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Testimony of the Department of Commerce and Consumer Affairs

**Before the
House Committee on Consumer Protection & Commerce
Tuesday, March 24, 2026
2:00 p.m.
State Capitol, Conference Room 329 and via videoconference**

**On the following measure:
S.B. 2425, S.D. 2, H.D. 1, RELATING TO HEALTH INSURANCE**

Chair Matayoshi, Vice Chair Grandinetti, 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 insurers, mutual benefit societies, and health maintenance organizations to honor a patient's written assignment of benefits to a substance use disorder treatment provider; (2) prohibit health insurance policies, plans, contracts, and agreements 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, mutual benefit societies, and health maintenance organizations 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, a benefit 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 written assignment of benefits (AOB) that is “validly executed in compliance with this title” for substance use disorder (SUD) services and issue payments directly to the provider within 30 days. The Department notes that the measure does not define when an AOB is “validly executed”, which could lead to disputes as to what constitutes a “validly executed” AOB.

Subsection (a) also provides that “payment under this subsection shall be issued within thirty days of receipt of a claim that meets the requirements of section 431:13-108”. HRS 431:13-108 defines a claim as “any claim, bill, or request for payment for all or any portion of health care services provided by a health care provider of services submitted by an **individual or pursuant to a contract or agreement with an entity**, using the entity's standard claim form with all required fields completed with correct and complete information.” Thus, 431:13-108 contemplates that the request for payment will come from services rendered by an in-network provider or the covered individual. However, an in-network provider would not require an assignment of benefits since the in-network can already accept direct payments. Therefore, the thirty-day payment requirement would be rendered moot if requested by an out-of-network provider. In addition, the bill’s language at Page 5, lines 10-12, on the “discharge of insurer’s obligation to the extent of payment made” is unclear as to how the “extent” of payment made is to be determined and when the insurer’s obligation has been met.

Subsection (b) prohibits anti-assignment clauses in insurance contracts for substance use disorder (SUD) treatment services. The Department recognizes the public interest in ensuring that reimbursement is directed to the SUD provider rather than the patient, mitigating the risks of relapse associated with patients in recovery

receiving large reimbursement checks. The Department notes that anti-assignment clauses are a tool for incentivizing network participation and managing premium costs.

Finally, 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.

TESTIMONY IN SUPPORT OF SB2425 HD1

Relating to Health Insurance

HLT Public Hearing March 18, 2026

Aloha Chair Matayoshi, Vice Chair Grandinetti, and Members of the Committee:

My name is Elliott Smith. I am the CEO of The Ohana Addiction Treatment Center on Hawai'i Island, the CEO of a treatment program in California, and a person in long-term recovery. I write in strong support of SB2425 HD1.

This bill has now passed the Senate 25-0, passed House HLT with amendments, and is before this Committee as the final step before a floor vote. The principal objections have been raised, heard, and addressed at every prior stage. I want to speak directly to those objections today, because at this point, the Committee deserves a candid accounting of what this bill actually does and what the opposition is actually asking you to reject.

THE PROBLEM IS REAL AND DOCUMENTED

In Hawai'i today, even when a patient signs a written Assignment of Benefits for substance use disorder treatment, insurers still route reimbursement directly to the patient. That means a person leaving residential treatment, often in the most vulnerable and clinically unstable period of their recovery, receives a large reimbursement check. Hawai'i providers have seen what happens next. We have seen relapse. We have seen fatal overdose. This is not a hypothetical.

It is also an access problem. Local families are asked to front tens of thousands of dollars for treatment and wait for reimbursement later, because providers cannot rely on direct payment even after a valid assignment is signed. Many families cannot do that. Treatment is delayed, avoided, or pushed to the mainland, away from 'ohana and the local support systems that matter most in early recovery.

And it is a claims transparency problem. Providers are routinely denied access to EOBs and basic claims information even when the patient has signed an AOB and HIPAA authorization. The patient ends up in the middle of claims disputes they are not equipped to manage, during a period when their focus should be on recovery.

THE FRAUD ARGUMENT DOES NOT MATCH WHAT THIS BILL DOES

The opposition has repeatedly invoked fraud as a reason to oppose this bill, including references to a \$650 million DOJ case in Arizona involving Medicaid claims for services never provided.

That case involved fabricated claims submitted to Medicaid. It has nothing to do with what SB2425 HD1 does.

This bill does not remove prior authorization. It does not remove medical necessity review. It does not remove documentation review, audits, denials, or recoupment. It does not require payment of non-covered claims. It does not prevent an insurer from denying an improper claim. Every fraud and utilization review tool insurers use today remains fully intact under this bill.

