H.B. NO. 2348

A BILL FOR AN ACT

RELATING TO THE HAWAII HEALTH INSURANCE GUARANTY ASSOCIATION.

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

SECTION 1. Currently, the State has two insurance guaranty associations that provide payment mechanisms for eligible covered claims when insurers are insolvent. The first, the Hawaii Insurance Guaranty Association, covers direct property and liability contracts. The second, the Hawaii Life and Disability Insurance Guaranty Association, covers life and accident and health or sickness insurance policies and insurance contracts.

Under the Hawaii Life and Disability Insurance Guaranty Association, member insurers are composed of Hawaii licensed carriers that provide life and accident and health or sickness insurance policies and insurance contracts. However, medical service organizations and health maintenance organizations are excluded from being Hawaii Life and Disability Insurance Guaranty Association members. That means that these organizations are not assessed to help pay the claims of an insolvent Hawaii Life and Disability Insurance Guaranty Association member but, also, that there is no guaranty

association to assist a financially insolvent medical service organization and health maintenance organization. The vast majority of Hawaii's residents maintain health insurance plans through these organizations.

The purpose of this Act is to protect Hawaii's health insurance policyholders and health care providers in case a medical service organization or health maintenance organization experiences financial insolvency.

SECTION 2. Chapter 431, article 16, Hawaii Revised Statutes, is amended by adding a new part to be appropriately designated and to read as follows:

"**PART . HAWAII HEALTH INSURANCE GUARANTY ASSOCIATION**

§431:16-A Title. This part shall be known as the Hawaii Health Insurance Guaranty Association Act.

§431:16-B Purpose. (a) The purpose of this part is to protect, subject to certain limitations, policy owners and health care providers against failure in the performance of contractual obligations under insurance policies issued by licensees under part 1 of chapter 432 and chapter 432D, and dental insurance policies issued by licensees under chapter 432G, because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(b) To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited herein, and members of the association are subject to assessment to provide funds to carry out the purpose of this part.

§431:16-C Scope. This part shall apply to insurance policies issued by licensees under part 1 of chapter 432 and chapter 432D, and dental insurance policies issued by licensees under chapter 432G. Limited benefit health insurance policies as defined in section 431:10A-102.5 are not included in this part.

§431:16-D Coverage and limitations. (a) This part shall provide coverage to policy owners for the policies and contracts specified in subsection (b).

(b)(1) This part shall provide coverage to the persons who have coverage under insurance policies issued by licensees under part 1 of chapter 432 and chapter 432D, and dental insurance policies issued by licensees under chapter 432G, and for supplemental contracts to any of these, in each case issued by member insurers except as limited by this part.

(2) This part shall not provide coverage for:

(A) Any portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy or contract owner;

(B) Any policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(C) Any portions of insurance policies issued by licensees under part 1 of chapter 432 and chapter 432D, and dental insurance policies issued by licensees under chapter 432G, to a plan or program of an employer, association, or other person to provide accident and health or sickness insurance to its employees, members, or other persons to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under:

(i) A Multiple Employer Welfare Arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended;

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan; or

(iv) An administrative services only contract;

(D) Any policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this State;

(E) Any portion of a policy or contract to the extent that the assessments required by this part with respect to the policy or contract are preempted or otherwise not permitted by federal or state law;

(F) Any obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

(i) Claims based on marketing materials;

(ii) Claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

(iii) Misrepresentations of or regarding policy benefits;

(iv) Extra-contractual claims; or

(v) A claim for penalties or consequential or incidental damages; or

(G) Any policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to part C or part D of subchapter XVIII, chapter 7, title 42 of the United States Code, commonly known as medicare part C and D, or any regulations adopted pursuant thereto.

