TESTIMONY OF
THE DEPARTMENT OF THE ATTORNEY GENERAL
KA ʻOIHANA O KA LOIO KUHINA
THIRTY-THIRD LEGISLATURE, 2026

ON THE FOLLOWING MEASURE:
S.B. NO. 2425, S.D. 2, RELATING TO HEALTH INSURANCE.

BEFORE THE:
HOUSE COMMITTEE ON HEALTH

DATE: Wednesday, March 18, 2026 **TIME:** 9:00 a.m.

LOCATION: State Capitol, Room 329

TESTIFIER(S): Anne E. Lopez, Attorney General, or
Christopher J.I. Leong, or Christopher T. Han, Deputy Attorneys General

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Chair Takayama and Members of the Committee:

The Department of the Attorney General provides the following comments.

This bill: (1) requires health insurance carriers to honor a covered person's written assignment of benefits to a substance use disorder treatment provider; (2) prohibits policy provisions that restrict or invalidate such assignments; (3) authorizes rulemaking and enforcement by the Insurance Commissioner; (4) deems violations to be unfair methods of competition and unfair or deceptive acts or practices; and (5) requires insurers to provide explanations of benefits to assigned providers upon request.

This bill could raise potential issues under the Contract Clause of the United States Constitution, which generally prohibits laws that substantially impair existing contractual relationships. U.S. Const. art. I, § 10, cl. 1. Because insurance policies are contracts, requiring insurers to honor assignments of benefits and prohibiting anti-assignment provisions could be construed as impairing policies that are already in effect at the time the bill becomes effective.

To mitigate this concern, we recommend inserting the following wording after page 8, line 5:

> SECTION 5. This Act shall not be applied so as to impair any contract existing as of the effective date of this Act in a manner violative of either the Constitution of the State of Hawaii or article I, section 10, of the United States Constitution.

The current sections 5 and 6 should then be renumbered as sections 6 and 7.

Thank you for the opportunity to provide comments.

JOSH GREEN, M.D.
GOVERNOR | KE KIA'ĀINA

SYLVIA LUKE
LIEUTENANT GOVERNOR | KA HOPE KIA'ĀINA

STATE OF HAWAII | KA MOKUʻĀINA ʻO HAWAIʻI
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Testimony of the Department of Commerce and Consumer Affairs

Before the
House Committee on Health
Wednesday, March 18, 2026
9:00 a.m.
State Capitol, Room 329 and via Videoconference

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

Chair Takayama, Vice Chair Keohokapu-Lee Loy, 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, 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.

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".

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.

THE OHANA HAWAII

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TESTIMONY IN SUPPORT OF SB2425 SD2
Relating to Health Insurance
HLT Public Hearing March 18, 2026

Aloha Chair Takayama, Vice Chair Keohokapu-Lee Loy, 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 SD2.

This measure addresses a real patient safety, access-to-care, and claims transparency problem in Hawai‘i. Today, even when a patient signs a written Assignment of Benefits for substance use disorder treatment, reimbursement is still too often routed to the patient instead of the treating provider. In the substance use disorder context, that is not just an administrative issue. It can become a safety issue.

A person leaving treatment is often in one of the most vulnerable periods of recovery. Sending a large reimbursement check directly to that person can destabilize recovery at exactly the wrong moment. Hawai‘i providers have seen the harm this practice can cause. This bill would help ensure that payment and claim information go where they belong, to the treating provider, rather than turning a patient in early recovery into the payment middleman.

It is also an access problem. Families are often asked to front very large sums of money for treatment and wait for reimbursement later because providers cannot rely on direct payment even after a valid assignment is signed. Many local families simply cannot do that. Treatment is delayed, avoided, or pushed to the mainland, away from ‘ohana and local support. Network statistics do not measure that real-world barrier.

SB2425 SD2 is a narrow and workable fix. It requires carriers to honor a written Assignment of Benefits that is validly executed in compliance with Hawai‘i law for covered substance use disorder treatment services and to issue payment directly to the provider. It also requires carriers to provide an Explanation of Benefits to the assigned provider upon request when the provider presents a valid AOB, power of attorney, or HIPAA-compliant authorization. The bill is limited to OHCA-licensed facilities providing residential or detoxification services for substance use disorders. It does not extend to unlicensed programs.

That narrowness matters, because many of the objections raised earlier have already been addressed.

First, this bill does not remove insurer safeguards.