The bill is also limited to OHCA-licensed residential and detoxification facilities. These are not fly-by-night operations. They are licensed and regulated by the State of Hawai'i.

Generalized fraud rhetoric is not a policy analysis of what this bill actually does. If a claim is improper, it can still be denied. If documentation is insufficient, it can still be challenged. If a provider is acting unlawfully, regulators can still investigate. Nothing in this bill changes that.

The question is not whether fraud exists somewhere in healthcare. The question is whether Hawai'i should continue routing reimbursement through patients in early recovery because of broad, unparticularized fraud concerns that do not apply to the mechanics of this bill.

THE NETWORK ARGUMENT DOES NOT ANSWER THE ACTUAL PROBLEM

HMSA has pointed to network numbers and denial-rate statistics to argue that access is not a problem. But those figures do not tell this Committee whether a family can actually begin treatment without fronting a large sum of money. They do not measure whether claim information is accessible to providers. They do not measure whether a patient in early recovery is being forced into the middle of a payment dispute.

HMSA has cited as having 86 facilities in its SUD network. Hawai'i has 23 licensed and accredited SUD treatment programs. That mismatch alone should give this Committee pause about accepting paper network counts as proof of real access.

A paper network is not the same thing as practical access. In substance use disorder treatment, timely placement, financial feasibility, geographic reality, and continuity of care all matter. If a family cannot afford to start local treatment because reimbursement is routed to the wrong place, then access has failed in practice regardless of what a network directory says on paper.

And network statistics will never capture the families who never start treatment at all because the financial burden is too high. Those patients do not appear in any denial data, any network count, or any claims metric. But they are real.

HMSA has also argued that this bill could increase costs. The opposite is true. The current system requires families to pay the full cost of treatment upfront and wait for reimbursement. That does not reduce costs. It prevents people from accessing treatment at all. And to the extent the opposition raises balance billing concerns, the federal No Surprises Act already protects

patients against surprise out-of-network bills. Those protections exist independently of this bill and are not weakened by it.

THIS IS NOT "SPECIAL TREATMENT" - IT IS A RESPONSE TO A SPECIFIC PATIENT SAFETY PROBLEM

The Department of Commerce and Consumer Affairs noted that this bill creates a status for SUD treatment providers not available to other provider classes.

That framing misses the point. This bill does not exist because one provider class is asking for a favor. It exists because there is a unique patient safety problem in a uniquely vulnerable treatment context.

The issue is not abstract. It is whether patients in early recovery, during one of the most clinically unstable periods of treatment and discharge, should receive insurance reimbursement directly and be left to navigate claims disputes themselves. No other treatment context presents that same combination of clinical vulnerability and financial risk in the same way.

The Legislature recognized that and narrowed the bill accordingly. That is responsible legislating, not special treatment.

THE "OUT-OF-NETWORK LEVERAGE" FRAMING IS WRONG

The opposition has framed this bill as though it gives out-of-network providers leverage to charge whatever they want. That is not what the bill does.

SB2425 HD1 does not set or change reimbursement rates. It does not require payment of non-covered claims. It does not eliminate coverage rules or rewrite network contracts. It does not prevent insurers from reviewing medical necessity or denying improper claims.

The bill only requires the carrier to honor the patient's valid written assignment and route payment to the provider when a covered claim is payable. That is payment routing. It is not rate setting. It is not leverage. It is making sure money the insurer has already decided to pay goes to the right place.

ANTI-ASSIGNMENT CLAUSES ARE NOT A PATIENT PROTECTION — THEY ARE THE PROBLEM

DCCA and HMSA have both argued that anti-assignment clauses are tools for incentivizing network participation and managing premium costs.

In practice, in the SUD treatment context, anti-assignment clauses are what force patients in early recovery to act as the payment middleman. They are the mechanism by which insurers route reimbursement to patients instead of providers, even when the patient has explicitly directed otherwise in writing.

Framing that as a "patient protection" requires ignoring what actually happens to the patient when reimbursement shows up in their hands during early recovery.

At least 29 states have already recognized that anti-assignment clauses should not override a patient's valid written AOB in contexts like this. Hawai'i is being asked to catch up, not break new ground.

