THE SENATE
THIRTY-THIRD LEGISLATURE, 2026
STATE OF HAWAII

S.B. NO. 2948

JAN 2 3 2026

A BILL FOR AN ACT

RELATING TO INSURANCE FRAUD.

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

PART I

SECTION 1. The legislature finds that insurance fraud is not a victimless crime and imposes substantial costs on policyholders, insurers, and state economies by increasing premiums, distorting insurance markets, and undermining public confidence in systems designed to provide protection during times of vulnerability. National data compiled by insurance regulators and industry oversight organizations estimate that insurance fraud results in annual costs exceeding $300,000,000,000 across the United States. State-level data demonstrates significant financial impact from fraudulent and abusive insurance claims over the past decade, including billions of dollars paid in bodily injury and related claims in multiple states.

The legislature further finds that regions exposed to natural disasters experience heightened risk of opportunistic fraud following emergency declarations, including unlicensed

contractor activity, litigation driven by false or inflated claims, and coordinated schemes involving improper financial inducements.

The legislature recognizes that insurance fraud increasingly operates across jurisdictional boundaries and that effective prevention and enforcement require coordinated, modernized, and data-driven responses. Florida, Kentucky, Louisiana, and North Dakota have enacted or proposed comprehensive insurance fraud reforms, including expanded statutory definitions, enhanced penalties, mandatory reporting requirements, and advanced analytic tools, that have resulted in substantial fraud recoveries and improved market stability. These other states' initiatives have been informed by collaborative, multi-state policy development efforts, including model frameworks and recommendations advanced through the National Council of Insurance Legislators and the National Association of Insurance Commissioners, which emphasize cross-agency coordination, standardized reporting, fraud analytics, and strong enforcement authority as essential components of effective insurance fraud prevention.

The purpose of this Act is to align the state insurance code with these multi-state legislative and enforcement efforts by establishing comprehensive insurance fraud prevention and enforcement mechanisms. The following new and amended sections are intended to deter fraudulent conduct, strengthen investigative and prosecutorial capacity, promote data sharing and modern enforcement tools, protect policyholders and insurers, and ensure market integrity, particularly during periods of heightened risk following declared emergencies.

PART II

SECTION 2. Section 431:2-401, Hawaii Revised Statutes, is amended by adding five new definitions to be appropriately inserted and to read as follows:

""Claim harvesting" means the solicitation, inducement, procurement, or acquisition of insurance claims or potential insurance claims through false, misleading, coercive, or deceptive practices.

"Disaster-related insurance activity" or "disaster-related services" means any insurance claim, solicitation, adjustment, repair, remediation, legal service, or construction service

arising from or related to a state-declared emergency, natural disaster, or catastrophic event.

"Fraud analytics" or "predictive analytics" means the use of statistical modeling, data mining, artificial intelligence, or other analytical techniques to identify patterns, trends, anomalies, or indicators of insurance fraud.

"Litigation financing arrangement" means any agreement under which a person or entity that is not a party to an insurance claim or legal action provides funding or financial assistance in exchange for a contingent interest in the proceeds of a claim or settlement.

"Post-loss assignment abuse" means the use of an assignment of insurance benefits or rights that are obtained, executed, or enforced through fraud, misrepresentation, coercion, or noncompliance with statutory disclosure, licensure, or bonding requirements."

PART III

SECTION 3. Chapter 431, Hawaii Revised Statutes, is amended by designating sections 431:2-401 to 431:2-410, as subpart A and inserting a title before section 431:2-401, to read as follows:

"A. General Provisions"

SECTION 4. Chapter 431, Hawaii Revised Statutes, is amended by adding three new sections to part IV, subpart A, of article 2 to be appropriately designated and to read as follows:

"**§431:2- Claims harvesting and solicitation; prohibited.** (a) No person shall engage in claims harvesting.

