ACT 116

S.B. NO. 2697

A Bill for an Act Relating to Insurance.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Chapter 431, Hawaii Revised Statutes is amended as follows:

1. By adding a new section to article 3 to be appropriately designated and to read:

"§431:3- Statement of actuarial opinion; property and casualty insurance; confidentiality. (a) The statement of actuarial opinion shall be provided with the annual statement in accordance with the property and casualty annual statement instruction as adopted by the National Association of Insurance Commissioners and shall be treated as a public document.

(b) Documents, materials, or other information related to or provided in connection with an actuarial report, working papers, or actuarial opinion summary that are in possession or control of the commissioner shall be confidential by law and privileged, shall not be made public, subject to subpoena or discovery, and shall not be admissible as evidence in any private civil action; provided that:

(1) The commissioner may release the documents to the Actuarial Board for Counseling and Discipline or its successor to the extent that the material is required for the purpose of professional disciplinary proceedings and that the Actuarial Board for Counseling and Discipline or its successor establishes procedures satisfactory to the commissioner for preserving the confidentiality of the documents;

(2) This section shall not be construed to limit the commissioner's authority to use the documents, materials, or other information in furtherance of any regulatory or legal action brought as part of the commissioner's official duties; and

(3) Neither the commissioner nor any person who received documents, materials, or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to this subsection.

(c) The commissioner may share documents, materials, or other information, including the confidential and privileged documents, materials, or information subject to subsections (a) and (b), with other state, federal, and

international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal, and international law enforcement authorities; provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, or information and has the legal authority to do so.

(d) The commissioner may receive documents, materials, or other information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions. The commissioner shall maintain as confidential or privileged, subject to subsection (b)(3), any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(e) The commissioner may enter into agreements governing sharing and use of information consistent with subsections (b), (c), and (d).

(f) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information subject to this section shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsections (b), (c), and (d)."

2. By adding a new section to part II of article 9 to be appropriately designated and to read:

"**§431:9- Reporting of actions.** (a) A licensee shall report in writing to the commissioner any civil or administrative action taken against the licensee in any jurisdiction or by any governmental agency in the United States within thirty days of the final disposition of the matter.

(b) Within thirty days of arraignment, a licensee shall report in writing to the commissioner any criminal prosecution of the licensee being taken in any jurisdiction.

(c) A report pursuant to this section shall include a copy of the initial complaint or indictment and any and all other relevant legal documents."

3. By amending subsection (c) of section 431:2-208 to read:

"(c) An insurer or licensee shall issue a written response with reasonable promptness, in no case more than fifteen working days, to any written inquiry made by the commissioner regarding a claim [~~or~~], consumer complaint[~~,~~], or sales or marketing practice. The response shall be more than an acknowledgment that the commissioner's communication has been received, and shall adequately address the concerns stated in the communication."

4. By amending subsection (a) of section 431:4F-103 to read:

"(a) An alien insurer may use this [~~State~~] state as a state of entry to transact insurance in the United States through a United States branch by:

(1) Qualifying as an insurer licensed to do business in this [~~State;~~] state; and

(2) Establishing [~~a~~] trust [~~account,~~] accounts, pursuant to [~~a~~] trust [~~agreement~~] agreements approved by the commissioner with a United States financial institution approved by the commissioner, in an amount at least equal to the minimum capital and surplus or authorized control level risk-based capital, whichever is greater, required to be maintained by a domestic insurer licensed [~~to do~~] for the same kind of insurance."

5. By amending subsection (d) of section 431:9-203 to read:

"(d) As used in this section, "change of status" includes but shall not be limited to change of legal name, assumed name, trade name, business ad-

dress, home address, mailing address, business phone number, business fax number, business electronic mail address, business website address, or home phone number."

6. By amending subsection (b) of section 431:9-228 to read:

"(b) The licensee shall [~~promptly~~] notify the commissioner of any change of business address[~~.~~] within thirty days of the change."

7. By amending subsection (f) of section 431:9A-107 to read:

"(f) A licensee shall:

(1) Inform the commissioner by any means acceptable to the commissioner of any change of status within thirty days of the change; and

(2) Report any change of status to the business registration division if the licensee is a business entity registered with the department of commerce and consumer affairs pursuant to title 23 or title 23A, or if the licensee has registered a trade name pursuant to part I of chapter 482.

Failure to timely inform the commissioner or the business registration division of a change of status may result in a penalty pursuant to section 431:2-203.

As used in this subsection, "change of status" includes but shall not be limited to change of legal name, assumed name, trade name, business address, home address, mailing address, business phone number, business fax number, business electronic mail address, or business website address."

8. By amending subsection (c) of section 431:9A-122 to read:

"(c) The licensee shall [~~promptly~~] notify the commissioner [~~in writing~~] of any change of business address[~~.~~] within thirty days of the change."

9. By adding a new definition in section 431:9C-101 to be appropriately inserted and to read:

""Producer" has the same meaning as in section 431:9A-102."

