ACT 250 S.B. NO. 2767

A Bill for an Act Relating to Insurance.

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

SECTION 1. Section 431:16-105, Hawaii Revised Statutes, is amended as follows:

1. By adding three new definitions to be appropriately inserted and to read:

""Insured" means any named insured, any additional insured, any vendor, any lessor, or any other party identified as an insured under the policy.

"Receiver" includes liquidator, rehabilitator, conservator, or ancillary receiver, as applicable.

"Self-insurer" means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance."

2. By amending the definitions of "covered claim" and "net direct written premiums" to read:

""Covered claim":

(1) Means an unpaid claim, including one for unearned premiums, submitted by a claimant, that arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this part applies issued by an insurer, if the insurer becomes an insolvent insurer after July 1, 2000, and:
   (A) The claimant or insured is a resident of this State at the time of the insured event; provided that for entities other than an individual, the residence of a claimant, insured, or policyholder is the state in which its principal place of business is located at the time of the insured event; or
   (B) The claim is a first party claim for damage to property with a permanent location in this State; and

(2) Shall not include:
   (A) Any amount awarded as punitive or exemplary damages;
   (B) Any amount sought as a return of premium under any retrospective rating plan;
   (C) Any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries, reinsurance recoveries, contribution, indemnification, or otherwise;
   (D) Any first party claims by an insured whose net worth exceeds $25,000,000 on December 31 of the year prior to the year in which the insurer becomes an insolvent insurer; provided that an insured's net worth on that date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis; [~~or~~]
   (E) Any first party claims by an insured who is an affiliate of the insolvent insurer[~~.~~];
   (F) Any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent;
   (G) Any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured

or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the association;

(H) Any claims for interest; or

(I) Any claim filed with the association or a liquidator for protection afforded under the insured's policy for incurred but not reported losses.

"Net direct written premiums" means direct gross premiums written in this State on insurance policies to which this part applies, including policy and membership fees, less [~~return~~] the following amounts:

(1) Return premiums [~~thereon~~];

(2) Premiums on policies not taken; and [~~dividends~~]

(3) Dividends paid or credited to policyholders on such direct business.

Net direct written premiums [~~do~~] shall not include premiums on contracts between insurers or reinsurers."

SECTION 2. Section 431:16-108, Hawaii Revised Statutes, is amended to read as follows:

"**§431:16-108 Powers and duties of the association.** (a) The association shall:

(1) Be obligated to the extent of the covered claims existing prior to the order of liquidation and arising within thirty days after the order of liquidation, or before the policy expiration date if less than thirty days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:

(A) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;

(B) An amount not exceeding $10,000 per policy for a covered claim for the return of unearned premium; or

(C) An amount not exceeding $300,000 per claim for all other covered claims.

In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the stated policy limit of the insolvent insurer under the policy from which the claim arises. Notwithstanding any other provisions of this part, a covered claim shall not include a claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. Any obligation of the association to defend an insured shall cease upon the association's payment or tender of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit;

(2) Be deemed the insurer, but only to the extent of its obligation on covered claims and to that extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to the right to pursue and retain salvage and subrogation recoverable on covered claim obligations to the extent paid by the association;

(3) Assess insurers amounts necessary to pay the obligations of the association under paragraph (1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and the cost of examinations under section 431:16-113, and other

expenses authorized by this part. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bears to the net direct written premiums of all member insurers for the preceding calendar year. Each member insurer shall be notified of the assessment not later than thirty days before it is due. No member insurer may be assessed in any year an amount greater than two per cent of that member insurer's net direct written premiums for the preceding calendar year. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. Payments shall be refunded to those companies receiving larger assessments by virtue of the deferment, or at the election of the companies, credited against future assessments. Each member insurer may set off against any assessment payments authorized by the administrator of the association to be made on covered claims and expenses incurred in the payment of the claims by the member insurer;

(4) Investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims and may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which the settlements, releases, and judgments may be properly contested. The association may appoint or substitute and direct legal counsel retained under liability insurance policies for the defense of covered claims;

(5) Notify the persons as the commissioner directs under section 431:16-ll0(b)(l);

(6) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but the designation may be declined by a member insurer;

(7) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and pay the other expenses of the association authorized by this part; and

(8) Have the authority, notwithstanding sections 431:10C-ll0 and 431:10C-111, to cancel all policies issued by an insolvent insurer. Covered claims under these policies shall be paid by the association in an amount not to exceed the stated policy limit of the insolvent

insurer under the policy from which the claim arises, or as provided under paragraph (1)(A) to (C), whichever is less.

(b) The association may:

(1) Employ or retain the persons as are necessary to handle claims and perform other duties of the association;

(2) Borrow funds necessary to effect the purposes of this part in accord with the plan of operation;

(3) Sue or be sued;

(4) Negotiate and become a party to the contracts as are necessary to carry out the purpose of this part; and

(5) Perform all other acts as are necessary or proper to effectuate the purpose of this part.