(b) Prohibited conduct under this section includes:

(1) Soliciting insurance claims or potential claims through false or misleading representations;

(2) Offering or providing anything of value, including cash, gifts, services, fee reductions, or other consideration, in exchange for the assignment of insurance benefits, the referral of a claimant, or the execution of a claim-related agreement;

(3) Using runners, call centers, social media campaigns, door-to-door solicitations, or disaster-response canvasing to obtain insurance claims through deception or coercion; and

(4) Misrepresenting licensure, qualifications, affiliations, or authority to induce a person to file or transfer an insurance claim.

(c) Each prohibited solicitation or inducement made in violation of this section shall constitute a separate violation.

§431:2- Litigation-related insurance fraud. (a) No person shall initiate, finance, support, or maintain litigation arising from an insurance claim using false, inflated, or unverified information.

(b) A litigation financing arrangement related to an insurance claim shall be prohibited if the arrangement:

(1) Is contingent upon the pursuit or maintenance of a fraudulent or unverified claim;

(2) Encourages inflated damages, unnecessary medical treatment, or manufactured injuries; or

(3) Obstructs disclosure of material information to an insurer or tribunal.

(c) Participation in a litigation financing arrangement in violation of this section shall constitute insurance fraud pursuant to this part.

§431:2- Confidentiality; centralized insurance fraud database; interagency data sharing. (a) Information obtained during an insurance fraud investigation, including all reports, data and information obtained pursuant to this part, shall be

confidential and not subject to disclosure, except as necessary for enforcement, prosecution, or otherwise required by law. The commissioner may share confidential information with prosecuting authorities, law enforcement agencies, regulatory agencies, or insurers for purposes of fraud detection and enforcement. Disclosure executed pursuant to this section shall not waive any privilege or confidentiality protection.

(b) The insurance commissioner may establish and maintain a centralized insurance fraud database for the collection, storage, analysis, and dissemination of information related to insurance fraud. The database may include:

(1) Fraud reports submitted under this part;

(2) Claims data and loss information;

(3) Licensing and disciplinary records; and

(4) Referral and enforcement outcomes.

(c) Access to the database, if established pursuant to subsection (b), shall be restricted to the commissioner, the insurance fraud investigations branch, and the authorized personnel of entities with whom the commissioner has entered into agreements to share data pursuant to this section. These entities may include:

(1) State and county agencies;

(2) Law enforcement entities;

(3) Prosecuting authorities;

(4) Other state insurance regulators;

(5) The National Association of Insurance Commissioners; and

(6) The National Council of Insurance Legislators.

(d) Data shared pursuant to this section shall be used solely for insurance fraud prevention, detection, investigation, prosecution, and development of enforcement strategies.

(e) The commissioner shall adopt reasonable policies for the retention, security, and destruction of insurance fraud data. Data management pursuant to this section shall comply with applicable state and federal privacy and cybersecurity standards."

PART IV

SECTION 5. Chapter 431, Hawaii Revised Statutes, is amended by adding a new subpart to article 2, part IV, to be appropriately designated and to read as follows:

"B. Disaster Related Insurance Fraud

§431:2- Post-loss assignment abuse; prohibited. (a) Post-loss assignment abuse is prohibited. A post-loss assignment of insurance benefits or rights shall be void and unenforceable if obtained through fraud, misrepresentation, coercion, or material nondisclosure.

(b) No person or insurer shall:

(1) Execute or enforce a post-loss assignment without providing clear written disclosure of the scope, duration, and financial impact of the assignment;

(2) Require or induce execution of a post-loss assignment as a condition of emergency or disaster-related services; or

(3) Use a post-loss assignment to circumvent licensing, bonding, or regulatory requirements.

(c) Any violation of this section shall constitute insurance fraud pursuant to this part.

§431:2- State-declared emergency fraud protections. Upon the issuance of a state or county emergency proclamation, the provisions of this part shall apply to all disaster-related insurance activity and shall be subject to heightened

enforcement standards pursuant to chapter 127A to prevent fraud, abuse, and exploitation of policyholders.

§431:2- Prohibition on emergency assignment coercion. No person or insurer shall require or induce a policyholder to execute a post-loss assignment of insurance benefits or rights as a condition of receiving emergency or disaster-related services. Any assignment obtained in violation of this section shall be deemed void and unenforceable. Each violation shall constitute an act of fraud under this part.