HMSA has argued that honoring assignments of benefits would weaken protections related to medical necessity, utilization review, billing accuracy, or fraud. That is not what SB2425 SD2 does. The 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 simply changes where payment and EOB information go after a valid assignment has been executed.

Second, this bill does not set reimbursement rates.

HMSA has framed the issue as though this bill would somehow force carriers to accept uncontrolled charges or give non-contracted providers the equivalent of in-network contracting rights. It does not. SB2425 SD2 does not set or change reimbursement rates. It does not eliminate coverage rules. It does not rewrite network contracts. It addresses payment routing and claim transparency only.

Third, the Senate already narrowed the bill in response to concerns.

Earlier concerns about breadth, unlicensed providers, and enforcement structure were taken seriously. SD2 is now limited to OHCA-licensed residential and detoxification providers. It uses existing insurance enforcement mechanisms. Violations are treated as unfair or deceptive insurance practices under existing Hawai‘i law. This is not a sprawling redesign of the insurance code. It is a targeted correction to a specific and documented problem.

Fourth, HMSA’s network and access arguments do not answer the actual problem.

HMSA has pointed to network numbers and denial-rate statistics, but those figures do not tell this Committee whether families can actually begin treatment without fronting enormous sums 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. And they do not measure the local families who never start treatment because the financial burden is too high.

HMSA has also asserted that the existence of contracted facilities shows there is no real access problem. But a paper network is not the same thing as practical access. In substance use disorder treatment, timely placement, financial feasibility, geography, and continuity of care 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.

Fifth, the fraud argument should be treated with caution.

HMSA has repeatedly invoked generalized fraud concerns in SUD treatment, including references to problems on the mainland. But generalized references to fraud are not a substitute for a policy analysis of what this bill actually does. Again, SB2425 SD2 leaves insurers' fraud controls intact. 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. The question before this Committee is not whether fraud exists somewhere in healthcare. The question is whether Hawai‘i should continue using patients in early recovery as the payment middleman because of broad and unparticularized fraud claims. It should not.

Sixth, the bill is legally more disciplined now than opponents suggest.

One earlier concern was that the term "valid" assignment was unclear. SD2 improves that by requiring a written assignment that is validly executed in compliance with Hawai‘i law. Another concern was administrative burden. But this bill relies on existing insurance enforcement authority rather than creating a wholly new payment bureaucracy. The Senate heard those concerns and still passed the bill unanimously, 25 to 0.

It is also important to be candid about what this bill does not solve. SB2425 SD2 is not a complete answer to every reimbursement-routing problem in every type of plan. It is a targeted state-law remedy addressing the portion of the market Hawai‘i can regulate directly. That is not a weakness. It is exactly how careful legislation should work. The fact that the broader problem may extend further is not a reason to do nothing where the Legislature clearly has authority to act.

Finally, Hawai‘i is not being asked to invent a radical concept here. According to the 2019 AHIP 50-state survey, twenty-nine states had already enacted laws or regulations requiring plans or HMOs to accept assignments of benefits or make direct payments in similar contexts. Hawai‘i is not stepping into unknown territory. It is catching up to a policy protection many other jurisdictions already recognize.

At bottom, the policy choice is simple: should Hawai‘i honor a patient's valid written Assignment of Benefits for covered substance use disorder treatment and ensure that payment and EOB information can go directly to the treating provider, or should patients in early recovery continue to be used as the payment middleman?

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 SD2.

Mahalo for the opportunity to testify.

Elliott M. Smith
Chief Executive Officer
The Ohana Addiction Treatment Center
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SB2425 SD2

SB2425 SD2 Fact Sheet

Hawai'i Assignment of Benefits Reform for SUD Treatment

Prepared for Hawai'i House Review | Updated March 2026

Passed Senate 25 to 0 | Transmitted to House

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:** 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 being denied timely access to EOBs and basic claim-status information even when the patient has signed an AOB and HIPAA authorization, forcing the patient to act as the middleman in denials and payment disputes.
- **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 SD2 DOES

- Requires health insurance carriers to honor a patient's written assignment of benefits and pay OHCA-licensed residential or detoxification SUD treatment providers directly
- Voids anti-assignment clauses in insurance contracts for covered SUD treatment claims
- Requires insurers to provide an Explanation of Benefits to the assigned provider upon request when proper patient authorization is presented
- Treats violations as unfair or deceptive insurance practices under Hawai'i insurance law
- Authorizes the Insurance Commissioner to adopt rules and enforce compliance

WHAT IT DOES NOT DO

- Does NOT remove insurer fraud 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 SD2 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

No new State reimbursement obligation is created from a new reimbursement direction obligation. The bill uses existing insurance enforcement mechanisms and does not create a new State payment obligation.