THE LEGISLATURE ALREADY DID THE HARD WORK

This bill has been heard, debated, and refined at every stage. The concerns raised by the opposition were taken seriously and addressed:

- The bill was narrowed to OHCA-licensed residential and detoxification providers only.
- Unlicensed programs are excluded.
- The private right of action was removed.
- "Valid" assignment language was clarified.
- The bill does not create new reporting requirements.
- Insurer review tools — prior auth, medical necessity, audits, denials, recoupment — are all preserved.
- Enforcement runs through Hawai'i's existing unfair or deceptive insurance practices framework.
- The Attorney General's Contract Clause concern was addressed in HD1, which added language clarifying that the measure does not impair any contract existing as of its effective date.

The Senate passed this bill 25-0. House HLT passed it with amendments. At this point, the remaining opposition is not about a flaw in the bill that has not been addressed. The remaining opposition is about whether insurers should be required to honor a patient's valid assignment of benefits at all.

THE POLICY CHOICE

The core policy choice before this Committee is whether Hawai'i will require carriers to honor a patient's valid written assignment of benefits for covered SUD treatment, while leaving insurer review tools fully intact, or continue placing patients in early recovery in the middle of payment and claims disputes for claims the carrier has already decided to cover.

For the safety of patients, the reality of families seeking care, and the practical accessibility of treatment in Hawai'i, I respectfully urge this Committee to pass SB2425 HD1.

Mahalo for the opportunity to testify.



Elliott M. Smith

Chief Executive Officer

The Ohana Addiction Treatment Center

Elliott@TheOhanaHawaii.com | (808) 746-9003



SB2425 HD1 Fact Sheet

Hawai'i Assignment of Benefits Reform for SUD Treatment

Updated for CPC Review | March 2026

Passed Senate 25-0, passed House HLT with amendments, now before CPC

THE PROBLEM

In Hawai'i, the largest health insurers do not honor a patient's written Assignment of Benefits for substance use disorder treatment and instead send reimbursement checks directly to the patient after treatment. These checks can be substantial and may arrive when the patient is still in early recovery. This creates patient safety risks, treatment access barriers, and claims transparency problems for Hawai'i families seeking care.

- **Patient safety risk:** Hawai'i providers have reported cases in which reimbursement checks sent to patients in early recovery were followed by relapse and, in some cases, fatal overdose.
- **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 being denied timely access to EOBs and other basic claims information needed to resolve denials and payment disputes, even when the patient has signed an AOB and HIPAA authorization forcing the patient to act as the middleman in denials and payment disputes.
- **Pressure to seek treatment out of state:** 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 HD1 DOES

- Requires carriers to honor a patient's valid written assignment of benefits and pay OHCA-licensed residential or detoxification SUD treatment providers directly for covered claims.
- Makes anti-assignment clauses unenforceable for covered SUD treatment claims assigned to OHCA-licensed residential or detoxification providers within the bill's scope.
- Requires insurers to provide an Explanation of Benefits to the assigned provider upon request when proper patient authorization is presented
- Makes noncompliance enforceable under Hawai'i's existing insurance-law framework governing unfair methods of competition and unfair or deceptive acts or practices.
- Authorizes the Insurance Commissioner to enforce compliance, and to adopt rules as needed.

WHAT IT DOES NOT DO

- Does NOT remove insurer fraud or payment-integrity protections. Prior authorization, medical necessity review, documentation review, audits, denials, and recoupment remain intact.
- Does NOT set or change reimbursement rates. Insurers still determine whether a claim is covered and payable. This bill only changes where payment goes after a valid written AOB is executed.
- Does NOT require payment of non-covered claims.
- SB2425 HD1 is a targeted state-law remedy addressing the portion of the AOB problem Hawai'i can regulate directly.
- Does NOT cover unlicensed providers. The bill is limited to OHCA-licensed residential and detoxification SUD facilities.

FISCAL IMPACT

The bill does not create any new State payment obligation. It only directs where a covered insurance payment goes after a valid assignment of benefits.

HOW THE LEGISLATURE NARROWED AND IMPROVED THE BILL

Concern Raised	How the Legislature Addressed It
Fraud risk from unlicensed providers	Limited the bill to OHCA-licensed substance use disorder treatment providers offering residential or detoxification services.
"Valid" assignment was unclear	HD1 now clarifies that the bill applies to a written assignment of benefits that is validly executed in compliance with the title.
Insurer utilization controls would be weakened	The bill does not remove prior authorization, medical necessity review, documentation review, audits, denials, or recoupment rights.
The bill was too broad	The Senate narrowed the bill to the portion of the market Hawai'i can regulate directly under state insurance law.
Administrative burden on carriers	The bill uses existing insurance enforcement authority and existing EOB processes rather than creating a new payment system.
The bill could undermine fraud control or insurer oversight.	It does not. The bill preserves prior authorization, medical necessity review, documentation review, audits, denials, and recoupment. The provider class is limited to OHCA-licensed residential and detoxification facilities.
Network participation already solves the access problem.	Network counts do not show whether families can begin treatment without large upfront payments, whether beds are available when needed, or whether providers can obtain the EOB information needed to resolve claims.