(c) Except for actions by the receiver, all actions relating to or arising out of this part against the association shall be brought in the courts in this State. The courts in this State shall have exclusive jurisdiction over all actions relating to or arising out of this part against the association.

The exclusive venue in any action by or against the association shall be the circuit court of the first judicial circuit of this State. The association, at its option, may waive this venue as to specific actions."

SECTION 3. Section 431:16-112, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Any person having a claim against an insurer whether or not the insurer is a member insurer under any provision in an insurance policy other than a policy of an insolvent insurer [~~which~~] that is also a covered claim, shall be required to exhaust first the person's rights under the policy. Any amount payable on a covered claim under this part shall be reduced by the amount of any recovery under the insurance policy. If there are any other policies issued by an insolvent insurer applicable to the covered claim, then all such policies [~~must first~~] shall be exhausted before any claim can be deemed a covered claim subject to being covered by the association.

(1) A claim under a policy providing liability coverage to a person who may be jointly and severally liable as a joint tortfeasor with a person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury, or loss that gave rise to the covered claim against the association.

(2) A claim under an insurance policy other than a life insurance policy shall include, but is not limited to:

(A) A claim against a health maintenance organization, a hospital plan corporation, a professional health service corporation, or disability insurance policy; and

(B) Any amount payable by or on behalf of a self-insurer.

(3) The person insured by the insolvent insurer's policy may not be pursued by a third-party claimant for any amount paid to the third party by which the association's obligation is reduced by the application of this section."

SECTION 4. Section 431:16-203, Hawaii Revised Statutes, is amended to read as follows:

"**§431:16-203 Coverage and limitations.** (a) This part shall provide coverage[~~,~~] for the policies and contracts specified in subsection (b) to:

(1) Persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under paragraph (2); [~~and~~]

(2) Persons who are owners of or certificate holders under such policies or contracts, except structured settlement annuities, and who:

(A) Are residents[~~;~~] of this State; or

(B) Are not residents[~~, but only under all of the following conditions:~~]; provided that:

(i) The [~~insurers which~~] insurer that issued [~~such~~] the policies or contracts [~~are~~] is domiciled in this State;

(ii) [~~Such insurers never held a license or certificate of authority in the states in which such persons reside;~~

~~(iii) Such states have associations similar to the association created by this part; and~~

~~(iv) Such persons are not eligible for coverage by such associations.~~] The state in which the persons reside has associations similar to the association created by this part; and

(iii) The persons are not eligible for coverage by an association in any other state because the insurer was not licensed in the state at the time specified in the state's guaranty association law;

(3) For structured settlement annuities specified in subsection (b), paragraphs (1) and (2) of this subsection shall not apply, and this part, except as provided in paragraphs (4) and (5) of this subsection, shall provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(A) Is a resident of this State, regardless of where the contract owner resides; or

(B) Is not a resident; provided that:

(i) The contract owner of the structured settlement annuity is a resident and neither the payee, beneficiary, nor contract owner is eligible for coverage by the association in the state in which the payee or contract owner resides; or

(ii) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this State and the state in which the contract owner resides has an association similar to the association created by this part, and neither the payee, beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;

(4) This part shall not provide coverage to a person who is a payee or beneficiary of a contract owner resident of this State, if the payee or beneficiary is afforded any coverage by the association of another state; and

(5) This part is intended to provide coverage to a person who is a resident of this State and, in certain circumstances, to a nonresident. To avoid duplicate coverage, if a person who would otherwise receive coverage under this part is provided coverage under the laws of any other state, the person shall not be provided coverage under this part. In determining the application of the provisions of this paragraph in situations where a person could be covered by the associa-

tion of more than one state, whether as an owner, payee, beneficiary, or assignee, this part shall be construed in conjunction with other state laws to result in coverage by only one association.

(b)(1) This part shall provide coverage to the persons specified in subsection (a) for direct, nongroup life, accident and health or sickness, or[1] annuity[~~, supplemental~~] policies or contracts, [~~and~~] for certificates under direct group life, accident and health or sickness, or annuity policies [~~and~~] or contracts, and for supplemental contracts to any of these, in each case issued by member insurers except as limited by this part[~~;~~]. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(2) This part shall not provide coverage for:

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

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

(C) Any portion of a policy or contract to the extent that the rate of interest on which it is based:

(i) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

(ii) On or after the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(D) Any portion of a policy or contract issued to a plan or program of an employer, association, or [~~similar entity~~] other person to provide life, accident and health or sickness, or annuity benefits to its employees [~~or~~], members, or other persons to the extent that [~~such~~] the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or [~~similar entity~~] other person under:

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

(ii) A minimum premium group insurance plan;

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

(iv) An administrative services only contract;

(E) Any portion of a policy or contract to the extent that it provides dividends [~~or~~], experience rating credits, or voting rights, or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of such policy or contract;

(F) Any policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certifi-

cate of authority to issue such policy or contract in this State; [~~and~~]