10. By amending section 431:9C-102 to read:

"**§431:9C-102 Licensure.** (a) No person, firm, association, or corporation shall act as a managing general agent, with respect to risks located in this [~~State~~] state for an insurer licensed in this [~~State,~~] state, unless licensed as a producer in this [~~State.~~] state.

(b) No person, firm, association, or corporation shall act as a managing general agent[~~,~~] representing an insurer domiciled in this [~~State~~] state with respect to risks located outside this [~~State,~~] state unless licensed as a producer in this [~~State.~~] state.

~~[(c) The commissioner shall require the managing general agent to furnish a bond in an amount equal to $100,000 or ten per cent of annual gross direct written premiums, whichever is greater, with an insurance company licensed to do business within the State or with an insurance company approved by the commissioner, for the protection of the insurer. Each managing general agent shall provide the commissioner with:~~

~~(1) Proof of the bond at the time of the initial application for licensure;~~

~~(2) Appropriate documentation at the time of each renewal to show that the bond continues to be in effect or that a new bond has been secured; and~~

~~(3) Any other report required by the commissioner.~~

~~(d) The commissioner shall require the managing general agent to maintain an errors and omissions policy in an amount equal to $1,000,000 or twenty-five per cent of annual gross direct written premiums, whichever is greater, with~~

~~an insurance company licensed to do business within the State or an insurance company approved by the commissioner. Each managing general agent shall provide the commissioner with:~~

~~(1) Proof of the policy at the time of the initial application for licensure;~~

~~(2) Appropriate documentation at the time of each renewal to show that the policy continues to be in effect or that a new policy has been secured; and~~

~~(3) Any other report required by the commissioner.~~]"

11. By amending section 431:9C-103 to read:

"**§431:9C-103 Required contract provisions.** No person, firm, association, or corporation acting as a managing general agent shall place business with an insurer unless there is in force[~~,~~] a written contract between the managing general agent and the insurer which sets forth the responsibilities of each party [~~and,~~]; where both the managing general agent and the insurer share responsibility for a particular function, specifies the division of those responsibilities[~~,~~] and which contains at least the following additional provisions:

(1) The insurer may terminate the contract for cause upon written notice to the managing general agent[~~. The insurer~~] and may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination;

(2) The managing general agent shall render accounts to the insurer detailing all transactions and shall remit all funds due under the contract to the insurer on not less than a monthly basis;

(3) All funds collected for the account of an insurer shall be held by the managing general agent in a fiduciary capacity and shall be deposited in an account in a bank which is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer by the managing general agent. The managing general agent may retain no more than three months estimated claims payments and allocated loss adjustment expenses;

(4) Separate records of business written by the managing general agent shall be maintained in the [~~licensee's~~] managing general agent's office. The insurer shall have [~~access to and~~] the right to access and to copy all accounts and records of the managing general agent related to the insurer's business in a form usable by the insurer[~~, and~~]; the commissioner shall have access to all books, bank accounts, and records of the managing general agent in a form usable to the commissioner. Records shall be in an organized form according to each class of insurance and shall include the following information to the extent it is applicable:

(A) A record of each insurance contract procured or issued, together with the names of the insurers and insureds, the amount of premium paid or to be paid, or the basis of the premium or consideration paid or to be paid, and a statement of the subject of the insurance;

(B) The names of any other licensees from whom business is accepted and the names of persons to whom commissions or allowances of any kind are promised or paid;

(C) A record of each investigation or adjustment undertaken or consummated and a statement of any fee, commission, or other compensation received or to be received by [~~the~~] an adjuster on account of [~~the~~] each investigation or adjustment;

(D) A record of each bill reviewed and a statement of any fee, commission, or other compensation received or to be received by the independent bill reviewer on account of the bill reviewed; and

(E) Any additional information as shall be customary or as may reasonably be required by the commissioner.

This paragraph shall not apply to life or accident and health or sickness insurance if the records required of [~~such~~] that insurance are customarily maintained in the offices of the insurer;

(5) The contract may not be assigned in whole or in part by the managing general agent;

(6) Appropriate underwriting guidelines including:

(A) The maximum annual premium volume;

(B) The basis of the rates to be charged;

(C) The types of risks which may be written;

(D) Maximum limits of liability;

(E) Applicable exclusions;

(F) Territorial limitations;

(G) Policy cancellation provisions; and

(H) The maximum policy period.

The insurer shall have the right to cancel or nonrenew any policy of insurance subject to the applicable laws and rules concerning the cancellation and nonrenewal of insurance policies;

(7) The insurer shall require the managing general agent to obtain and maintain a surety bond for the protection of the insurer. The bond amount shall be $100,000 or ten per cent of the managing general agent's total nationwide annual written premium for the insurer in the prior calendar year, whichever is greater; provided that the amount of the surety bond shall not exceed $500,000;

(8) The insurer shall require the managing general agent to obtain and maintain an errors and omissions policy in the minimum amount of $1,000,000;

[~~(7)~~] (9) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(A) All claims shall be reported to the insurer in a timely manner;

(B) A copy of the claim file shall be sent to the insurer [~~at its~~] upon request or as soon as it becomes known that the claim:

(i) Has the potential to exceed [~~an~~] a threshold amount determined by the commissioner or [~~exceeds the~~] a limit set by the insurer, whichever is less;

(ii) Involves a coverage dispute;

(iii) May exceed the managing general agent's claims settlement authority;

(iv) Is open for more than six months; or

(v) Is closed by payment of [~~an~~] a threshold amount set by the commissioner or an amount set by the insurer, whichever is less;

(C) All claim files shall be the joint property of the insurer and managing general agent. However, upon an order of liquidation of the insurer, the files shall become the sole property of the insurer or its estate; provided that the managing general agent shall have reasonable access to and the right to copy the files on a timely basis;

(D) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract[. The]; provided that the insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination; and

(E) Where electronic claims files are in existence, the contract shall address the timely transmission of the data;

[(8)] (10) If the contract provides for a sharing of interim profits by the managing general agent[,] and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves [or], controlling claim payments, or in any other manner, interim profits shall not be paid to the managing general agent until one year after they are earned for property insurance business and five years after they are earned on casualty business and, in any event, not until the profits have been verified through examination pursuant to section 431:9C-105; and

[(9)] (11) The managing general agent shall not:

(A) Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with whom those automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured, and commission schedules;

(B) Commit the insurer to participate in insurance or reinsurance syndicates;

(C) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which the producer is appointed;

(D) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one per cent of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;

(E) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report shall be promptly forwarded to the insurer;

(F) Permit its subagent to serve on the board of directors of the insurer;

(G) Employ an individual who is also employed by the insurer [also]; or

(H) Appoint a sub-managing general agent."

12. By amending section 431:9C-104 to read:

"**[§]§431:9C-104[§] Duties of insurers.** (a) An insurer shall have on file an independent financial examination in a form acceptable to the commissioner of each managing general agent with whom it has done business [in a form acceptable to the commissioner].

(b) If a managing general agent establishes loss reserves, the insurer shall annually obtain the opinion of an independent actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business pro-

duced by the managing general agent. [~~This is~~] The opinion required by this subsection shall be in addition to any other required loss reserve certification required by this chapter.

(c) The insurer shall conduct at least semiannually an on-site review of the underwriting and claims processing operations of the managing general agent.

(d) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the managing general agent.

(e) The insurer shall notify the commissioner in writing within thirty days of entering into or terminating a contract with a managing general agent. [~~Notices~~] Notice of the appointment of a managing general agent shall include a statement of the duties [~~which~~] that the managing general agent is expected to perform on behalf of the insurer, the lines of insurance for which the managing general agent [~~is to~~] shall be authorized to act, and any other information the commissioner may [~~request.~~] require.

(f) An insurer shall review its books and records each quarter to determine if any producer[~~, as defined in section 431:11A-101,~~] has become a managing general agent[~~.~~] of the insurer. If the insurer determines that a producer has become a managing general agent[~~,~~] of the insurer, the insurer shall promptly notify the producer and the commissioner [~~of the determination~~] and the insurer and producer shall both fully comply with this article within thirty days.

(g) An insurer shall not appoint to its board of directors an officer, director, employee, subagent, or controlling shareholder of any of its managing general agents; provided that this subsection shall not apply to relationships governed by article 11.

(h) The insurer shall keep the bond and the errors and omissions policy required by section 431:9C-103 on file for review by the commissioner or other applicable regulatory agency."

13. By amending section 431:9N-102 to read:

"**[~~[~~§431:9N-102[~~]~~] License denial, nonrenewal, suspension, or revocation.** In addition to [~~causes in~~] the authority granted by section 431:9A-112, the commissioner may deny, place on probation, suspend, revoke, or refuse to issue or renew a bail agent's license and may levy a civil fine or penalty in accordance with articles 2 and 9A, or take any combination of these actions, for any of the following causes:

(1) [~~Failing~~] Failure to satisfy, pay, or otherwise discharge a bail forfeiture judgment after [~~having~~] the bail agent's name [~~placed~~] is on the board for more than forty-five consecutive days for the same forfeiture;

(2) Failure to satisfy, pay, or otherwise discharge a final, nonappealable bail forfeiture judgment within sixty days following notice of entry of judgment;

[~~(2)~~ ~~Failing~~] (3) Failure to report, to preserve without use and retain separately, or to return collateral [~~taken~~] received as security on any bond to the principal or depositor of the collateral;

[~~(3)~~ ~~Failing~~] (4) Failure to pay a final, nonappealable judgment award for failure to return or repay collateral received to secure a bond;

[~~(4)~~] (5) Continuing [~~to execute~~] execution of bail bonds in any court in this [~~State~~] state while on the board, where the bail forfeiture judgment that resulted in [~~being placed~~] placement on the board has not been paid, stayed, vacated, exonerated, or otherwise discharged; or

[~~(5) Paying,~~] (6) Payment, directly or indirectly, of any commission, service fee, brokerage, or other valuable consideration to any person selling, soliciting, or negotiating bail within this [~~State~~] state unless, at the time the services were performed, the person was [~~a~~] duly licensed [~~bail agent~~] for the performance of the services."