AT LEAST 29 STATES RECOGNIZE AOB OR DIRECT-PAYMENT PROTECTIONS

According to a 2019 50-state summary published by AHIP, twenty-nine states, including Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, Ohio, Rhode Island, South Dakota, Tennessee, Texas, Virginia, and Wyoming, had already enacted laws or regulations requiring health insurance plans or HMOs to accept assignments of benefits or make direct payments to non-participating providers. Hawai'i has not yet adopted protections that many other states already recognize.

NETWORK / ACCESS METRICS: WHAT THEY DO NOT SHOW

- Facility counts alone do not establish real access to treatment. A paper network is not the same as timely placement, geographic access, or practical affordability.
- Network adequacy claims do not measure whether families can actually start treatment without large upfront payments.
- Claim denial data do not capture patients who never enter treatment because they cannot front the cost while waiting for reimbursement.
- This bill addresses a real-world access barrier that network statistics do not measure: whether treatment can actually begin without the patient being forced to act as the payment middleman.
- HMSA has cited having 86 facilities in its SUD network, but Hawai'i has only 23 licensed and accredited SUD treatment programs. Paper network counts built on that kind of mismatch do not prove real access.

LEGISLATIVE AND COMMUNITY SUPPORT TO DATE

SB2425 advanced through the Senate process and received support from providers, clinicians, community leaders, and public advocates.

- **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 by this problem. The barriers addressed by SB2425 HD1 impact thousands of Hawai'i families seeking SUD treatment.

WHY SB2425 HD1 IS READY TO MOVE FORWARD

- **HD1 narrowed the bill's scope.** The Senate narrowed the bill's scope, and the House has kept the bill targeted to OHCA-licensed residential and detoxification SUD facilities.
- **Insurer safeguards remain fully intact.** SB2425 HD1 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 or deceptive insurance practices framework and the Insurance Commissioner's authority, rather than through a new standalone enforcement system.
- **The bill is a targeted payment-routing and transparency fix.** SB2425 HD1 does not set reimbursement rates. It requires carriers to honor a patient's valid written assignment of benefits for covered substance use disorder treatment and requires EOB access to the assigned provider upon request with proper authorization.
- **The principal objections raised earlier in the process have already been addressed.** The bill no longer covers unlicensed programs, no longer creates a private right of action, does not set reimbursement rates, does not require payment of non-covered claims, and preserves all insurer review tools. The bill passed the Senate 25-0 and passed House HLT with amendments.

CORE POLICY CHOICE FOR THE LEGISLATURE:

The core policy choice is whether Hawai'i will require carriers to honor a patient's valid written assignment of benefits for covered SUD treatment, while leaving insurer review tools fully intact, or continue placing patients in early recovery in the middle of payment and claims disputes for claims the carrier has already decided to cover.



March 24, 2026

The Honorable Scot Z. Matayoshi, Chair
The Honorable Tina Grandinetti, Vice Chair

House Committee on Consumer Protection & Commerce (CPC)

Re: SB 2425 SD2 HD1 – RELATING TO HEALTH INSURANCE.

Dear Chair Matayoshi, Vice Chair Grandinetti, Members of the Committee:

Hawaii Medical Service Association (HMSA) appreciates the opportunity to submit testimony opposing SB 2245 SD2 HD1, which would require health insurance carriers to honor a patient's written assignment of benefits to a substance use disorder (SUD) treatment provider. This measure would also prohibit health insurance contracts from including anti-assignment clauses, authorize the Insurance Commissioner to adopt rules and take enforcement action to ensure compliance, deem violations to be unfair or deceptive acts or practices, and require insurers to furnish an explanation of benefits to the assigned provider upon request.

HMSA recognizes and appreciates the Legislature's valid concerns over directly reimbursing patients who are receiving treatment for substance use disorder. In acknowledgement of these concerns, and following discussions with the Chair of the House Health Committee, we have agreed to a compromise that addresses the issue while preserving essential safeguards around care quality, fraud prevention, network stability, and affordability.

