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Testimony of the Department of Commerce and Consumer Affairs

Before the
Senate Committee on Judiciary
Friday, February 27, 2026
10:30 a.m.
State Capitol, Room 016 and via Videoconference

On the following measure:
S.B. 2425, S.D. 1, RELATING TO HEALTH INSURANCE

WRITTEN TESTIMONY ONLY

Chair Rhoads, Vice Chair Gabbard, and Members of the Committee:

My name is Scott K. Saiki, and I am the Insurance Commissioner (Commissioner) of the Department of Commerce and Consumer Affairs' (Department) Insurance Division. The Department offers comments on this bill.

The purpose of this bill is to: (1) require health insurance carriers to honor a patient's written assignment of benefits to a substance use disorder treatment provider; (2) prohibit health insurance contracts from including anti-assignment clauses that restrict or invalidate a patient's right to assign benefits; (3) authorize the Insurance Commissioner to adopt rules and take enforcement action to ensure compliance; (4) deem violations to be unfair methods of competition and unfair or deceptive acts or practices; and (5) require insurers to furnish an explanation of benefits to the assigned provider upon request.

The Department notes that this bill establishes a special status for substance use disorder (SUD) treatment providers that is currently unavailable to any other class of health care provider in Hawaii. The measure allows SUD treatment providers to bypass anti-assignment clauses and pursue a private right of action against insurance carriers. These benefits are not afforded to other health care providers and is a shift in the Insurance Code, which focuses its protections and legal remedies on the policyholder rather than the health care provider.

Subsection (a) requires health insurers to honor a valid written assignment of benefits (AOB) for substance use disorder (SUD) services and issue payments directly to the provider within 30 days. The Department notes that the term "valid" is not a defined term, which could lead to disputes as to what constitutes a "valid" AOB.

Subsection (b) treats any provision in an insurance contract that restricts or prohibits the assignment of benefits to a SUD provider as unenforceable. Currently, carriers use anti-assignment clauses as leverage to encourage providers to join their networks and accept lower rates. By removing this restriction, the bill may disincentivize SUD providers to remain "in-network," potentially leading to higher out-of-network costs.

The Department notes that the enforcement language in subsection (e) is largely duplicative of the authority granted in subsection (d). Specifically, subsection (d) already designates any violation of this section, including the requirements for an explanation of benefits (EOB), as an unfair or deceptive act or practice under HRS 431:13-103. A violation of 431:13-103 would already be considered a "violation of state insurance law" that would be "subject to enforcement action". The Department also notes that subsection (e) is unclear regarding when a violation for failing to provide an EOB would occur. While it mandates that carriers furnish an EOB to an assigned provider "upon request," the measure lacks a specific timeline or deadline for compliance. This ambiguity could lead to disputes over whether a "failure to provide" has occurred or if the EOB is simply still in process.

Thank you for the opportunity to testify.

Hawaii Association of Health Plans

February 27, 2026

To: Chair Rhoads, Vice Chair Gabbard, and Members of the Senate Committee on Judiciary

From: Hawaii Association of Health Plans Public Policy Committee
Date/Location: Feb. 27, 2026; 10:30 a.m./Conference Room 016 & Videoconference

Re: SB 2425 SD1 – Relating to Health Insurance

The Hawaii Association of Health Plans (HAHP) respectfully opposes SB 2425 SD1. HAHP is a statewide partnership that unifies Hawaii's health plans to improve the health of Hawaii's communities together. A majority of Hawaii residents receive their health coverage through a plan associated with one of our organizations.

HAHP appreciates the Legislature's commitment to improving access to substance use disorder (SUD) treatment. However, requiring mandatory direct payment to out-of-network providers raises serious concerns. The SUD treatment sector is already recognized as high-risk for fraud. Mandating direct payment can unintentionally incentivize high-risk practices and increases the likelihood that patients will be balance billed, especially when out-of-network providers charge significantly higher rates than contracted partners.

Contracted arrangements between health plans and providers are essential to protecting patients, promoting appropriate care, and managing costs. For these reasons, we respectfully recommend exploring alternative solutions that expand access without weakening patient protection.

Thank you for the opportunity to share our **opposition** of SB 2425 SD1.

Sincerely,

HAHP Public Policy Committee
cc: HAHP Board Members

My name is Bridget Heady, Licensed Mental Health Counselor, and I serve as an Executive Director in Hawai‘i’s recovery and treatment community. I am writing in strong support of SB2425 / HB2209 because I have personally seen how the current insurance reimbursement practice can harm the very people it is meant to help.