14. By amending section 431:10-244 to read:

"§431:10-244 Filing procedure for contracts approved by commissioner. Each insurance contract requiring approval by the commissioner pursuant to this code, section 392-48 [~~and~~], or section 386-124 and each contract certified by the insurer to be in conformity with this code shall be accompanied by a $20 fee payable to the commissioner, which [~~fee~~] shall be deposited [~~in~~] into the commissioner's education and training fund."

15. By amending section 431:10A-105 to read:

"§431:10A-105 Required provisions. Except as provided in section 431:10A-107, each policy of accident and health or sickness insurance delivered or issued for delivery to any person in this [~~State~~] state shall contain the provisions set forth below. These provisions shall be in the words in which they appear below; provided that the insurer may substitute corresponding provisions of different wording [~~approved by the commissioner~~] certified by an officer of the insurer to be in substantial conformance with the wording below that are in each instance not less favorable in any respect to the insured or the beneficiary. The provisions shall be preceded individually by the specified caption, or by [~~such~~] appropriate individual or group captions or subcaptions [~~as the commissioner may approve.~~] that are substantially similar to the specified captions. The provisions required by this section are as follows:

(1) "Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless the approval is endorsed on or attached to this policy. No agent has authority to change this policy or to waive any of its provisions[~~.~~]";

(2) (A) "Time Limit on Certain Defenses:

(i) After three years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for this policy shall be used to void this policy or to deny a claim for loss incurred or disability [~~(~~] as defined in the policy[~~)~~] commencing after the expiration of the three-year period[~~.~~]; and

(ii) No claim for loss incurred or disability [~~(~~]as defined in the policy[~~)~~] commencing after three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded on the date of loss from coverage by name or specific description effective [~~on the date of loss~~] had existed prior to the effective date of coverage of this policy[~~.~~]";

(B) The policy provision set forth in subparagraph (A)(i) shall not be construed to affect any legal requirement for avoidance of a policy or denial of a claim during the initial three-year period, nor to limit the application of section 431:10A-106(1) through (4) in the event of misstatement with respect to age [~~or~~], occupation, or other insurance[~~.~~]; and

(C) A policy that the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of subparagraph (A)(i) the following provision [~~(~~]from which the clause in parentheses may be omitted at the insurer's option[~~)~~]: "Incontestable: After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application[~~.~~]";

(3) (A) "Grace period: A grace period of (insert a number not less than seven for weekly premium policies, ten for monthly premium policies, and thirty-one for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force[~~.~~]";

(B) A policy that contains a cancellation provision may add at the end of the [~~above~~] provision[~~:~~] required by subparagraph (A): "subject to the right of the insurer to cancel in accordance with the cancellation provision[~~.~~]"; and

(C) A policy in which the insurer reserves the right to refuse any renewal shall have at the beginning of the [~~above~~] provision[~~:~~] required by subparagraph (A): "Unless not less than thirty days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted[~~.~~]";

(4) (A) "Reinstatement: If any renewal premium is not paid within the time granted to the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided that if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of the application by the insurer or, lacking approval, upon the forty-fifth day following the date of conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than ten days after that date. In all other respects the insured and insurer shall have the same rights as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with the reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement[~~.~~]"; and

(B) The last sentence in subparagraph (A) may be omitted from any policy that the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue[~~.~~];

(5) (A) "Notice of Claim: Written notice of claim [~~must~~] shall be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at (insert the location of the office as the insurer may designate for the purpose) or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer[~~.~~]"; and

(B) In a policy providing a loss of time benefit that may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences in subparagraph (A): "Subject to the qualification set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of the disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of the claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in giving notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which notice is actually given[~~.~~]";

(6) "Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant [~~the~~] any forms[~~,~~] that are usually furnished by it for filing proofs of loss. If the forms are not furnished within fifteen days after the giving of notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made[~~.~~]";

(7) "Proofs of Loss: In case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, written proof of loss must be furnished to the insurer at its office within ninety days after the termination of the period for which the insurer is liable, and in case of claim for any other loss within ninety days after the date of loss. Failure to furnish proof of loss within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within the time required, provided proof is furnished as soon as reasonably possible and in no event, except [~~in~~] the absence of legal capacity, later than fifteen months from the time proof is otherwise required[~~.~~]";

(8) "Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment [~~will~~] shall be paid immediately upon receipt of due written proof of loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic

payment [~~will~~] shall be paid (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability [~~will~~] shall be paid immediately upon receipt of due written proof[~~.~~]";

(9) (A) "Payment of Claims: Indemnity for loss of life [~~will~~] shall be payable in accordance with the beneficiary designation and the provisions respecting payment which may be prescribed herein and effective at the time of payment. If no designation or provision is then effective, the indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the designated beneficiary or to the estate of the insured. All other indemnities [~~will~~] shall be payable to the insured[~~.~~]"; and

(B) [~~The~~] Either or both of the following provisions[~~, or either of them,~~] may be included with the provision set forth in subparagraph (A) at the option of the insurer:

(i) "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay the indemnity, up to an amount not exceeding $2,000 to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of the payment[~~.~~]"; and

(ii) "Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of loss, be paid directly to the hospital or person rendering the services; but it is not required that the service be rendered by a particular hospital or person[~~.~~]";

(10) "Physical Examinations and Autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law[~~.~~]";

(11) "Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No action at law or in equity shall be brought after the expiration of three years after the time written proof of loss is required to be furnished[~~.~~]"; and

(12) (A) "Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change [~~of~~] the beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy[~~.~~]"; and

(B) The first clause of subparagraph (A), relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option."