Requiring health plans to honor a patient's assignment of benefits to non-participating providers removes essential protections that help ensure services are medically necessary, clinically appropriate, and accurately billed. Given this and the fact that we have already begun implementing this agreed-upon solution, we respectfully request that the committee defer this measure, as it is no longer necessary.

Sincerely,

Walden Au
Director of Government Relations

LATE

March 24, 2026

To: Chair Matayoshi, Vice Chair Grandinetti, and Members of the House Committee on Consumer Protection and Commerce (CPC)

From: Hawaii Association of Health Plans Public Policy Committee

Date/Location: Mar. 24, 2026; 2:00 p.m./Conference Room 329 & Videoconference

Re: Testimony opposing SB 2425 SD2 HD1 – Relating to Health Insurance

The Hawaii Association of Health Plans (HAHP) respectfully opposes SB 2425 SD2 HD1. 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 SD2 HD1.

Sincerely,

HAHP Public Policy Committee

cc: HAHP Board Members

LATE

SB-2425-HD-1

Submitted on: 3/23/2026 3:22:06 PM

Testimony for CPC on 3/24/2026 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Brian Baker	Hina Mauka	Comments	Written Testimony Only

Comments:

Hina Mauka Comments on SB2425, SD2, HD1:

ALOHA CHAIR, VICE CHAIR, AND DISTINGUISHED COMMITTEE MEMBERS. My name is Brian Baker. I am the President and CEO for Hina Mauka, a mental health and substance use disorder treatment and prevention agency for thousands of adults and adolescents on Oahu and Kauai, including recovery-oriented services and housing transitional living programs.

COMMENTS only:

Mahalo for the opportunity to provide additional comments on this bill. Hina Mauka had previously supported this bill in an attempt to rectify the downstream impact of large insurance provider payments going directly into the hands of people new to their sobriety journey. In work with the state’s largest insurer, they have developed a way to alleviate that concern. Given the size and influence of this insurer, I feel confident that other insurance companies will follow suit. Given these changes, I no longer feel the need to support this bill moving forward.

Mahalo again for the opportunity to provide comments.

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 HD1 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 HD1 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 HD1 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

LATE

SB-2425-HD-1

Submitted on: 3/23/2026 4:44:27 PM

Testimony for CPC on 3/24/2026 2:00:00 PM

Submitted By	Organization	Testifier Position	Testify
Joseph DeVasto	Individual	Support	Remotely Via Zoom

Comments:

Aloha,

My name is Joseph DeVasto, and I am writing in **strong** support of SB 2425 relating to health insurance.

I am a mental health professional specializing in addiction medicine with over 15 years of experience. I have worked with Big Island Substance Abuse Counseling, participated in the island's Drug Court system, and collaborated with intensive outpatient programs including Lokahi and Mental Health Kokua. My work has always been rooted in a deep commitment to the people of Hawai'i and a belief that individuals can change, heal, and recover especially when given access to appropriate, timely treatment.

Through my experience, I have seen that while the Big Island and other outer islands offer some support for individuals struggling with addiction particularly those involved in the legal system there remains a significant, underserved population. Many individuals who are not court-mandated fall through the cracks, unable to access the care they need due to financial barriers related to what this proposed bill is attempting to fix.

This gap in care is not just a systems issue it is a matter of life and death.

If I may, I would like to share a story from today one that, unfortunately, is not uncommon. I received a call from a 25-year-old woman who works full-time at a coffee farm in Konawhile attending school part-time. She is hardworking, driven, and aspires to become a marine biologist. She is also struggling with addiction, mental health challenges, and active suicidal ideation following a relapse. She reached out for help, ready and willing to enter treatment immediately. However, she was unable to access care due to the out-of-pocket costs. Her family could not afford treatment, and she had to be referred elsewhere, delaying care and increasing her risk.

This is the reality for too many in our community. There is a demographic of hardworking individuals and families those who contribute to our islands and want to remain here who are left without access to critical treatment services. They are motivated, they are ready, but the system does not meet them where they are. In my experience, these delays often have devastating consequences. People relapse, their conditions worsen, and too often, lives are lost to overdose or suicide.

We must do better. Expanding access to health insurance coverage for mental health and substance use treatment is essential. It ensures that individuals can receive care when they need it most—not weeks or months later, not after another crisis, but in the moment they are ready to change.

I strongly urge you to support SB 2425. This bill represents an opportunity to close a dangerous gap in care and to support the health, safety, and future of Hawai'i's people.

Sincerely,

Joseph DeVasto, MA, LMHC, CCAR

