later than March 1 of the
18 year after the reporting period. If the state agency is unable
19 to post the report of findings by March 1, the state agency
20 shall notify the legislature in writing within ten days and

1 include an estimated date of posting, reasons for the delay, and
2 if applicable, a corrective action plan.
3 **§323D- Health care appropriateness and necessity**
4 **working group; established.** (a) There is established the
5 health care appropriateness and necessity working group within
6 the state agency. The working group shall:
7 (1) Determine by research and consensus:
8 (A) The most respected peer-reviewed national
9 scientific standards;
10 (B) Clinical guidelines; and
11 (C) Appropriate use criteria published by federal
12 agencies, academic institutions, and professional
13 societies,
14 that correspond to each of the most frequent clinical
15 treatments, procedures, medications, diagnostic
16 images, laboratory and diagnostic tests, or types of
17 medical equipment prescribed by licensed physicians
18 and other health care providers in the State that
19 trigger prior authorization determinations by the
20 utilization review entities;

1 (2) Assess whether it is appropriate to require prior
2 authorization for each considered clinical treatment,
3 procedure, medication, diagnostic image, laboratory
4 and diagnostic test, or type of medical equipment
5 prescribed by licensed physicians and other health
6 care providers;
7 (3) Make recommendations on standards for third party
8 reviewers related to the specialty expertise of those
9 reviewing and for those discussing a patient's denial
10 with the patient's health care provider;
11 (4) Recommend appropriate time frames within which urgent
12 and standard requests shall be decided;
13 (5) Monitor anticipated federal developments related to
14 prior authorization for health care services and
15 consider these developments when making its
16 recommendations;
17 (6) Assess industry progress toward, and readiness to
18 implement, any recommendations; and
19 (7) Make recommendations on treatments for common chronic
20 or long-term conditions for which prior authorization

1 may remain valid for the duration of the treatment in
2 the appropriate clinical setting.
3 (b) The administrator of the state agency shall invite the
4 following to be members of the working group:
5 (1) Five members representing the insurance industry, to
6 be selected by the Hawaii Association of Health Plans;
7 (2) Five members representing licensed health care
8 professionals, two of whom shall be selected by the
9 Hawaii Medical Association, two of whom shall be
10 selected by the Healthcare Association of Hawaii, and
11 one of whom shall be selected by the center for
12 nursing; and
13 (3) Five members representing consumers of health care or
14 employers, two of whom shall be selected by the board
15 of trustees of the Hawaii employer-union health
16 benefits trust fund, one of whom shall be a consumer
17 selected by the statewide health coordinating council,
18 one of whom shall be selected by the Hawaii Primary
19 Care Association, and one of whom shall be selected by
20 Papa Ola Lokahi.

1 The members of the working group shall elect a chairperson
2 and vice chairperson from amongst themselves. The director of
3 health, insurance commissioner, and administrator of the
4 med-QUEST division of the department of human services shall
5 each appoint an ex-officio advisor for the working group.
6 (c) The working group shall submit a report of its
7 findings and recommendations regarding information under
8 subsection (a), including any proposed legislation, to the
9 legislature no later than twenty days prior to the convening of
10 the regular session of 2026 and each regular session thereafter.
11 (d) The recommendations of the working group shall be
12 advisory only and not mandatory for health care facilities,
13 health care professionals, insurers, and utilization review
14 entities. The state agency shall promote the recommendations
15 among health care facilities, health care professionals,
16 insurers, and utilization review entities and shall publish
17 annually in its report to the legislature the extent and impacts
18 of its use in the State.
19 (e) The state agency shall seek transparency and agreement
20 among health care facilities, health care professionals,
21 insurers, utilization review entities, and consumers related to

1 the most respected clinical, scientific, and efficacious
2 standards, guidelines, and appropriate use criteria
3 corresponding to medical treatments and services most commonly
4 triggering prior authorization determinations to reduce
5 uncertainty around common prior authorization processes, and
6 also foster automation of prior authorization to the benefit of
7 all. The state agency shall explore means of achieving
8 statewide health sector agreement on means of automating prior
9 authorization determinations that decrease delays and
10 disruptions of medically necessary patient care in the near
11 future."
12 SECTION 3. Section 323D-2, Hawaii Revised Statutes, is
13 amended by adding four new definitions to be appropriately
14 inserted and to read as follows:
15 ""Health care professional" has the same meaning as defined
16 in section 431:26-101.
17 "Prior authorization" means the process by which a
18 utilization review entity determines the medical necessity or
19 medical appropriateness of otherwise covered health care
20 services before the health care services are rendered. "Prior
21 authorization" includes any health insurer's or utilization