When individuals in early recovery receive large insurance checks directly, it often places them in an impossible position to choose to continue their recovery journey or an option to fail. Early recovery is a fragile time. Many people are rebuilding their lives, learning stability, and trying to stay focused on healing. Handing someone a large sum of money during this stage can create overwhelming stress, trigger relapse, and undo progress. I have witnessed clients become confused, ashamed, or discouraged, sometimes walking away from care altogether because they did not know how to manage. They use this money to further deepen their addiction causing emotional regret, guilt and shame. In some circumstances this includes the death of the client, using drugs after being sober for any period of time poses an immediate threat to life. Sending large insurance reimbursement checks directly to individuals in early recovery can be deadly, as sudden access to significant funds increases the risk of relapse, overdose, and loss of life during one of the most vulnerable periods of recovery. Passing SB2425 / HB2209 is necessary to protect lives, reduce preventable harm, and ensure people can continue treatment safely and close to their family and community.

I have also seen how this system pushes people to leave Hawai‘i for treatment on the mainland, separating them from their own families, culture, and support systems. Healing is strongest when people are surrounded by community. When treatment here becomes financially unstable, everyone loses, clients, providers, and Hawai‘i as a whole.

This bill is about protecting people when they are most vulnerable. It is about reducing harm, supporting recovery, and allowing treatment providers to focus on care rather than financial chaos. SB2425 / HB2209 would help ensure continuity of treatment and keep recovery services accessible right here at home.

I respectfully urge you to pass this bill and stand with the individuals and families working toward healing and stability in our community.

Thank you for your time, consideration, and commitment to the people of Hawai‘i.

Bridget Heady, LMHC

An Independent Licensee of the Blue Cross and Blue Shield Association

February 27, 2026

The Honorable Karl Rhoads, Chair
The Honorable Mike Gabbard, Vice Chair

Senate Committee on Judiciary,

Re: SB 2425 SD1 – RELATING TO HEALTH INSURANCE.

Dear Chair Rhoads, Vice Chair Gabbard and Members of the Committee:

Hawaii Medical Service Association (HMSA) appreciates the opportunity to provide comments expressing strong concerns on SB 2245 SD1, which would require health insurance carriers to honor a patient's written assignment of benefits to a substance use disorder treatment provider. Prohibits health insurance contracts from including anti-assignment clauses that restrict or invalidate a patient's right to assign benefits. Authorizes the Insurance Commissioner to adopt rules and take enforcement action to ensure compliance. Deems violations to be unfair methods of competition and unfair or deceptive acts or practices. Requires insurers to furnish an explanation of benefits to the assigned provider upon request.

While HMSA supports efforts to improve access to SUD treatment, SB 2245 SD1 creates significant operational, financial, and consumer-protection risks that ultimately undermine coordinated, evidence-based care for patients.

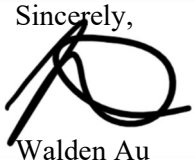
Health plans enter into agreements with participating providers to ensure that members receive high-quality care at predictable, affordable costs. Requiring health plans to honor a patient's assignments of benefits to non-participating providers, while prohibiting contractual safeguards such as anti-assignment clauses removes critical protections that ensure services are medically necessary, clinically appropriate, and billed accurately.

Mandating direct payment to out-of-network providers is also concerning, as it weakens the ability of health plans to safeguard patients from excessive charges, unnecessary services, and potential fraud. SUD treatment is already a high-risk area for fraud, eliminating these oversight tools would significantly increase those risks. We are particularly worried that this bill could unintentionally open the door for bad actors to scam individuals struggling with substance use disorder. There has been significant fraud around this area in the mainland.

Finally, giving non-participating providers the same payment rights as contracted providers removes incentives to join health plan networks. Over time, this could reduce network adequacy, increase costs for patients, and diminished oversight of treatment quality.

Given the combined risks to patient affordability, care quality, fraud prevention, and network stability, HMSA has strong concerns with this measure. Thank you for the opportunity to express our concerns.

Sincerely,



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TESTIMONY IN SUPPORT OF SB2425 SD1
Relating to Health Insurance
JDC Public Hearing February 27, 2026

Aloha Chair Rhoads, Vice Chair Gabbard, and Members of the Committee on Judiciary,

My name is Elliott Michael Smith, and I am the CEO of The Ohana Addiction Treatment Center on Hawai‘i Island. I am also a person in recovery. I respectfully submit this testimony in **strong support** of **SB2425 SD1**.

SB2425 SD1 is a narrow patient protection, consumer protection, and access-to-care measure for substance use disorder treatment. It requires insurers to honor a patient's valid written Assignment of Benefits and route payment and the Explanation of Benefits to the assigned provider, rather than sending reimbursement directly to the patient after treatment. It does not set reimbursement rates, expand coverage mandates, or remove insurer claim review tools. It addresses payment routing and claim transparency only.

This matters because the current system harms patients in three direct ways.