16. By amending section 431:10A-106 to read:

"**§431:10A-106 Optional provisions.** Except as provided in section 431:10A-107, no policy of accident and health or sickness insurance delivered or issued for delivery to any person in this [~~State~~] state shall contain the provisions set forth below unless the provisions are in the words in which they appear below; provided that the insurer may substitute corresponding provisions of different wording [~~approved by the commissioner~~] certified by an officer of the insurer to be in substantial conformance with the wording below that are in each instance not less favorable in any respect to the insured or the beneficiary. [~~Such~~] The provisions listed in this section are optional provisions. Any [~~such provision~~] of the following provisions contained in the policy shall be preceded individually by the specified caption or, at the option of the insurer, by [~~such~~] appropriate individual or group captions or subcaptions [~~as the commissioner may approve.~~] substantially similar to the specified caption. The provisions are as follows:

(1) "Change of Occupation: If the insured is injured or contracts sickness after having changed occupations to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only [~~such~~] the portion of the indemnities provided in this policy [~~as~~] that the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured's occupation changes to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of [~~such~~] the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is [~~the~~] more recent. In applying this provision, the classification of occupational risk and the premium shall be [~~such~~] those as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if [~~such~~] a filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in [~~such~~] the state where the insured resided prior to the occurrence of the loss or prior to the date of proof of change in occupation[~~.~~]";

(2) "Misstatement of Age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the insured's correct age[~~.~~]";

(3) Other insurance in this insurer shall be in one of the following forms:

(A) "Other Insurance in This Insurer: If an accident and health or sickness policy or policies previously issued by the insurer to the insured [~~be~~] concurrently in force [~~concurrently herewith~~], making the aggregate indemnity for (insert type of coverage or coverages) in excess of $ (insert maximum limit of indemnity or indemnities) the excess insurance shall be void and all

premiums paid for [~~such~~] the excess shall be returned to the insured or to the insured's estate[.]"; or

(B) "Other Insurance in This Insurer: Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one [~~such~~] policy elected by the insured, the insured's beneficiary, or the insured's estate, as the case may be, and the insurer [~~will~~] shall return all premiums paid for all other [~~such~~] policies[.]";

(4) Insurance with other insurers. Either or both of the following forms shall be used:

(A) (i) "Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for [~~such~~] the proportion of the loss [~~as the amount which~~] that would otherwise have been payable [~~hereunder~~] plus the total of the like amounts under all [~~such~~] the other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for [~~such~~] the loss, and for the return of [~~such~~] the portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the like amount of [~~such~~] other coverage shall be taken as the amount which the services rendered would have cost in the absence of [~~such~~] the other coverage[.]"; and

(ii) "Insurance with Other Insurers: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for [~~such~~] benefits under this policy shall be for [~~such~~] the proportion of the indemnities otherwise provided hereunder for [~~such~~] a loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all the indemnities for [~~such~~] the loss, and for the return of [~~such~~] the portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined[.]";

(B) If the provision set forth in subparagraph (A)(i) is included in a policy that also contains the provision set forth in subparagraph (A)(ii), there shall be added to the caption of the subparagraph (A)(i) provision the phrase, "expense incurred benefits[.]"[1];

(C) The insurer may, at its option, include in the provision set forth in subparagraph (A)(i) a definition of other valid coverage, approved as to form by the commissioner, which [~~definition~~] shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this State or any other state or territory of the

United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of [~~such~~] a definition the term shall not include group insurance, automobile medical payment insurance, or coverage provided by hospital or medical service organizations, union welfare plans, or employer or employee benefit organizations. For the purpose of applying the provision set forth in subparagraph (A)(i) with respect to any insured, any amount of benefit provided for [~~such~~] an insured pursuant to any compulsory benefit statute (including any workers' compensation or employers' liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be other valid coverage of which the insurer has had notice. In applying the provision set forth in subparagraph (A)(i), no third party liability coverage shall be included as other valid coverage[~~.~~];

(D) If the provision set forth in subparagraph (A)(ii) is included in a policy that also contains the provision set forth in subparagraph (A)(i), there shall be added to the caption of the subparagraph (A)(ii) provision the phrase, "other benefits"[~~.~~]; and