§431:2- Advertising and solicitation restrictions during emergencies. (a) During a declared emergency, no person or insurer shall advertise or solicit disaster-related insurance services in a manner that is false, misleading, or deceptive, including:

(1) Representing affiliation with an insurer, government agency, or emergency authority without authorization;

(2) Guaranteeing claim approval or specific settlement outcomes; or

(3) Using high-pressure tactics to obtain insurance assignments or contracts.

(b) Each prohibited advertisement or solicitation shall constitute a separate violation.

§431:2- Coordination with emergency management agencies. The commissioner may coordinate with state and county emergency management agencies, law enforcement, and licensing boards to monitor, investigate, and enforce compliance with this part during declared emergencies."

PART V

SECTION 6. Section 431:2-211, Hawaii Revised Statutes, is amended to read as follows:

"**§431:2-211 Annual report.** The commissioner[~~, as early each year as accurate preparation enables,~~] shall [~~prepare and~~] submit a report of its findings and recommendations, including any proposed legislation, to the legislature [~~a report which shall contain:~~] no later than twenty days prior to the convening of each regular session, which shall include but not be limited to:

(1) The condition of all insurers authorized to do business in this State during the preceding year[~~.~~];

(2) A summary of abuses and deficiencies in benefit payments, the complaints made to the commissioner and

their disposition, and the extent of compliance and noncompliance by each insurer with the provisions of this code[~~.~~];

(3) The number and types of insurance fraud investigations, as well as referrals for prosecution of insurance fraud, enforcement outcomes for insurance fraud prosecutions, amounts recovered from insurance fraud, and emerging fraud trends; and

[~~(3)~~] (4) Such additional information and comments relative to insurance activities in this State as the commissioner deems proper."

SECTION 7. Section 431:2-402, Hawaii Revised Statutes, is amended to read as follows:

"**§431:2-402 Insurance fraud investigations branch.** (a) There is established in the insurance division the insurance fraud investigations branch for the purposes set forth in this part.

(b) The branch shall:

(1) Conduct a statewide program for the prevention of insurance fraud under title 24, including chapters 431, 432, and 432D; provided that the branch shall not

have jurisdiction over workers' compensation under chapter 386;

(2) Notwithstanding any other law to the contrary, investigate and prosecute in administrative hearings and courts of competent jurisdiction all persons involved in insurance fraud violations; and

(3) Promote public and industry-wide education about insurance fraud.

(c) The branch may review and take appropriate action on complaints of fraud relating to insurance under title 24, including chapters 431, 432, and 432D, but excluding workers' compensation insurance under chapter 386. The branch may deploy fraud analytics or predictive analytics and case flagging systems to identify patterns, anomalies, and indicators of insurance fraud; prioritize investigations; and allocate enforcement resources; provided that the use of fraud analytics or predictive analytics shall not create a presumption of wrongdoing nor shall it be used as the sole basis for enforcement action.

(d) The commissioner shall employ or retain, by contract or otherwise, attorneys, investigators, investigator assistants,

auditors, accountants, physicians, health care professionals, paralegals, consultants, experts, and other professional, technical, and support staff as necessary to promote the effective and efficient conduct of the branch's activities. The commissioner may hire these employees without regard to chapter[~~s~~] 76 or 89.

(e) Notwithstanding any other law to the contrary, an attorney employed or retained by the branch may represent the State in any criminal, civil, or administrative proceeding to enforce all applicable state laws relating to insurance fraud, including criminal prosecutions, disciplinary actions, and actions for declaratory and injunctive relief. The attorney general may designate an attorney as a special deputy attorney general for purposes of this subsection.

(f) Investigators appointed and commissioned under this part shall have and may exercise all of the powers and authority of a police officer or of a deputy sheriff.

(g) Funding for the branch shall come from the compliance resolution fund established by section 26-9(o).

(h) The commissioner may adopt rules pursuant to chapter 91 to implement and administer this part, including rules

governing reporting thresholds, data submission standards, and analytic methodologies."