First, it creates a **patient safety risk**. When reimbursement is routed to the patient instead of the provider, large checks, often $10,000 to $30,000, can reach people in early recovery at an extremely vulnerable time. Hawai‘i providers have documented relapse and fatal outcomes associated with this payment-routing practice.

Second, it creates a major **access barrier**. Families are often forced to pay tens of thousands of dollars upfront and then wait months for reimbursement. Many cannot do that, which means treatment is delayed or never begins at all. HMSA's reliance on a low denial-rate figure does not answer this problem because that figure only reflects claims that were actually submitted and processed. It does not capture patients who never entered treatment because the upfront financial barrier was too high, or families who gave up before a claim was ever filed.

Third, it creates a **claims-transparency problem** that leaves patients in the middle. Providers report that HMSA denies the provider the EOB and basic claim-status information, even with a valid AOB and HIPAA authorization, and directs the provider to obtain it from the member. That

means the patient becomes the middleman in resolving denials or nonpayment, even after treatment. SB2425 SD1 fixes that by requiring EOBs to go to the assigned provider.

HMSA has argued that honoring valid AOBs would weaken protections against fraud, excessive charges, unnecessary services, or poor documentation. But SB2425 SD1 does **not** remove any of those tools. Prior authorization, medical necessity review, utilization review, documentation requirements, audits, denials, and recoupment all remain fully intact. The Senate committees also already narrowed this bill in SD1 to OHCA-licensed facilities only, removed the private right of action, and removed the annual reporting requirement. In other words, major scope and administrative concerns have already been addressed while preserving the bill's patient-protection purpose.

HMSA has also relied heavily on network and access arguments, but those arguments do not answer the real patient-access question before this Committee. HMSA represented that 86% of SUD facilities are in-network, yet also acknowledged it does not have wait-time data for substance use treatment. Without wait-time data, that percentage does not show whether patients can actually obtain timely care. That figure also appears to combine very different categories of programs, including Medicaid/QUEST-contracted facilities, with commercial plan access, even though the patients most affected by anti-assignment practices are working families on employer-sponsored commercial plans.

That distinction matters because the commercial-access problem is being obscured by publicly supported treatment capacity. According to the DOH Alcohol And Drug Abuse Division Accreditation List revised January 12, 2026, 23 accredited programs are listed, and 19 of those entries are marked "CONTRACTED," while 4 are marked "NOT CONTRACTED." ADAD has advised that "CONTRACTED" refers to state-funded programs. This means much of the treatment capacity HMSA points to as evidence of network adequacy is tied to publicly funded treatment capacity, not purely commercial access. At the same time, HMSA's best and final offer to The Ohana was approximately **$209 per day** for 24-hour residential treatment including room and board, medical oversight, nursing, group programming, individual therapy, case management, and clinical documentation. That is not a financially workable commercial rate for comprehensive residential care. This is not genuine commercial access. It is cost shifting to the State and taxpayers while allowing HMSA to claim network adequacy on paper.

SB2425 SD1 is also not unusual in concept. According to the health insurance industry's own 50-state Assignment of Benefits summary, at least **29 states** have enacted laws or regulations requiring insurers or HMOs to accept assignments of benefits or make direct payments to non-participating providers. Hawai‘i would not be acting outside the mainstream by adopting a narrower, SUD-specific version of that approach.

This is also not just about one insurer. While HMSA has led the opposition to this bill, other carriers such as HMAA and UHA have already stopped this practice. SB2425 SD1 would simply

codify for all carriers what responsible insurers are already doing voluntarily. That matters because it shows honoring valid AOBs is workable in Hawai‘i without removing legitimate claim-review or anti-fraud tools.

At bottom, this Committee has a clear policy choice: whether Hawai‘i law should protect patients in early recovery and honor their valid written Assignment of Benefits, or preserve insurer discretion to route payment away from the provider after treatment and leave vulnerable patients in the middle of claims resolution.

SB2425 SD1 is a narrow, reasonable, and necessary reform. It protects patients, improves transparency, and helps preserve real access to treatment here in Hawai‘i.

For these reasons, I respectfully urge the Committee to pass **SB2425 SD1**.

Mahalo for your time and consideration.

Elliott M. Smith
Chief Executive Officer
The Ohana Addiction Treatment Center
Elliott@TheOhanaHawaii.com | (808) 746-9003

SB2425 SD1

SB2425 SD1 Fact Sheet

Hawai'i Assignment of Benefits Reform for SUD Treatment

Prepared for Senate Judiciary Committee (JDC) review of SB2425 SD1

THE PROBLEM

Hawai'i insurers, primarily HMSA, do not honor patients' written Assignment of Benefits (AOB) for substance use disorder treatment in these cases and instead send reimbursement checks ($10,000-$30,000+) directly to patients in early recovery. This creates patient safety and access problems for Hawai'i families seeking treatment.