(E) The insurer may, at its option, include in the provision set forth in subparagraph (A)(ii) a definition of other valid coverage, approved as to form by the commissioner, which [~~definition~~] shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this [~~State~~] state or any other state or territory of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of [~~such~~] a definition the term shall not include group insurance, or benefits provided by union welfare plans or employer or employee benefit organizations. For the purpose of applying the provision set forth in subparagraph (A)(ii) with respect to any insured, any amount of benefit provided for [~~such~~] an insured pursuant to any compulsory benefit statute [~~(~~]including any workers' compensation or employers' liability statute[~~)~~], whether provided by a governmental agency or otherwise, shall in all cases be deemed to be other valid coverage of which the insurer has had notice. In applying the provision set forth in subparagraph (A)(ii), no third party liability coverage shall be included as other valid coverage[~~.~~];

(5) (A) "Relation of Earnings to Insurance: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, [~~shall exceed~~] exceeds the monthly earnings of the insured at the time disability commenced or the insured's average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is [~~the~~] greater, the insurer [~~will~~] shall be liable only for [~~such~~] the proportionate amount of [~~such~~] benefits under this policy as the amount of [~~such~~] the monthly earnings or [~~such~~] average monthly earnings of the insured

bears to the total amount of monthly benefits for the same loss under all [~~such~~] coverage upon the insured at the time [~~such~~] disability commences and for the return of [~~such~~] the part of the premiums paid during [~~such~~] the two preceding years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all [~~such~~] coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in [~~such~~] the coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time[~~.~~]";

(B) The policy provision in subparagraph (A) may be inserted only in a policy which the insured has the right to continue in force, subject to its terms by the timely payment of premiums until at least age fifty or, in the case of a policy issued after age forty-four, for at least five years from its date of issue[~~.~~]; and

(C) The insurer may, at its option, include in the provision set forth in subparagraph (A) a definition of valid loss of time coverage approved as to form by the commissioner, which [~~definition~~] shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this [~~State~~] state or any state, district, or territory of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of [~~such~~] approved coverages. In the absence of [~~such~~] a definition [~~such~~] the terms shall not include any coverage provided for [~~such~~] an insured pursuant to any compulsory benefit statute [~~(~~]including any workers' compensation or employers' liability statute[~~)~~], or benefits provided by union welfare plans or by employer or employee benefit organizations[~~.~~];

(6) "Unpaid Premium: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted [~~therefrom.~~] from the claim";

(7) "Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to the insured's last address as shown by the records of the insurer[~~, stating~~]. The notice shall state when, not less than five days thereafter, [~~such~~] the cancellation shall be effective[~~; and after~~]. After the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on [~~such~~] a later date [~~as may be~~] specified in [~~such~~] the notice. In the event of cancellation, the insurer [~~will~~] shall return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation[~~.~~]";

(8) "Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on [~~such~~] the effective date is hereby

amended to conform to the minimum requirements of [~~such~~] the applicable statutes[~~.~~]";

(9) "Illegal Occupation: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation[~~.~~]"; and

(10) "Intoxicants and Narcotics: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."""

17. By amending section 431:10A-107 to read:

"**§431:10A-107 Inapplicable or inconsistent provisions.** If any provision of section 431:10A-105 to section 431:10A-111 is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer[~~, with the approval of the commissioner,~~] shall omit from [~~such~~] the policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision [~~in such manner as~~] to make the provision [~~as~~] contained in the policy consistent with the coverage provided by the policy. An officer of the insurer shall certify conformity with the requirements of state statutes in accordance with this section."

18. By amending section 431:10C-210 to read:

"**§431:10C-210 Publication of premium rates.** The commissioner shall publish annually, in a newspaper of general circulation in the [~~State,~~] state, notice of availability of a list of all motor vehicle insurers with representative annual premiums for motor vehicle insurance. [~~In addition, the~~] The commissioner shall have information on premiums for motor vehicle insurance which shall be available to the public on request."

19. By amending subsection (d) of section 431:10C-215 to read:

"(d)(1) Each insurer licensed to transact motor vehicle insurance or optional additional insurance business in this [~~State~~] state shall provide the commissioner with periodic reports on every aspect of the motor vehicle insurance and the optional additional insurance business the insurer transacts in [~~the State,~~] this state, including, but not limited to[~~,~~] reports on the investment, reserve, reinsurance, loss and profit experience, ratemaking and schedules, claims received and paid; and

(2) Each insurer subject to this section shall, not less frequently than quarterly, maintain a report [~~to the commissioner~~] of the details of each claim received, claim paid, application for and sale of a motor vehicle insurance policy, each termination and renewal refusal notice posted, and each cancellation and refusal to renew effected on both motor vehicle insurance and optional additional insurance policy transactions. The insurer shall make available and submit a report to the commissioner at the commissioner's request."

20. By amending subsection (a) of section 431:10D-111 to read:

"(a) A life insurer may, under [~~such~~] policy provisions or agreements [~~as have been approved by the commissioner consistent with this section~~], contract for and accept premium deposits in addition to the regular premiums specified in the policy, for the purpose of paying future premiums, [~~or~~] to facilitate conversion of the policy, or to increase the benefits [~~thereof.~~] of the policy, according to this section."

21. By amending subsection (c) of section 431:10D-603 to read:

"(c) If the buyer's guide and disclosure document are not provided at or before the time of application, a free-look period of no less than fifteen days shall be provided for the applicant to return the annuity contract without penalty, which period shall run [~~concurrently~~] consecutively with any other free-look period provided by law."