SECTION 8. Section 431:2-403, Hawaii Revised Statutes, is amended to read as follows:

"**§431:2-403 Insurance fraud.** (a) A person commits the offense of insurance fraud if the person:

(1) Intentionally or knowingly misrepresents or conceals, or attempts to misrepresent or conceal, material facts, opinions, intention, or law to obtain or attempt to obtain coverage, benefits, recovery, or compensation:

(A) When presenting, or causing or permitting to be presented, an application, whether written, typed, or transmitted through electronic media, for the issuance or renewal of an insurance policy or reinsurance contract;

(B) When presenting, or causing or permitting to be presented, false information on a claim for payment;

(C) When presenting, or causing or permitting to be presented, a claim for the payment of a loss;

(D) When presenting, or causing or permitting to be presented, multiple claims for the same loss or injury, including knowingly presenting [~~such~~] multiple and duplicative claims to more than one insurer;

(E) When presenting, or causing or permitting to be presented, any claim for payment of a health care benefit;

(F) When presenting, or causing or permitting to be presented, a claim for a health care benefit that was not used by, or provided on behalf of, the claimant;

(G) When presenting, or causing or permitting to be presented, improper multiple and duplicative claims for payment of the same health care benefit;

(H) When presenting, or causing or permitting to be presented, for payment any undercharges for benefits on behalf of a specific claimant unless any known overcharges for benefits under this

article for that claimant are presented for reconciliation at the same time;

(I) When fabricating, altering, concealing, making an entry in, or destroying a document whether typed, written, or through an audio or video tape or electronic media;

(J) When presenting, or causing or permitting to be presented, to a person, insurer, or other licensee false, incomplete, or misleading information to obtain coverage or payment otherwise available under an insurance policy;

(K) When presenting, or causing or permitting to be presented, to a person or producer, information about a person's status as a licensee that induces a person or insurer to purchase an insurance policy or reinsurance contract; [~~and~~]

(L) When making, or causing or permitting to be made, any statement, either typed, written, or through audio or video tape or electronic media, or claims by the person or on behalf of a person

with regard to obtaining legal recovery or benefits; and

(M) When presenting, causing to be presented, or preparing with knowledge or belief that it will be presented, any statement, application, estimate, invoice, record, or document containing false, incomplete, misleading, of deceptive information in support of an insurance claim, policy application, premium calculation, or benefit determination;

(2) Intentionally or knowingly aids, agrees, or attempts to aid, solicit, or conspire with any person who engages in an unlawful act as defined under this section; [~~or~~]

(3) Intentionally or knowingly makes, causes, or permits to be presented, any false statements or claims by any person or on behalf of any person during an official proceeding as defined by section 710-1000[~~.~~]; and

(4) Intentionally or knowingly offers or provides anything of value, including cash, gifts, services, or fee reductions, in exchange for the assignment of

insurance benefits, the referral of a claimant, or the execution of a claim-related agreement;

(5) Intentionally or knowingly initiates, supports, or benefits from a litigation financing arrangement arising from an insurance claim using false, inflated, or unverified information;

(6) Knowingly concealing, suppressing, or omitting any material fact that affects an insurer's evaluation, adjustment, settlement, or payment of a claim; or

(7) Knowingly benefiting directly or indirectly from the proceeds of insurance fraud.

If a person commits or attempts to commit any of the foregoing offenses at any stage of the insurance transaction, including but not limited to policy issuance, underwriting, claims solicitation, claims adjustment, payment, litigation, or settlement, each offense, omission, transaction, or claim submitted in furtherance thereof shall constitute a separate offense.

(b) Violation of subsection (a) is a criminal offense and shall constitute:

(1) A class B felony if the value of the benefits, recovery, or compensation obtained or attempted to be obtained exceeds $20,000[~~,~~] or if the offense involves a pattern or practice of insurance fraud;

(2) A class C felony if the value of the benefits, recovery, or compensation obtained or attempted to be obtained exceeds [~~$750,~~] $1,500 but is less than $20,000; or

(3) A misdemeanor if the value of the benefits, recovery, or compensation obtained or attempted to be obtained is [~~not in excess of $750.~~] less than $1,500.