- **Patient safety risk:** Large reimbursement checks sent directly to patients in early recovery can create relapse risk at a highly vulnerable time. Hawai'i providers have documented relapse and fatal outcomes associated with this payment-routing practice.
- **Access barrier for local families:** Because providers cannot rely on direct payment after a valid AOB is signed, families are often required to pay large amounts upfront and wait for reimbursement, which can delay or prevent treatment access.
- **Patients are forced into the middle of claims resolution:** Providers report that HMSA denies the provider the EOB and basic claim-status information, even with a valid AOB and HIPAA authorization, and directs the provider to obtain it from the member. This leaves patients in the middle and prevents providers from helping resolve denials or nonpayment in a timely way.
- **Off-island displacement:** When local treatment is not financially accessible, Hawai'i residents may be forced to seek treatment on the mainland, away from family and cultural support.

WHAT SB2425 SD1 DOES

- Requires insurers to honor a patient's written AOB and pay OHCA-licensed SUD treatment providers directly
- Voids anti-assignment clauses in insurance contracts for covered SUD treatment claims
- Requires insurers to provide Explanation of Benefits (EOB) and claim status information to assigned providers
- Designates violations as unfair insurance practices under HRS 431:13-103
- Grants the Insurance Commissioner rulemaking and enforcement authority

WHAT IT DOES NOT DO

- Does NOT remove any insurer fraud protections - prior authorization, medical necessity review, documentation review, audits, denials, and recoupment all remain fully intact
- Does NOT set or change reimbursement rates - insurers still determine payment rates and whether claims are payable; this bill only changes who receives payment when payment is made
- Does NOT cover unlicensed providers - SD1 narrowed the definition to OHCA-licensed facilities only

FISCAL IMPACT

No new State reimbursement obligation is created from a new reimbursement direction obligation. The bill redirects existing insurance payments from patients to assigned providers and uses existing unfair insurance practice enforcement mechanisms. The annual reporting requirement was removed in SD1.

SD1 ALREADY ADDRESSED OPPOSITION CONCERNS

Concern Raised	How SD1 Responds
Fraud risk from unlicensed providers	Removed — only OHCA-licensed facilities covered
Private right of action for providers	Removed
Administrative burden of annual reporting	Removed
Insurer utilization controls weakened	All controls preserved — bill doesn't touch them

29 STATES ALREADY HAVE SIMILAR LAWS

AL, AK, AR, CA, CO, CT, DE, FL, GA, ID, IL, IN, KY, LA, ME, MD, MA, MS, MO, NV, NH, NJ, OH, RI, SD, TN, TX, VA, WY

We are not aware of any state repealing similar legislation for the reasons raised in opposition testimony, and no Hawai'i-specific evidence of widespread provider fraud was presented in opposition testimony.

NETWORK / ACCESS METRICS: WHAT THEY DO NOT SHOW

- Facility counts alone do not establish timely access to treatment.
- Submitted-claim denial rates do not capture patients who never begin treatment because they cannot pay upfront.
- SB2425 SD1 addresses payment routing and EOB transparency after a valid AOB. It does not set reimbursement rates or alter insurer utilization management authority.

SUPPORT ON RECORD (SENATE HHS/CPN)

- Mayor C. Kimo Alameda, Ph.D. - County of Hawai'i
- Hawai'i Substance Abuse Coalition (HSAC)
- Hina Mauka - Brian Baker, President & CEO
- Intervention 911 / Ken Seeley - A&E's "Intervention"
- Dr. Michael McGrath, MD - 30 years addiction medicine in Hawai'i
- Gil Keith-Agaran, former Hawai'i State Senator (individual written testimony in support)
- 13 individual testifiers, including physicians, licensed counselors, treatment providers, and community advocates

Broader community impact: Formal testimony reflects only a portion of those affected. The barriers addressed by SB2425 SD1 impact thousands of Hawai'i families seeking SUD treatment.

WHY JDC CAN HEAR SB2425 SD1 NOW

- **SD1 narrowed the bill's scope.** The Senate committees limited coverage to OHCA-licensed facilities and removed issues that drew procedural concerns in earlier testimony.
- **Insurer safeguards remain fully intact.** SB2425 SD1 does not remove prior authorization, medical necessity review, documentation requirements, audits, denials, or recoupment.
- **The bill uses an existing enforcement framework.** Violations are addressed through Hawai'i's unfair insurance practices statute and Insurance Commissioner rulemaking authority, rather than creating a new standalone enforcement system.
- **The bill is a targeted payment-routing and transparency fix.** SB2425 SD1 does not set reimbursement rates. It addresses direct payment and EOB access after a valid AOB is signed.

CORE POLICY CHOICE FOR THE LEGISLATURE:

Honor the patient's valid written assignment of benefits for SUD treatment, or continue allowing payment to be routed to the patient instead of the provider after treatment.