(c) The benefits for which the association may become liable for insurance policies issued by licensees under part 1 of chapter 432 and chapter 432D shall in no event exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer, or

(2) With respect to any one life, regardless of the number of insurance policies issued by licensees under part 1 of chapter 432 and chapter 432D:

(A) $100,000 for coverages not defined as disability insurance or basic hospital, medical, and

surgical insurance, or major medical insurance or long-term care insurance, including any net cash surrender and net cash withdrawal values; or

(B) $500,000 for basic hospital, medical, and surgical insurance or major medical insurance.

(d)(1) The benefits for a dental insurance policy issued under chapter 432G shall be subject to section 432G-6(e)(1) prior to any benefits for which the association may become liable under (d)(2).

(2) In the event of an insolvency, the combined benefits to be received by the policyholder from the dental insurance policy, any insurance obtained pursuant to section 432G-6(e)(1), and the association shall not exceed the lesser of the dental insurance policy's benefit limit or $3,000.

(e) In no event shall the association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life under subsection (c) except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under subsection (c)(2)(B), in which case the aggregate liability of the association shall not exceed $500,000 with respect to any one individual.

(f) The limitations set forth in this section are limitations on the benefits for which the association is obligated before taking into account its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this part may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(g) In performing its obligations to provide coverage under section 431:16-I, the association shall not be required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

§431:16-E Construction. This part shall be liberally construed to effect the purpose under section 431:16-B, which shall constitute an aid and guide to interpretation.

§431:16-F Definitions. As used in this part:

"Association" means the Hawaii health insurance guaranty association created under section 431:16-G.

"Authorized assessment" or "authorized" when used in the context of assessments means a resolution by the board of directors that has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount.

"Called assessment" or "called" when used in the context of assessments means a notice that has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice.

"Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section 431:16-D.

"Covered policy" means any policy, contract, or portion of a policy or contract for which coverage is provided under section 431:16-D.

"Extra-contractual claims" shall include, but not be limited to, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs.

"Impaired insurer" means a member insurer that after July 1, 2019, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Insolvent insurer" means a member insurer that after July 1, 2019, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

"Insurer" or "member insurer" means any insurer licensed under part 1 of chapter 432, chapter 432D, and chapter 432G, and includes any insurer whose license or certificate of authority in this State under these chapters may have been suspended, revoked, not renewed, or voluntarily withdrawn.

"Owner", "policy holder", "policy owner", or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract. The terms "owner", "contract owner", and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

"Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

"Premiums" means amounts and considerations received on covered policies or contracts less premiums, considerations and

deposits returned thereon, and less dividends and experience credits thereon. Premiums does not include any amounts or consideration received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under section 431:16-D(b), except that assessable premium shall not be reduced on accounts under section 431:16-D(b)(2)(C) relating to interest limitations and section 431:16-D(c)(2) relating to limitations with respect to any one life and any one contract holder.

"Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

"Resident" means a person to whom a contractual obligation is owed and who resides in this State on the date of entry of a court order that determines a member insurer to be an impaired or insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States who are:

(1) Residents of foreign countries; or

(2) Residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this part,

shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

"State" means a state, the District of Columbia, Puerto Rico, or a United States possession, territory, or protectorate.

"Supplemental contract" means a written agreement entered into for the distribution of proceeds under an accident and health or sickness contract, except for limited benefit health insurance as defined in section 431:10A-102.5.

§431:16-G Creation of the association. (a) There is created a nonprofit legal entity to be known as the Hawaii health insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under the plan of operation established and approved under section 431:16-K and shall exercise its powers through a board of directors established under section 431:16-H.

(b) For administration purposes, the administrator of the Hawaii life and disability insurance guaranty association shall

also be the administrator of the association. The association shall pay reasonable costs and fees commensurate with the administrator's work for the association to the Hawaii life and disability insurance guaranty association.

(c) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this State. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

§431:16-H Board of directors. (a) The board of directors of the association shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational

meeting, each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial members.

(b) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors, but members of the board shall not otherwise be compensated by the association for their services.