1 review entity's requirement that an insured or a health care
2 facility or health care professional notify the insurer or
3 utilization review entity before providing health care services
4 to determine eligibility for payment or coverage.
5 "Prior authorization data" means data required for
6 compliance with federal law and the regulations of the federal
7 Centers for Medicare and Medicaid Services, including those
8 promulgated under title 42 Code of Federal Regulations sections
9 422.122(c), 438.210(f), 440.230(e)(3), and 457.732(c).
10 "Utilization review entity" means an individual or entity
11 that performs prior authorization for one or more of the
12 following entities:
13 (1) An insurer governed by chapter 431, article 10A; a
14 mutual benefit society governed by chapter 432,
15 article 1; a fraternal benefit society governed by
16 chapter 432, article 2; or a health maintenance
17 organization governed by chapter 432D; or
18 (2) Any other individual that provides, offers to provide,
19 or administers hospital, outpatient, medical,
20 prescription drug, or other health benefits to an
21 individual treated by a health care facility or health

1 care professional in the State under a policy,

2 contract, plan, or agreement."

3 SECTION 4. New statutory material is underscored.

4 SECTION 5. This Act shall take effect upon its approval.

ACT 47

S.B. NO. 1035

A Bill for an Act Relating to the General Excise Tax.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. The legislature finds that under the current general excise tax, there is an incongruity in the way medical service providers are treated. Medical services rendered at a nonprofit hospital, infirmary, or sanitarium are exempt from the general excise tax, while the same services rendered by individual or group practices or clinics are fully taxable. Presently, government programs such as medicare, medicaid, and TRICARE do not compensate for the difference created by the general excise tax, leading to some inconsistency in the economic impact to health care providers.

Accordingly, the purpose of this Act is to exempt medical and dental service providers who receive medicare, medicaid, and TRICARE payments from the general excise tax to encourage cost-effective patient outcomes.

SECTION 2. Section 237-24.3, Hawaii Revised Statutes, is amended to read as follows:

"**§237-24.3 Additional amounts not taxable.** In addition to the amounts not taxable under section 237-24, this chapter shall not apply to:

(1) Amounts received from the loading, transportation, and unloading of agricultural commodities shipped for a producer or produce dealer on one island of this State to a person, firm, or organization on another island of this State. The terms "agricultural commodity", "producer", and "produce dealer" shall be defined in the same manner as they are defined in section 147-1; provided that agricultural commodities need not have been produced in the State;

(2) Amounts received by the manager, submanager, or board of directors of:

   (A) An association of a condominium property regime established in accordance with chapter 514B or any predecessor thereto; or

   (B) A nonprofit homeowners or community association incorporated in accordance with chapter 414D or any predecessor thereto and existing pursuant to covenants running with the land,

   in reimbursement of sums paid for common expenses;

(3) Amounts received or accrued from:

   (A) The loading or unloading of cargo from ships, barges, vessels, or aircraft, including stevedoring services as defined in section 382-1, whether or not the ships, barges, vessels, or aircraft travel between the State and other states or countries or between the islands of the State;

   (B) Tugboat services including pilotage fees performed within the State, and the towage of ships, barges, or vessels in and out of state harbors, or from one pier to another;

(C) The transportation of pilots or governmental officials to ships, barges, or vessels offshore; rigging gear; checking freight and similar services; standby charges; and use of moorings and running mooring lines; and

(D) Wharfage and demurrage imposed under chapter 266 that is paid to the department of transportation;

(4) Amounts received by an employee benefit plan by way of contributions, dividends, interest, and other income; and amounts received by a nonprofit organization or office, as payments for costs and expenses incurred for the administration of an employee benefit plan; provided that this exemption shall not apply to any gross rental income or gross rental proceeds received after June 30, 1994, as income from investments in real property in this State; and provided further that gross rental income or gross rental proceeds from investments in real property received by an employee benefit plan after June 30, 1994, under written contracts executed prior to July 1, 1994, shall not be taxed until the contracts are renegotiated, renewed, or extended, or until after December 31, 1998, whichever is earlier. For the purposes of this paragraph, "employee benefit plan" means any plan as defined in title 29 United States Code section 1002(3), as amended;