THE SENATE ALREADY NARROWED AND IMPROVED THE BILL	
Concern Raised	**How the Senate 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	SD2 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.

29 STATES ALREADY HAVE SIMILAR LAWS

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.

SENATE RECORD OF SUPPORT

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 SD2 impact thousands of Hawai'i families seeking SUD treatment.

WHY SB2425 SD2 IS READY FOR HOUSE REVIEW

- **SD2 narrowed the bill's scope.** The Senate limited the bill to OHCA-licensed facilities providing residential or detoxification services for substance use disorders, then passed the bill 25 to 0.
- **Insurer safeguards remain fully intact.** SB2425 SD2 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 SD2 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.

CORE POLICY CHOICE FOR THE LEGISLATURE:

Should Hawai'i honor a patient's valid written assignment of benefits for covered substance use disorder treatment and ensure that payment and EOB information can go directly to the treating provider, or should patients in early recovery continue to be used as the payment middleman?

Hawaii Association of Health Plans

March 18, 2026

To: Chair Takayama, Vice Chair Keohokapu-Lee Loy, and Members of the House Committee on Health (HLT)

From: Hawaii Association of Health Plans Public Policy Committee
Date/Location: Mar. 18, 2026; 9:00 a.m./Conference Room 329 & Videoconference

Re: Testimony opposing 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

An Independent Licensee of the Blue Cross and Blue Shield Association

March 18, 2026

The Honorable Gregg Takayama, Chair
The Honorable Sue Keohokapu-Lee Loy, Vice Chair

House Committee on Health

Re: SB 2425 SD1 – RELATING TO HEALTH INSURANCE.

Dear Chair Takayama, Vice Chair Sue Keohokapu-Lee Loy, Members of the Committee:

Hawaii Medical Service Association (HMSA) appreciates the opportunity to submit testimony opposing 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 support our residents seeking treatment for substance use disorder (SUD), 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 members receive high-quality care at predictable, affordable costs. Requiring health plans to honor a patient's assignment of benefits to non-participating providers—while prohibiting contractual safeguards such as anti-assignment clauses—removes essential protections that help ensure services are medically necessary, clinically appropriate, and accurately billed.

Across the country. there are documented allegations of fraud occurring nationwide in the SUD)space, with bad actors taking advantage of a vulnerable population and negatively impacting the health care system including:

- **In 2025, the U.S. Department of Justice charged an operator with orchestrating a $650 million scheme involving at least 41 substance abuse treatment clinics in Arizona**, submitting Medicaid (AHCCCS) claims for services never provided, medically unnecessary, or so substandard as to serve no treatment purpose. Many patients were recruited from homeless communities and tribal lands. [justice.gov]
- **According to a 2025 federal indictment in the Central District of California, the operator of True Help LLC ran a $2.7 million illegal kickback scheme** tied to addiction treatment facilities throughout Orange County, including more than $2.3 million in kickbacks received and over $454,000 paid to a single patient broker. [ftc.gov]
- **In 2025, NUWAY Alliance agreed to pay $18.5 million** following allegations that the organization paid kickbacks and double-billed Medicaid for intensive outpatient SUD services over several years in Minnesota. [oig.ssa.gov]

An Independent Licensee of the Blue Cross and Blue Shield Association

These cases illustrate the very real risks associated with payment flows and referral structures outside the oversight and accountability of contracted provider networks. An assignment of benefits may lead to an inability to enforce medical-necessity standards, billing accuracy safeguards, or quality requirements increases exposure to:

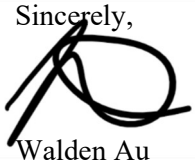
- Higher out-of-pocket costs for patients;
- Lower clinical quality due to inadequate oversight;
- Greater vulnerability to fraud and abuse, as demonstrated by federal enforcement actions;
- Destabilization of provider networks, undermining long-term access to sustainable, coordinated care.

HMSA understands the concerns raised by legislators and stakeholders in previous hearings regarding direct reimbursements being made to patients who receive treatment at a non-participating facility. We are actively working to address this issue and are committed to implementing solutions that best support our members throughout their SUD treatment journey.

Given the combined risks to patient affordability, care quality, fraud prevention, and network stability, HMSA has strong concerns with SB 2245 SD1.

Thank you for the opportunity to oppose this measure.

Sincerely,



Walden Au
Director of Government Relations