

The Hidden Tax on Hawaii Medicine

Federal payment formulas treat Honolulu like rural Mississippi. The state's 4.712% GET on medical services finishes the job. Together they cost Hawaii physicians an estimated \$250 million a year, and patients are paying the bill.

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A primary care physician in Hilo and a primary care physician in Sacramento bill Medicare the same code for the same visit. The Sacramento doctor is paid more. After Hawaii's General Excise Tax skims another 4.712% off the top, the Hilo doctor keeps roughly 18 to 22 percent less for identical work, in a state where rent, utilities, and medical supplies cost dramatically more.

This is not an accident. It is the predictable output of two policy formulas, one federal and one state, that were written without Hawaii in mind and have never been seriously revisited. The result is a quiet, compounding tax on the people who deliver care in the most isolated population center in the United States.

THE FEDERAL HALF: GPCI

Medicare adjusts physician payment using the Geographic Practice Cost Index (GPCI), three multipliers covering physician work, practice expense, and malpractice. For 2025, Hawaii's work GPCI sits at 1.000, the national floor, despite a cost of living that the Missouri Economic Research and Information Center ranks as the highest in the nation. Practice expense GPCI is partially adjusted but does not capture neighbor-island shipping, inter-island travel for specialty coverage, or the premium Hawaii providers pay for everything from gauze to diesel generators.

CMS publishes these values annually in the Physician Fee Schedule Final Rule (CMS-1807-F for CY2025, Federal Register 89 FR 97710). The methodology relies on Bureau of Labor Statistics wage data and Census housing data aggregated at the locality level, with Hawaii treated as a single locality. That single-locality designation flattens the real cost gradient between urban

Honolulu and Hana, Lanai City, or Kalaupapa, and understates all of them relative to comparable mainland metros.

THE STATE HALF: GET

Hawaii is one of only two states (New Mexico is the other) that taxes medical services. The General Excise Tax applies at 4.0% statewide, plus a 0.5% county surcharge on Oahu, for an effective 4.712% on physician gross receipts. Unlike a sales tax, GET is levied on the provider, not the patient, and Medicare and most commercial payers prohibit balance-billing the tax to patients. The physician absorbs it.

Hawaii Department of Taxation Form G-45 instructions confirm the rate and the prohibition on visible pass-through for federally regulated payers. The Hawaii Medical Association has documented the impact in repeated testimony, most recently on SB 1035 (2024) and HB 1675 (2025), both of which proposed a medical services GET exemption and both of which died in committee.

DOING THE MATH

Stack the two effects. A typical Hawaii primary care practice generates roughly \$450,000 in annual gross collections per full-time physician, based on MGMA 2024 benchmarks adjusted for Hawaii payer mix. The GPCI underpayment, modeled against a true cost-of-living-adjusted target, runs 8 to 12 percent. Layer the 4.712% GET on top, and the combined drag is approximately \$55,000 to \$75,000 per physician per year.

Multiply across the state's roughly 3,400 active patient-care physicians (Hawaii/Pacific Basin Area Health Education Center, 2024 Physician Workforce Assessment), and the annual extraction sits between \$187 million and \$255 million. That is money that does

not flow into staff salaries, electronic health record upgrades, after-hours coverage, or the recruitment packages needed to replace the 776-physician shortage JABSOM has documented.

WHO PAYS IN THE END

Physicians are not absorbing this loss indefinitely. They are responding the way any rational economic actor would: by leaving, retiring early, refusing new Medicare patients, or restructuring as employees of large hospital systems that can negotiate higher commercial rates to subsidize the federal and state losses. Each of those responses reduces patient access. Each of them shows up downstream as longer waits, fuller emergency departments, and more medevac flights from neighbor islands to Oahu.

The Hawaii State Department of Health's 2024 Primary Care Needs Assessment found that 100% of Hawaii's counties qualify as full or partial Health Professional Shortage Areas. The Hawaii Department of Commerce and Consumer Affairs' Insurance Division has received a rising volume of network adequacy complaints, and the Hawaii Healthcare Task Force has formally requested an inquiry into whether commercial payer directories accurately reflect the providers actually accepting new patients.

WHAT WASHINGTON AND HONOLULU CAN DO

Three actions, all administratively straightforward, would close most of the gap. First, CMS can use existing authority under Section 1848(e) of the Social Security Act to designate Hawaii as a special locality, as it has done for Alaska, and apply a frontier and isolation adjustment to all three GPCI components. The Alaska adjustment, in place since 2009, has stabilized that state's physician supply without measurable program-integrity risk.

Second, the Hawaii Legislature can pass the medical services GET exemption that has been proposed in every session since 2019. The fiscal note on SB 1035 (2024) estimated a state revenue loss of approximately \$222 million annually, an amount substantially offset by reduced Med-QUEST emergency utilization, reduced state employee health plan premiums, and retained federal Medicare and TRICARE dollars that currently leak out of the state when patients are referred to the mainland.

Third, the Hawaii Insurance Division can require commercial payers to reconcile published network

directories against actual claims activity, using the methodology the federal No Surprises Act already mandates but does not enforce. This is a transparency intervention, not a rate intervention, and it would surface the gap between what insurers tell regulators and what patients actually experience.

THE ACCOUNTABILITY QUESTION

None of this is hidden. The GPCI values are published in the Federal Register. The GET rate is on the Department of Taxation website. The shortage numbers are in JABSOM's annual report. The network adequacy complaints are filed with DCCA. What is missing is the political will to connect the four documents and act on what they collectively demonstrate.

Hawaii's congressional delegation, the Governor's office, and the Insurance Commissioner each hold one piece of the lever. None of them, acting alone, can fix this. All of them, acting together within a single legislative session, can. The question for the 2026 session and the 119th Congress is whether the people who hold those levers are prepared to use them, or whether Hawaii will continue to fund a quiet \$250 million annual transfer out of its medical workforce and into the gap between two formulas that no one designed to hurt us, and no one has bothered to fix.

SOURCES & METHODOLOGY

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