§431:16-I Powers and duties of the association. (a) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, that are approved by the commissioner, and that are, except in cases of court ordered conservation or rehabilitation, also approved by the impaired insurer:

(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer;

(2) Provide such moneys, pledges, notes, guarantees, or other means as are proper to effectuate subsection (a)(1) and assure payment of the contractual obligations of the impaired insurer pending action under subsection (a)(1); or

(3) Loan money to the impaired insurer.

(b) If a member insurer is an insolvent insurer, the association shall, in its discretion:

(1) (A) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer; or

(B) Assure payment of the contractual obligations of the insolvent insurer; and

(C) Provide such moneys, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or

(2) Provide benefits and coverages in accordance with the following provisions:

(A) With respect to non-group insurance policies issued by licensees under part 1 of chapter 432 and chapter 432D, and dental insurance policies issued by licensees under chapter 432G, make

available to each known insured, make available substitute coverage on an individual basis in accordance with subparagraph (B).

(B) (i) In providing the substitute coverage required under subparagraph (C), the association may offer either to reissue the terminated coverage or to issue an alternative policy.

(ii) Alternative or reissued policies shall be offered without requiring evidence of insurability and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(iii) The association may reinsure any alternative or reissued policy.

(C) (i) Alternative policies adopted by the association shall be subject to the approval of the commissioner or the receivership court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(ii) Alternative policies shall contain at least the minimum statutory provisions required in this State and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(iii) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(D) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age

and class of risk, subject to approval of the domiciliary insurance commissioner or by a court of competent jurisdiction.

(E) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.

(c) Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this part with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this part.

(d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association

shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

(e) The protection provided by this part shall not apply where any guaranty protection is provided to residents of this State by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this State.

(f) In carrying out its duties under subsection (b), the association may, subject to approval by a court in this State, impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this part are less than the amounts needed to assure full and prompt performance of the association's duties under this part, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; and

(g) If the association fails to act within a reasonable period of time as provided in subsection (b), the commissioner shall have the powers and duties of the association under this part with respect to the insolvent insurer.

(h) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(i) The association shall have standing to appear or intervene before any court or agency in this State with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this part or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before any court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(j)(1) Any person receiving benefits under this part shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this part, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and causes of action by any payee, policy or contract owner, beneficiary, or insured as a condition precedent to the receipt of any right or benefits conferred by this part upon such person.

(2) The subrogation rights of the association under this section shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this part.

(3) In addition to paragraphs (1) and (2), the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have

been available to the impaired or insolvent insurer, owner, beneficiary, or payee of a policy or contract with respect to the policy or contracts.

(4) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the association.

(5) If the association has provided benefits with respect to a covered obligation and a person recovers amounts to which the association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association.

(k) The association may:

(1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this part;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 431:16-J, and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of this part; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) Employ or retain such persons as are necessary to handle the financial transactions of the association and to perform such other functions as become necessary or proper under this part;

(5) Take such legal action as may be necessary to avoid payment of improper claims or to recover payment of improper claims;

(6) Exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic accident and health or sickness insurer, but in no case may the association issue insurance policies other than those issued to perform its obligations under this part;

(7) Organize itself as a corporation or in other legal form permitted by the laws of the State;

(8) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this part with respect to the person, and the person shall promptly comply with the request; and

(9) Take other necessary or appropriate action to discharge its duties and obligations under this part or to exercise its powers under this part.

(10) The association may join an organization of one or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

(m) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation or rehabilitation, the association may elect to succeed to the rights of the insolvent insurer, arising after the date of the order of liquidation or rehabilitation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that the contract provides coverage for losses occurring after the date of the order of liquidation or

rehabilitation. As a condition to making this election, the association shall pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

(n) The board of directors of the association shall have discretion and shall exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this part in an economical and efficient manner.

(o) Where the association has arranged or offered to provide the benefits of this part to a covered person under a plan or arrangement that fulfills the association's obligations under this part, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(p) Venue in a suit against the association arising under this part shall be in the circuit court of the first circuit. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this part.