22. By amending subsection (b) of section 431:11-101 to read:

"(b) The commissioner may exempt:

(1) Any insurer or class of insurers from any provision of this article, when the commissioner deems the exemption consistent with the purposes of this article and in the public interest; or

(2) Upon request of the person required to supply information or perform an act, that person from any provision of this article, when the commissioner deems the exception consistent with the purposes of this article and in the public interest."

23. By amending subsection (a) of section 431:11-106 to read:

"(a)(1) Transactions within a holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(A) The terms shall be fair and reasonable;

(B) Charges or fees for services performed shall be reasonable;

(C) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(D) The books, accounts, and records of each party to all transactions shall be maintained so as to clearly and accurately disclose the nature and details of the transactions including the accounting information necessary to support the reasonableness of the charges or fees to the respective parties; and

(E) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs[~~.~~];

(2) The following transactions involving a domestic insurer and any person in its holding company system [~~may~~] shall not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty days prior thereto, or a shorter period as the commissioner may permit, and the commissioner has not disapproved it within that period:

(A) Sales, purchases, exchanges, loans[~~,~~] or extensions of credit, guarantees, or investments; provided that the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three per cent of the insurer's admitted assets or twenty-five per cent of surplus as regards policyholders each as of the thirty-first day of December next preceding; or

(ii) With respect to life insurers, three per cent of the insurer's admitted assets as of the thirty-first day of December next preceding;

(B) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of, or to make investments in, any affiliate of the insurer making the

loans or extensions of credit; provided that the transactions are equal to or exceed:

(i) With respect to nonlife insurers, the lesser of three per cent of the insurer's admitted assets or twenty-five per cent of surplus as regards policyholders each as of the thirty-first day of December next preceding; or

(ii) With respect to life insurers, three per cent of the insurer's admitted assets as of the thirty-first day of December next preceding;

(C) Reinsurance agreements or modifications thereto in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds five per cent of the insurer's surplus as regards policyholders, as of the thirty-first day of December next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one or more affiliates of the insurer;

(D) All management agreements, service contracts, and all cost-sharing arrangements; and

(E) Any material transactions, specified by rule, which the commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing in this section shall be deemed to authorize or permit any transactions which, in the case of an insurer not a member of the same holding company system, would be otherwise contrary to law[~~.~~];

(3) A domestic insurer may not enter into transactions[~~,~~] which are part of a plan or series of like transactions with persons within the holding company system[~~,~~] if the purpose of those separate transactions is to avoid the statutory threshold amount and thus avoid the review that would otherwise occur. If the commissioner determines that the separate transactions were entered into over any twelve-month period for that purpose, the commissioner may exercise the commissioner's authority under section 431:11-111[~~.~~];

(4) The commissioner, in reviewing transactions pursuant to subsection (a)(2), shall consider whether the transactions comply with the standards set forth in subsection (a)(1) and whether they may adversely affect the interests of policyholders[~~.~~]; and

(5) The commissioner shall be notified within thirty days of any investment of the domestic insurer in any one [~~corporation~~] person if the total investment in the [~~corporation~~] person by the insurance holding company system exceeds ten per cent of the corporation's voting securities."

24. By amending subsection (f) of section 431:13-103 to read:

"(f) An insurer or licensee shall issue a written response with reasonable promptness, in no case more than fifteen working days, to any written inquiry made by the commissioner regarding a claim [~~or~~], consumer complaint[~~.~~], or sales or marketing practice. The response shall be more than an acknowledgment that the commissioner's communication has been received, and shall adequately address the concerns stated in the communication."

25. By amending subsection (b) of section 431:19-107 to read:

"(b) Each class 3 captive insurance company shall annually file with the commissioner the following:

(1) Annual statement and audit:
(A) On or before March 1, or such day subsequent thereto as the commissioner upon request and for cause may specify, an annual statement using the National Association of Insurance Commissioners' annual statement blank plus any additional information required by the commissioner, which shall be a true statement of its financial condition, transactions, and affairs as of the immediately preceding December 31. The reported information shall be verified by oaths of at least two of the captive's principal officers;
(B) On or before June 1, or such day subsequent thereto as the commissioner upon request and for cause may specify, an audit by a designated independent certified public accountant or accounting firm of the financial statements reporting the financial condition and results of the operation of the captive; and
(C) The annual statement and audit shall be prepared in accordance with the National Association of Insurance Commissioners' annual statement instructions, accounting practices and procedures manual, and rules adopted by the commissioner following the [~~practice~~] practices and procedures prescribed by the National Association of Insurance [~~Commissioners' practices and procedures manuals;~~] Commissioners; and
(2) On or before each March 1, or such day subsequent thereto as the commissioner upon request and for cause may specify, a risk-based capital report in accordance with section 431:3-402; provided that a class 3 association captive insurance company shall not be required to file risk-based capital reports with the National Association of Insurance Commissioners."

26. By amending the definition of "member" in section 431:30-102 to read:

""Member" means the [~~person chosen by~~] commissioner of a compacting state, as its representative to the commission, or the [~~person's~~] commissioner's designee."