(5) Amounts received for purchases made with United States Department of Agriculture food coupons under the federal food stamp program, and amounts received for purchases made with United States Department of Agriculture food vouchers under the Special Supplemental Foods Program for Women, Infants and Children;

(6) Amounts received by a hospital, infirmary, medical clinic, health care facility, pharmacy, or a practitioner licensed to administer the drug to an individual for selling prescription drugs or prosthetic devices to an individual; provided that this paragraph shall not apply to any amounts received for services provided in selling prescription drugs or prosthetic devices. As used in this paragraph:

"Prescription drugs" are those drugs defined under section 328-1 and dispensed by filling or refilling a written or oral prescription by a practitioner licensed under law to administer the drug and sold by a licensed pharmacist under section 328-16 or practitioners licensed to administer drugs; provided that "prescription drugs" shall not include cannabis or manufactured cannabis products authorized pursuant to chapters 329 and 329D; and

"Prosthetic device" means any artificial device or appliance, instrument, apparatus, or contrivance, including their components, parts, accessories, and replacements thereof, used to replace a missing or surgically removed part of the human body, which is prescribed by a licensed practitioner of medicine, osteopathy, or podiatry and that is sold by the practitioner or that is dispensed and sold by a dealer of prosthetic devices; provided that "prosthetic device" shall not mean any auditory, ophthalmic, dental, or ocular device or appliance, instrument, apparatus, or contrivance;

(7) Taxes on transient accommodations imposed by chapter 237D and passed on and collected by operators holding certificates of registration under that chapter;

(8) Amounts received as dues by an unincorporated merchants association from its membership for advertising media, promotional, and advertising costs for the promotion of the association for the benefit

of its members as a whole and not for the benefit of an individual member or group of members less than the entire membership;

(9) Amounts received by a labor organization for real property leased to:

(A) A labor organization; or

(B) A trust fund established by a labor organization for the benefit of its members, families, and dependents for medical or hospital care, pensions on retirement or death of employees, apprenticeship and training, and other membership service programs.

As used in this paragraph, "labor organization" means a labor organization exempt from federal income tax under section 501(c)(5) of the Internal Revenue Code, as amended;

(10) Amounts received from foreign diplomats and consular officials who are holding cards issued or authorized by the United States Department of State granting them an exemption from state taxes; [~~and~~]

(11) Amounts received as rent for the rental or leasing of aircraft or aircraft engines used by the lessees or renters for interstate air transportation of passengers and goods. For purposes of this paragraph, payments made pursuant to a lease shall be considered rent regardless of whether the lease is an operating lease or a financing lease. The definition of "interstate air transportation" is the same as in 49 U.S.C. section 40102[~~.~~]; and

(12) Amounts received by a hospital, infirmary, medical clinic, health care facility, or pharmacy, or a medical or dental practitioner, for healthcare-related goods or services purchased under the medicare, medicaid, or TRICARE programs. For the purposes of this paragraph, the healthcare-related services need not be performed by a medical or dental practitioner but may be performed by a physician's assistant, nurse, or other employee under the medical or dental practitioner's direction. As used in this paragraph:

"Medicaid" means the program established under Title XIX of the Social Security Act of 1935, as amended;

"Medical or dental practitioner" means a physician or osteopathic physician licensed pursuant to chapter 453; a dentist licensed under chapter 448; an advanced practice registered nurse licensed pursuant to chapter 457; or a pharmacist licensed pursuant to chapter 461;

"Medicare" means the program established under Title XVIII of the Social Security Act of 1935, as amended; and

"TRICARE" means the program of the Department of Defense military health system managed by the Defense Health Agency, or any successor program."

SECTION 3. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 4. This Act shall take effect on January 1, 2026.

(Approved June 3, 2024.)

Appendix 6: Researchers who assisted with this project in 2025

Alexandra Liane Jaeger
Arianna Aukai
Bryce Withy-Berry
Caleb Kurasaki
Calina Ryan
Christian Leidholm
Corina Liang
Della Lin
Dominick Philippe Guiwa
Eden Thompson
Jarvia Crecia Agbayani
Kasey Emoto
Katarina Kato
Keiko Shinha
Kyani Bateman
Lauren Chen
Mallory Watanabe
Maxx Kau
Mele Bjornson
Stacie Miura
Travis Osaki
Vy Tran
Zachary Lieberman
Zachary Oglesby