Each violation of this section shall constitute a separate offense regardless of whether an insurer sustains a financial loss. A pattern or practice of insurance fraud exists when a person commits two or more violations of this section within five years. A pattern or practice of insurance fraud shall constitute an aggravating factor for purposes of penalties, enforcement actions, and prosecutorial discretion.

(c) This section shall not supersede any other law relating to theft, fraud, or deception. Insurance fraud may be prosecuted under this part, or any other applicable statute or

common law, or through civil actions or administrative enforcement, and all [~~such~~] applicable remedies shall be cumulative.

(d) A business entity shall be liable for insurance fraud committed by an officer, employee, agent, or contractor acting within the scope of the entity's business or for the benefit of the entity. Lack of direct knowledge by the entity shall not preclude liability if the entity failed to implement reasonable compliance or oversight measures."

SECTION 9. Section 431:2-405, Hawaii Revised Statutes, is amended by amending subsections (a) and (b) to read as follows:

"(a) In addition to or in lieu of criminal penalties under section 431:2-403(b), any person who commits insurance fraud as defined under section 431:2-403, may be subject to the administrative penalties or civil fines established in this section.

(b) If a person is found to have knowingly committed insurance fraud under this part, the commissioner may assess any or all of the following penalties:

(1) Restitution to any insurer, policyholder, or any other person, including the State or county for costs

incurred related to investigation or enforcement, of benefits or payments fraudulently received or other damages or costs incurred;

(2) A fine of not less than $5,000 and not more than [~~$10,000~~] $50,000 for each violation; [~~and~~]

(3) Reimbursement of attorneys' fees and costs of the party sustaining a loss under this part; provided that the State shall be exempt from paying attorneys' fees and costs to other parties[~~.~~];

(4) Sanctions, including but not limited to license suspension, license revocation, or probationary licensing conditions; and

(5) Disgorgement of profits obtained through insurance fraud."

SECTION 10. Section 431:2-409, Hawaii Revised Statutes, is amended to read as follows:

"**[~~§~~]§431:2-409[~~]~~] Mandatory reporting[~~.~~]; whistleblower protection.** (a) Within sixty days of an insurer or other licensee's employee or agent discovering credible information indicating a violation of section 431:2-403, or as soon thereafter as practicable, the insurer or licensee shall provide

to the branch information, including documents and other evidence, regarding the alleged violation of section 431:2-403. The insurance fraud investigations branch shall work with the insurer or licensee to determine what information shall be provided.

(b) Information provided pursuant to this section shall be protected from public disclosure to the extent authorized by chapter 92F and section 431:2-209; provided that the branch may release the information in an administrative or judicial proceeding to enforce this part to federal, state, or local law enforcement or regulatory authorities, the National Association of Insurance Commissioners, the National Insurance Crime Bureau, or an insurer or other licensee aggrieved by the alleged violation of section 431:2-403.

(c) An insurer or a person that submits a report of suspected insurance fraud to the insurance fraud investigations branch or a law enforcement agency in good faith shall be immune from civil or administrative liability arising from the report. Any retaliation from an employer against an employee who makes a report of suspected insurance fraud in good faith shall constitute a violation of section 378-62. This subsection shall

not apply to knowingly submitting false or malicious reports of suspected insurance fraud."

SECTION 11. Section 431:2-410, Hawaii Revised Statutes, is amended to read as follows:

"**[~~[~~]§431:2-410[~~]~~] Deposit into the compliance resolution fund.** All moneys that have been recovered by the department of commerce and consumer affairs as a result of prosecuting insurance fraud violations pursuant to this part, including civil fines, criminal fines, administrative fines, forfeitures, disgorged funds, and settlements, but not including restitution made pursuant to section 431:2-404, 431:2-405(b)(1), or 431:2-408, shall be deposited into the compliance resolution fund established pursuant to section 26-9(o)."

