THE SENATE
THIRTY-THIRD LEGISLATURE, 2026
STATE OF HAWAII

S.B. NO. 2964

JAN 23 2026

A BILL FOR AN ACT

RELATING TO PROPERTY INSURANCE.

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

SECTION 1. The legislature finds that widespread underinsurance slows community disaster recovery and increases the cost of aid provided by nonprofit and governmental entities. The legislature further finds that the 2023 Maui wildfires revealed that many homeowners were severely underinsured, leaving many affected residents unable to rebuild and forcing them into debt or permanent displacement.

The legislature recognizes that Hawaii faces rapidly escalating rebuilding costs due to the State's geographic isolation and reliance on imported materials, high labor costs, limited workforce availability, and lengthy permitting and rebuilding timelines. These factors cause replacement costs to rise quickly, often outpacing policy limits if coverage is not reviewed regularly.

The legislature notes that most homeowners do not receive annual updates about whether their coverage matches the current cost of rebuilding. Homeowners often discover that they are

underinsured only after a catastrophic loss. This lack of transparency leaves policyholders vulnerable and less likely to recover fully following a disaster.

The legislature finds that other states offer models for property insurance reform. Colorado requires insurers to disclose construction cost estimates at each renewal; to offer enhanced coverage, such as extended replacement cost and law and ordinance coverage; and to consider homeowner-provided estimates. California requires insurers providing replacement cost estimates to update their data annually and to include in the estimates detailed cost components such as labor, permits, demolition, and debris removal.

The legislature finds that Hawaii does not require annual replacement cost disclosures or offers to purchase full replacement coverage. Without these protections, homeowners may unknowingly remain underinsured, post-disaster rebuilding delays may increase, and nonprofit and government disaster relief efforts may face higher costs and longer timelines.

Accordingly, the purpose of this Act is to support faster and more resilient community recovery after disasters. Specifically, this Act requires insurers to:

(1) Give policyholders accurate, current information about dwelling rebuilding costs; and

(2) Annually disclose to policyholders whether rebuilding costs are fully covered, and if not, to offer full coverage.

SECTION 2. Chapter 431, Hawaii Revised Statutes, is amended by adding a new part to article 10E to be appropriately designated and to read as follows:

"**PART . REPLACEMENT COST DISCLOSURE AND INSURANCE TO VALUE**

§431:10E-A Definitions. As used in this part:

"Dwelling coverage limit" means the maximum amount the homeowners insurer will pay to repair, rebuild, or replace the home's physical structure and attached items after a covered loss.

"Homeowners insurance" has the same meaning as in section 431:14-110.8.

"Homeowners insurer" has the same meaning as in section 431:14-110.8.

"Policyholder" means the person named as the insured under the homeowners insurance.

"Replacement cost" means the amount necessary to repair, rebuild, or replace damaged property with materials of like kind and quality, without deduction for depreciation.

§431:10E-B Annual disclosure requirements. (a) At least once every twelve months and coinciding with policy renewal, each homeowners insurer shall provide the policyholder with a written replacement cost estimate prepared in accordance with section 431:10E-D that clearly states whether the current dwelling coverage limit will cover the replacement cost.

(b) The disclosure shall be titled "Replacement Cost Disclosure" and shall be delivered:

(1) In paper or electronic format; and

(2) Separately from the policy renewal package.

§431:10E-C Offer to insure to replacement cost. (a) If the dwelling coverage limit is less than the replacement cost, the homeowners insurer shall offer the policyholder the option to purchase additional coverage under the homeowners insurance to increase the dwelling coverage limit to equal the replacement cost.

(b) The offer shall:

(1) Include the premium for the increased coverage;

(2) Remain open for thirty days; and

(3) Be renewed annually.

§431:10E-D Requirements for replacement cost estimates. Any replacement cost estimate provided under this part shall:

(1) Be specific to the insured property;

(2) Be based on current local labor and material costs;

(3) Include all components of the replacement cost, including the cost of:

(A) Labor and materials;

(B) Overhead and profit;

(C) Demolition and debris removal;

(D) Architectural and engineering fees;

(E) Permits and inspections; and

(F) Other necessary costs;

(4) Take into consideration any estimate from a contractor or an architect submitted by the policyholder; and

(5) Be updated annually to reflect current costs.

§431:10E-E Recordkeeping and transparency. For at least five years after the homeowners insurance term has expired, homeowners insurers shall maintain documentation that supports

each replacement cost estimate and notes the policyholder's decision to accept or decline replacement cost coverage.

§431:10E-F Enforcement. Failure to comply with this part shall constitute an unfair or deceptive act or practice in the business of insurance under section 431:13-103."

SECTION 3. 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~~] that 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~~] that is false, or maliciously critical of or derogatory to the financial condition of an insurer, and [~~which~~] that 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~~] that 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~~] that 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~~] that 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~~] that fairly represents the saving in collection expense;

(C) [~~Readjustment of~~] Readjusting 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~~] distributing savings, earnings, or surplus equitably among a class of policyholders, all in accordance with this article; and

(E) [~~A~~] Offering 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, if 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~~] Failing to maintain a complete record of all the complaints [~~that it has~~] received since the date of [~~its~~] the 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~~] In the case of any insurance producer, or an insurer where no producer is involved, failing 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 disclose replacement cost or offer to insure to value. In the case of any homeowners insurer, failing to comply with part of article 10E of chapter 431."

SECTION 4. 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 5. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 6. This Act shall take effect upon its approval.

INTRODUCED BY:

S.B. NO. 2964

Report Title:
Homeowners Insurance; Underinsurance; Replacement Cost Value; Mandatory Disclosure; Offer to Insure to Value; Record Keeping

Description:
Requires homeowners insurers to provide policyholders with annual disclosures of replacement cost value and the sufficiency of policyholder's coverage. Requires homeowners insurers to offer annually to policyholders increased coverage if the property is underinsured. Requires homeowners insurers to maintain records of disclosures and offers for 5 years. Provides that failure to comply constitutes an unfair or deceptive act or practice in the business of insurance.

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