(q) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under subsection (a) or (b), the association may, subject to

approval of the receivership court, issue substitute coverage for a policy or contract by issuing an alternative policy or contract in accordance with the following provisions:

(1) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(2) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

§431:16-J Assessments. (a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at eighteen per cent per annum on and after the due date.

(b) There shall be two assessments, as follows:

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs, other expenses, and examinations conducted under the authority of section 431:16-M(e). Class A assessments

may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under section 431:16-I with regard to an impaired or an insolvent insurer.

(c)(1) The amount of any class A assessment shall be determined by the board of directors and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board of directors may provide that it be credited against future class B assessments. A non-pro rata assessment shall not exceed $300 per member insurer in any one calendar year. The amount of any class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula that may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board of directors in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers shall be in the proportion that the premiums received on

business in this State by each assessed member insurer on policies or contracts covered for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to the premiums received on business in this State for the calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this part. Classification of assessments under subsection (b) and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred in whole or part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused the deferral have been removed or rectified, the member shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(e)(1) Subject to the provisions of paragraph (2), the total of all assessments authorized by the association with respect to a member insurer shall not in any one calendar year exceed two per cent of the insurer's average premiums received in this State on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(2) If two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in this section shall be equal and limited to the higher of the three-year average annual premiums for the applicable account as calculated pursuant to this section.

(3) If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this part.

The board of directors may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account,

the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses and claims.

(g) It shall be proper for any member insurer, in determining its premium rates within the scope of this part, to consider the amount reasonably necessary to meet its assessment obligations under this part.

(h) The association shall issue to each insurer paying an assessment under this part, other than a class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

(i)(1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and that sets forth a brief statement of the grounds for the protest.

(2) Within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest, unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(3) Within thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of the final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal the final decision to the commissioner.

(4) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision with or without a recommendation from the association.

(5) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Interest on a refund due a protesting member shall be paid at the rate actually earned by the association.

(j) The association may request information of member insurers to aid in the exercise of its powers under this section and member insurers shall promptly comply with any request.

§431:16-K Plan of operation.

(a)(1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or if the commissioner has not disapproved it within thirty days.

(2) If the association fails to submit a suitable plan of operation within one hundred twenty days following January 1, 2019, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this part. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this part:

(1) Establish procedures for handling the assets of the association;

(2) Establish the amount and method of reimbursing members of the board of directors under section 431:16-H(c);

(3) Establish regular places and times for meetings, including telephone conference calls of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;

(6) Establish any additional procedures for assessments under section 431:16-J;

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association;

(8) Establish procedures to remove a director for cause, including the case in which a director is affiliated with a member insurer that becomes an impaired or insolvent insurer; and

(9) Require the board of directors to establish a policy and procedure for addressing conflicts of interests.

(d) The plan of operation may provide that any or all powers and duties of the association, except those under sections 431:16-208(k)(3) and 431:16-J, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association,

or its equivalent, in two or more states. The corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this part.

§431:16-L Duties and powers of the commissioner. (a) In addition to the duties and powers enumerated elsewhere in this part, the commissioner shall:

(1) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer;

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with a

demand shall not excuse the association from the performance of its powers and duties under this part;

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five per cent of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.

(c) Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within sixty days of the final action being appealed. If a member insurer is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to

the member insurer. Any final action or order of the commissioner shall be subject to judicial review in the circuit court of the first judicial circuit.

(d) The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this part.

§431:16-M Prevention of insolvencies. (a) To aid in the detection and prevention of insurer insolvencies or impairments, it shall be the duty of the commissioner:

(1) To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when the commissioner takes any of the following actions against a member insurer:

(A) Revocation of license;

(B) Suspension of license; or

(C) Makes any formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the State, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors.