SECTION 12. Section 431:13-103, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate,

illustration, circular, statement, sales presentation, omission, or comparison that:

(A) Misrepresents the benefits, advantages, conditions, or terms of any insurance policy;

(B) Misrepresents the dividends or share of the surplus to be received on any insurance policy;

(C) Makes any false or misleading statement as to the dividends or share of surplus previously paid on any insurance policy;

(D) Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(E) Uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof;

(F) Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy;

(G) Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy;

(H) Misrepresents any insurance policy as being shares of stock;

(I) Publishes or advertises the assets of any insurer without publishing or advertising with equal conspicuousness the liabilities of the insurer, both as shown by its last annual statement; or

(J) Publishes or advertises the capital of any insurer without stating specifically the amount of paid-in and subscribed capital;

(2) False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing

any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading;

(3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance;

(4) Boycott, coercion, and intimidation.

(A) Entering into any agreement to commit, or by any action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; or

(B) Entering into any agreement on the condition, agreement, or understanding that a policy will

not be issued or renewed unless the prospective insured contracts for another class or an additional policy of the same class of insurance with the same insurer;

(5) False financial statements.

(A) Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of a material fact as to the financial condition of an insurer; or

(B) Knowingly making any false entry of a material fact in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or who has authority by law to

examine into its condition or into any of its affairs, or, with like intent, knowingly omitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer;

(6) Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance;

(7) Unfair discrimination.

(A) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any policy of life insurance or annuity contract or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract;

(B) Making or permitting any unfair discrimination in favor of particular individuals or persons, or between insureds or subjects of insurance having substantially like insuring, risk, and exposure factors, or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charge therefor, or in the benefits payable or in any other rights or privilege accruing thereunder;

(C) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk, unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(D) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, canceling, or limiting the amount of insurance coverage on a residential property risk, or the personal property contained therein, because of the age of the residential property, unless:

(i) The refusal, cancellation, or limitation is for a business purpose which is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(E) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex or marital status of the individual; however, nothing in this subsection shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits;

(F) Terminating or modifying coverage, or refusing to issue or renew any property or casualty policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired; provided that this subparagraph shall not apply to accident and health or sickness insurance sold by a casualty insurer; provided further that this subparagraph shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract;

(G) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual based solely upon the individual's having taken a human immunodeficiency virus (HIV) test prior to applying for insurance; or

(H) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because the individual

refuses to consent to the release of information which is confidential as provided in section 325-101; provided that nothing in this subparagraph shall prohibit an insurer from obtaining and using the results of a test satisfying the requirements of the commissioner, which was taken with the consent of an applicant for insurance; provided further that any applicant for insurance who is tested for HIV infection shall be afforded the opportunity to obtain the test results, within a reasonable time after being tested, and that the confidentiality of the test results shall be maintained as provided by section 325-101;

(8) Rebates. Except as otherwise expressly provided by law:

(A) Knowingly permitting or offering to make or making any contract of insurance, or agreement as to the contract other than as plainly expressed in the contract, or paying or allowing, or giving or offering to pay, allow, or give, directly or

indirectly, as inducement to the insurance, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits, or any valuable consideration or inducement not specified in the contract; or

(B) Giving, selling, or purchasing, or offering to give, sell, or purchase as inducement to the insurance or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value not specified in the contract;

(9) Nothing in paragraph (7) or (8) shall be construed as including within the definition of discrimination or rebates any of the following practices:

(A) In the case of any life insurance policy or annuity contract, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance; provided that any

bonus or abatement of premiums shall be fair and equitable to policyholders and in the best interests of the insurer and its policyholders;

(B) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense;

(C) Readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for the policy year;

(D) In the case of any contract of insurance, the distribution of savings, earnings, or surplus equitably among a class of policyholders, all in accordance with this article; and

(E) A reward under a wellness program established under a health care plan that favors an individual if the wellness program meets the following requirements:

(i) The wellness program is reasonably designed to promote health or prevent disease;

(ii) An individual has an opportunity to qualify for the reward at least once a year;

(iii) The reward is available for all similarly situated individuals;

(iv) The wellness program has alternative standards for individuals who are unable to obtain the reward because of a health factor;

(v) Alternative standards are available for an individual who is unable to participate in a reward program because of a health condition;

(vi) The insurer provides information explaining the standard for achieving the reward and discloses the alternative standards; and