27. By amending subsection (d) of section 431:30-112 to read:

"(d) A compacting state may opt out of a uniform standard, either by legislation or by rule adopted by the insurance commissioner. If a compacting state elects to opt out of a uniform standard by rule, it shall:
(1) Give written notice to the commission no later than ten business days after the later of the adoption of the uniform standard or the state becoming a compacting state; [~~and~~]
(2) Find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state that warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The commissioner shall consider and balance the following factors and find that the conditions in the state and needs of the citizens of the state outweigh:
(A) The intent of the legislature to participate in, and reap the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this [~~Act;~~] article; and

(B) The presumption that a uniform standard adopted by the commission provides reasonable protections to consumers of the relevant product.

Notwithstanding the foregoing, a compacting state may, at the time of its enactment of this compact, prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for such opt out in the enacted compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any state to participate in this compact. [~~Such an~~] An opt out pursuant to this section shall be effective at the time of enactment of this compact by the compacting state and shall apply to all existing uniform standards involving long-term care insurance products and those subsequently adopted[~~.~~]; and

(3) In accordance with the provisions of paragraph (2), this State does prospectively opt out of all uniform standards involving long-term care insurance products promulgated by the commission, as this State has previously enacted article 10H providing additional standards for federal conformity and universal availability for reciprocal beneficiary and multi-generation populace which facilitates flexibility and innovation in the development of long-term care insurance coverage."

SECTION 2. Section 432:1-404, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Each society shall file with the commissioner annually, on or before March 1 in each year, a statement under oath, and in such form and detail as the commissioner shall prescribe; provided that any association or society organized and operating as a nonprofit medical indemnity or hospital service association shall file a report with the commissioner covering the preceding calendar year and verified by at least two principal officers. Each mutual benefit society shall file quarterly with the commissioner, on or before the forty-fifth day after each quarter, a copy of its quarterly report verified by at least two principal officers. The report shall comply with sections 431:3-301 and 431:3-302. The commissioner may prescribe the forms on which the report is to be filed.

In addition, any association or society organized and operating as a nonprofit medical indemnity or hospital service association annually shall file with the commissioner the following by the dates specified:

(1) An audit, by an independent certified public accountant or an accounting firm designated by the association or society, of the financial statements, reporting the financial condition and results of operations of the association or society on or before June 1, or a later date as the commissioner upon request or for cause may specify. The association or society, on an annual basis and prior to the commencement of the audit, shall notify the commissioner in writing of the name and address of the person or firm retained to conduct the annual audit. The commissioner may disapprove the association's or society's designation within fifteen days of receipt of the association's or society's notice, and the association or society shall be required to designate another independent certified public accountant or accounting firm. The audit required [~~in~~] by this paragraph shall be prepared in accordance with the National Association of Insurance Commissioners' [~~annual statement instructions,~~] accounting practices and procedures manual and rules adopted by the commissioner following the practices and procedures prescribed

by the National Association of Insurance [~~Commissioners' accounting practices and procedures manuals;~~] Commissioners; and

(2) A description of the available grievance procedures, the total number of grievances handled through those procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances on or before March 1."

SECTION 3. Section 432D-5, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Every health maintenance organization shall file annually, on or before March 1, a report verified by at least two principal officers covering the preceding calendar year. Each health maintenance organization shall file quarterly with the commissioner, on or before the forty-fifth day after each quarter, a copy of its quarterly report verified by at least two principal officers. These reports shall comply with sections 431:3-301 and 431:3-302. The commissioner may prescribe the forms on which the reports are to be filed. In addition, the health maintenance organization annually shall file with the commissioner the following by the dates specified:

(1) An audit, by an independent certified public accountant or an accounting firm designated by the health maintenance organization of the financial statements, reporting the financial condition and results of operations of the health maintenance organization on or before June 1, or a later date as the commissioner upon request or for cause may specify. The health maintenance organization, on an annual basis and prior to the commencement of the audit, shall notify the commissioner in writing of the name and address of the person or firm retained to conduct the annual audit. The commissioner may disapprove the health maintenance organization's designation within fifteen days of receipt of the health maintenance organization's notice, and the health maintenance organization shall be required to designate another independent certified public accountant or accounting firm. The audit required [~~in~~] by this paragraph shall be prepared in accordance with the National Association of Insurance Commissioners' [~~annual statement instructions;~~] accounting practices and procedures manual and rules adopted by the commissioner following the practices and procedures prescribed by the National Association of Insurance [~~Commissioners' accounting practices and procedures manuals;~~] Commissioners;

(2) A list of the providers who have executed a contract that complies with section 432D-8(d) on or before March 1; and

(3) A description of the available grievance procedures, the total number of grievances handled through those procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances on or before March 1."

SECTION 4. Section 431:30-105, Hawaii Revised Statutes, is repealed.

SECTION 5. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.[2]

SECTION 6. This Act shall take effect on July 1, 2010.

(Approved May 18, 2010.)

Notes

1. So in original.
2. Edited pursuant to HRS §23G-16.5.