The notice shall be mailed to all commissioners within thirty days following the action taken or the date on which the action occurs;

(2) To report to the board of directors when the commissioner has taken any of the actions set forth in paragraph (1) or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner;

(3) To report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member company that the company may be an impaired or insolvent insurer; and

(4) To furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in

carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the commissioner's duties and responsibilities regarding the financial condition of member companies and companies seeking admission to transact insurance business in this State.

(c) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this State. The reports and recommendations shall not be considered public documents.

(d) It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be an impaired insurer or insolvent insurer.

(e) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of such request, the commissioner shall begin the examination. The examination may be conducted as a National Association of Insurance Commissioners' examination or may be conducted by such persons as the commissioner designates. The cost of the examination shall be paid by the association and the examination report shall be treated the same as other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this shall not excuse the commissioner from complying with subsection (a). The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner, but it shall not be open to public inspection prior to the release of the examination report to the public.

(f) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(g) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the board of directors of guaranty associations in other states in preparing a report on the history and causes for insolvency of a particular insurer and may adopt by reference any report prepared by such other associations.

§431:16-N Recoupment of assessment. (a) Each member insurer shall annually recoup the assessments paid in the preceding years by the insurer under this part. The recoupment shall be recovered by means of a surcharge on premiums charged for accident and health or sickness policies. Prior to recoupment, each member insurer shall submit its plan for recoupment to the commissioner for approval. The surcharge shall be at a uniform percentage rate reasonably calculated to recoup the assessment paid by the member insurer. Any excess recovery by a member insurer shall be credited pro rata to that member insurer's policyholders' premiums in the succeeding year unless there has been a subsequent assessment, in which case the excess will be used to pay the amount of the subsequent

assessment. If a member insurer fails to recoup the entire amount of its assessment in the first year under the procedure provided in this section, it may repeat the procedure in succeeding years until the full assessment is recouped.

(b) Each insurer shall provide to the Hawaii health insurance guaranty association an accounting of its recoupments. The Hawaii health insurance guaranty association shall compile the insurers' accountings and submit it as part of its annual report to the commissioner.

(c) The amount of and reason for any surcharge shall be separately stated on any billing sent an insured. The surcharge shall not be considered premiums for any other purpose, including the computation of gross premium tax or the determination of producer commissions.

§431:16-O Miscellaneous provisions. (a) Nothing in this part shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under section 431:16-I. The records of the association with respect to an impaired or

insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, except:

(1) Upon the termination of the impairment or insolvency of the insurer; or

(2) Upon the order of a court of competent jurisdiction.

Nothing in this subsection shall limit the duty of the association to render a report of its activities under section 431:2-304(b).

(c) For the purpose of carrying out its obligations under this part, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to section 431:16-I(j). Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this part. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves

that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(d) As a creditor of the impaired or insolvent insurer as established in subsection (c) and consistent with section 431:15-324, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this part. If the liquidator has not, within one hundred twenty days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(e)(1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policy owners of the insolvent insurer, and any other party with a bona fide

interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under section 431:16-I with respect to such insurer have been fully recovered by the association.

(f)(1) If an order for liquidation or rehabilitation of an insurer domiciled in this State has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (2) to (4).

(2) No distribution shall be recoverable if the insurer shows that the distribution was lawful and reasonable when paid and that the insurer did not know, and could not reasonably have known, that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions the person received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions the person would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under paragraph (3) is insolvent, all its affiliates that controlled it at the time the

distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

§431:16-P Tax exemptions. The association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real property.

§431:16-Q Immunity. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives, for any action or omission by them in the performance of their powers and duties under this part. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

§431:16-R Stay of proceedings; reopening default judgments. All proceedings in which the insolvent insurer is a party in any court in this State shall be stayed one-hundred eighty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers

or duties. As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have such judgment set aside by the same court that issued the judgment and shall be permitted to defend against the suit on the merits.

§431:16-S Prohibited advertisement of association act in insurance sales; notice to policyholders. (a) No person, including an insurer and a producer or an affiliate of an insurer, shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, which uses the existence of the Hawaii health insurance guaranty association of this State for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by the Hawaii Health Insurance Guaranty Association Act. This section shall not apply to the Hawaii health insurance guaranty association or any other entity that does not sell or solicit insurance.