(vii) The total rewards for all wellness programs under the health care plan do not exceed twenty per cent of the cost of coverage;

(10) Refusing to provide or limiting coverage available to an individual because the individual may have a third-party claim for recovery of damages; provided that:

(A) Where damages are recovered by judgment or settlement of a third-party claim, reimbursement of past benefits paid shall be allowed pursuant to section 663-10;

(B) This paragraph shall not apply to entities licensed under chapter 386 or 431:10C; and

(C) For entities licensed under chapter 432 or 432D:

(i) It shall not be a violation of this section to refuse to provide or limit coverage available to an individual because the entity determines that the individual reasonably appears to have coverage available under chapter 386 or 431:10C; and

(ii) Payment of claims to an individual who may have a third-party claim for recovery of

damages may be conditioned upon the individual first signing and submitting to the entity documents to secure the lien and reimbursement rights of the entity and providing information reasonably related to the entity's investigation of its liability for coverage.

Any individual who knows or reasonably should know that the individual may have a third-party claim for recovery of damages and who fails to provide timely notice of the potential claim to the entity, shall be deemed to have waived the prohibition of this paragraph against refusal or limitation of coverage. "Third-party claim" for purposes of this paragraph means any tort claim for monetary recovery or damages that the individual has against any person, entity, or insurer, other than the entity licensed under chapter 432 or 432D;

(11) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following:

(A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(B) With respect to claims arising under its policies, failing to respond with reasonable promptness, in no case more than fifteen working days, to communications received from:

(i) The insurer's policyholder;

(ii) Any other persons, including the commissioner; or

(iii) The insurer of a person involved in an incident in which the insurer's policyholder is also involved.

The response shall be more than an acknowledgment that such person's communication has been received and shall adequately address the concerns stated in the communication;

(C) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(D) Refusing to pay claims without conducting a reasonable investigation based upon all available information;

(E) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(F) Failing to offer payment within thirty calendar days of affirmation of liability, if the amount of the claim has been determined and is not in dispute;

(G) Failing to provide the insured, or when applicable the insured's beneficiary, with a reasonable written explanation for any delay, on every claim remaining unresolved for thirty calendar days from the date it was reported;

(H) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(I) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(J) Attempting to settle a claim for less than the amount to which a reasonable person would have believed the person was entitled by reference to written or printed advertising material accompanying or made part of an application;

(K) Attempting to settle claims on the basis of an application that was altered without notice, knowledge, or consent of the insured;

(L) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(M) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or

compromises less than the amount awarded in arbitration;

(N) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician or advanced practice registered nurse of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(O) Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage to influence settlements under other portions of the insurance policy coverage;

(P) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; and

(Q) Indicating to the insured on any payment draft, check, or in any accompanying letter that the payment is "final" or is "a release" of any claim if additional benefits relating to the claim are probable under coverages afforded by the policy; unless the policy limit has been paid or there is a bona fide dispute over either the coverage or the amount payable under the policy;

(12) Failure to maintain complaint handling procedures. Failure of any insurer to maintain a complete record of all the complaints that it has received since the date of its last examination under section 431:2-302. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaints, and the time it took to process each complaint. For purposes of this section, "complaint" means any written communication primarily expressing a grievance;

(13) Misrepresentation in insurance applications. Making false or fraudulent statements or representations on

or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, producer, or individual; [~~and~~]

(14) Failure to obtain information. Failure of any insurance producer, or an insurer where no producer is involved, to comply with section 431:10D-623(a), (b), or (c) by making reasonable efforts to obtain information about a consumer before making a recommendation to the consumer to purchase or exchange an annuity[~~.~~]; and

(15) Failure to comply with timelines during a declared emergency. Failure of any insurer to ensure timely and accurate handling of claims in compliance with reasonable inspection and documentation timelines established by the commissioner during a state of emergency or local emergency duly declared by the governor or a mayor pursuant to chapter 127A."

SECTION 13. Section 444-10.6, Hawaii Revised Statutes, is amended to read as follows:

"§444-10.6 **State of emergency or disaster; emergency licensure; penalties.** (a) Notwithstanding any other provision of law to the contrary, the board may issue emergency contractor's licenses during a local or state of emergency or disaster duly declared by the governor under chapter 209 or a mayor pursuant to chapter 127A or 209 upon a determination by the board that a shortage of Hawaii licensed contractors exists.

(b) To qualify for an emergency contractor's license, an applicant shall:

(1) Provide proof of licensure as a contractor in another state with similar contractor licensing requirements as those in this State, that the license is current, and that it has been in good standing for the past two years;

(2) Provide proof of liability and property damage insurance, obtained through an insurer authorized to do business in this State or other insurer acceptable to the board;

(3) Submit proof of workers' compensation insurance as specified in the board's rules;

(4) Submit a current financial statement prepared by a certified public accountant and applicable credit reports as specified in the board's rules;

(5) Pay all applicable application and license fees, including recovery fund and education fund fees;

(6) Submit a state tax clearance statement; and

(7) Provide proof of bond in the amount and in such form as set forth in section 444-16.5.

(c) The classifications of emergency contractor's licenses issued and the duration of the emergency contractor's licenses shall be determined by the board based on the nature and duration of the state of emergency or disaster, and the needs and best interests of the public.

(d) The board may delegate the issuance of emergency contractor's licenses to its administrative staff; provided that the applicant shall be required to meet all of the requirements specified in this section before the issuance of the license.

(e) Any person who violates section 444-9, in connection with the offer or performance of repairs to a residential or nonresidential structure for damage caused by a natural disaster in a political subdivision for which a state of emergency or

disaster is proclaimed by the governor, may be punished by a fine of up to $10,000, imprisonment up to one year, or both, in addition to all other remedies or penalties.

(f) During a state of emergency or a local state of emergency duly declared by the governor or a mayor pursuant to either chapter 127A or 209, the insurance commissioner may require all licensed contractors and licensed emergency contractors to maintain proof of bonding or financial responsibility as a condition of engaging in insured contracting activity. Failure to comply with bonding requirements imposed under this subsection shall constitute grounds for administrative penalties established in section 431:2-405. No contractor shall:

(1) Misrepresent the necessity, cost, or scope of repairs or remediation;

(2) Perform or bill for services not rendered;

(3) Represent that the contractor is affiliated with an insurer, government agency, or emergency response authority; or

(4) Solicit insurance proceeds directly from an insured claimant for services not yet performed.

The insurance commissioner may coordinate with state and county emergency management agencies, law enforcement, and the contractors license board to monitor, investigate, and enforce compliance with this subsection pursuant to part IV of chapter 431, article 2."

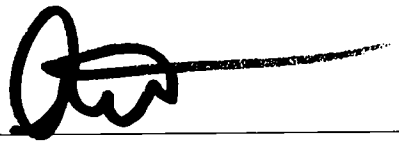
SECTION 14. If any provision of this Act, or the application thereof to any person or circumstance, is held invalid, the invalidity does not affect other provisions or applications of the Act that can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 15. There is appropriated out of the general revenues of the State of Hawaii the sum of $ or so much thereof as may be necessary for fiscal year 2026-2027 to be deposited into the compliance resolution fund to support insurance fraud investigations.

The sum appropriated shall be expended by the department of commerce and consumer affairs for the purposes of this Act.

SECTION 16. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 17. This Act shall take effect on July 1, 2026.

INTRODUCED BY: 

S.B. NO. 2948

Report Title:
DCCA; Insurance Division; Insurance Fraud Investigations Branch; Insurance Commissioner; Insurance Fraud; Declarations of Emergency; Centralized Database; Whistleblower Protection; Data Security; Contractors; Penalties; Reports; Appropriation

Description:
Increases the scope of insurance fraud and certain offenses. Augments offenses by contractors and insurers during a declared emergency. Clarifies the penalties for the offense of insurance fraud and the capabilities and operations of the Insurance Fraud Investigations Branch, including the annual report to the Legislature and the protection of sensitive information. Adds protection for insurance fraud whistleblowers. Authorizes the Insurance Commissioner to establish a centralized database for authorized agencies to track insurance fraud data. Appropriates funds.

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