(b) Within one hundred eighty days of January 1, 2019, the association shall prepare a summary document describing the general purposes and current limitations of this part and complying with subsection (c). This document shall be submitted to the commissioner for approval. Sixty days after receiving approval, no insurer may deliver a policy or contract described in section 431:16-D to a policyholder or contract holder unless the document is delivered to the policyholder or contract holder at the time of delivery of the policy or contract, except if subsection (d) applies. The document shall also be available upon request by a policyholder. The distribution, delivery, contents, or interpretation of this document shall not mean that either the policy or the contract or the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to this part may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder, or insured any greater rights than those stated in this part.

(c) The document prepared under subsection (b) shall contain a clear and conspicuous disclaimer on its face. The

commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(1) State the name and address of the Hawaii health insurance guaranty association and the insurance division;

(2) Prominently warn the policy or contract holder that the Hawaii health insurance guaranty association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and be conditioned on continued residence in this State;

(3) State that the insurer and its producers are prohibited by law from using the existence of the Hawaii health insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(4) Emphasize that the policy or contract holder should not rely on coverage under the Hawaii health insurance guaranty association when selecting an insurer; and

(5) Provide other information as directed by the commissioner.

(d) No insurer or producer may deliver a policy or contract described in section 431:16-D(b)(1) and excluded under section 431:16-D(b)(2)(A) from coverage under this part unless the insurer or producer, prior to or at the time of delivery, gives the policy or contract holder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the Hawaii health insurance guaranty association. The commissioner shall by rule specify the form and content of the notice."

SECTION 3. In codifying the new sections added by section 2 of this Act, the revisor of statutes shall substitute appropriate section numbers for the letters used in designating the new sections in this Act.

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

INTRODUCED BY: _____

BY REQUEST

JAN 2 2 2018

H.B. NO. 2348

Report Title:
Health insurance; Guaranty fund; Guaranty association; Hawaii health insurance guaranty association; Hawaii life and disability insurance guaranty association; Insolvency; Medical service organization; Mutual benefit society; Health maintenance organization; Health care provider; Covered claim; Chapter 431; Article 16

Description:
Creates and establishes an insurance guaranty fund for Hawaii domestic medical service organizations and health maintenance organizations.

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

HB2348

JUSTIFICATION SHEET

DEPARTMENT: Commerce and Consumer Affairs

TITLE: A BILL FOR AN ACT RELATING TO THE HAWAII HEALTH INSURANCE GUARANTY ASSOCIATION.

PURPOSE: This bill creates and establishes an insurance guaranty fund for Hawaii domestic medical service organizations and health maintenance organizations.

MEANS: Add a new part to chapter 431, article 16, Hawaii Revised Statutes.

JUSTIFICATION: The vast majority of Hawaii's citizens have health care insurance provided by either a medical service organization (i.e., mutual benefit society) or a health maintenance organization. Should one of these domestic health insurers face financial insolvency, policyholders and health care providers will not have the benefit of a guaranty association to assist in the payment of covered claims. Ensuring that covered claims will be paid minimizes the potential of financial loss to policyholders and health care providers and encourages continued health care treatment under policies affected by an insurer's financial insolvency.

Impact on the public: Policyholders and health care providers will benefit from the creation of a health insurance guaranty fund for domestic medical service organizations and health maintenance organizations, as coverages under existing policies of a financially insolvent insurer will continue until new policies are procured.

Impact on the department and other agencies: The Insurance Commissioner's existing duties will be expanded to provide administrative support to the newly created health insurance guaranty association.

HB2348

GENERAL FUNDS:	None.
OTHER FUNDS:	None.
PPBS PROGRAM DESIGNATION:	CCA-106.
OTHER AFFECTED AGENCIES:	None.
EFFECTIVE DATE:	Upon approval.