(G) [~~Any annuity contract or group annuity certificate which is not issued to or owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.~~] Any portion of a policy or contract to the extent that the assessments required by this part with respect to the policy or contract are preempted or otherwise not permitted by federal or state law;

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

(i) Claims based on marketing materials;

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

(iii) Misrepresentations of or regarding policy benefits;

(iv) Extra-contractual claims; or

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

(I) Any contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(J) Any unallocated annuity contract;

(K) Any portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but that have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this part. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under section 431:16-403(b)(2)(L), the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency and shall not be subject to forfeiture; or

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

(c) The benefits for which the association may become liable shall in no event exceed the lesser of:

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

(2) With respect to any one life, regardless of the number of policies or contracts:

(A) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

[~~(B) $100,000 in accident and health or sickness insurance benefits, including any net cash surrender and net cash withdrawal values;~~

~~(C) $100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;~~

~~provided that in no event shall the association be liable to expend more than $300,000 in the aggregate with respect to any one life under subparagraphs (A), (B), and (C).~~]

(B) In accident and health or sickness insurance benefits:

(i) $100,000 for coverages not defined as disability insurance or basic hospital, medical, and surgical insurance, or major medical insurance or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(ii) $300,000 for disability insurance and $300,000 for long-term care insurance; or

(iii) $500,000 for basic hospital, medical, and surgical insurance or major medical insurance;

(C) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(D) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any.

(d) In no event shall the association be obligated to cover more than:

(1) An aggregate of $300,000 in benefits with respect to any one life under subsection (c) except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under subsection (c)(2)(B), in which case the aggregate liability of the association shall not exceed $500,000 with respect to any one individual; or

(2) $5,000,000 in benefits with respect to one owner or multiple nongroup policies of life insurance, regardless of:

(A) The number of policies and contracts held by the owner;

(B) Whether the policy owner is an individual, firm, corporation, or other person; and

(C) Whether the persons insured are officers, managers, employees, or other persons.

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

(f) In performing its obligations to provide coverage under section 431:16-208, the association shall not be required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, the contractual obligations of the insolvent or impaired insurer under a covered

policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract."

SECTION 5. Section 431:16-205, Hawaii Revised Statutes, is amended as follows:

1. By adding seven new definitions to be appropriately inserted and to read:

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

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

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

"Owner", "policy owner", or "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms "owner", "contract owner", and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

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

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

"Structured settlement annuity" means an annuity purchased to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant."

2. By amending the definitions of "covered policy", "impaired insurer", "member insurer", "person", "premiums", "resident", and "supplemental contract" to read:

""Covered policy" means any policy or contract [~~within the scope of this part~~] or portion of a policy or contract for which coverage is provided under section 431:16-203.

"Impaired insurer" means a member insurer that after July 1, 1988, is not an insolvent insurer, and[~~:~~

~~(1) Is deemed by the commissioner to be potentially unable to fulfill its contractual obligations; or~~

~~(2) Is~~] is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

"Member insurer" means any insurer licensed or who holds a certificate of authority to transact in this State any kind of insurance for which coverage is provided under section 431:16-203, and includes any insurer whose license or certificate of authority in this State may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:

(1) A nonprofit hospital or medical service organization;
(2) A health maintenance organization;
(3) A fraternal benefit society;
(4) A mandatory state pooling plan;

(5) A mutual assessment company or any entity that operates on an assessment basis;
(6) An insurance exchange; [~~or~~]
(7) An organization that has a certificate or license limited to the issuance of charitable gift annuities; or
[~~(7)~~] (8) Any entity similar to any of the above.

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

"Premiums" means amounts and considerations received on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. Premiums does not include any amounts or consideration received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under section 431:16-203(b) except that assessable premium shall not be reduced on accounts under section 431:16-203(b)(2)(C) relating to interest limitations and section 431:16-203(c)(2) relating to limitations with respect to any one life and any one contract holder. Premiums shall also not include:
(1) Premiums on an unallocated annuity contract; or
(2) Premiums in excess of $5,000,000, regardless of:
(A) The number of policies or contracts held by the owner, with respect to multiple non-group policies of life insurance owned by one owner;
(B) Whether the policy owner is an individual, firm, corporation, or other person; and
(C) Whether the persons insured are officers, managers, employees, or other persons.

"Resident" means [~~any~~] a person to whom a contractual obligation is owed and who resides in this State [~~at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed.~~] on the date of entry of a court order that determines a member insurer to be an impaired insurer or an insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States who are:
(1) Residents of foreign countries; or
(2) Residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this part,
shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

"Supplemental contract" means [~~any~~] a written agreement entered into for the distribution of [~~policy or contract~~] proceeds[~~.~~] under a life, health, or annuity policy or life, health, or annuity contract."

SECTION 6. Section 431:16-206, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

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

SECTION 7. Section 431:16-208, Hawaii Revised Statutes, is amended to read as follows:

"§431:16-208 Powers and duties of the association. (a) If a member insurer is an impaired [~~domestic~~] insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, that are approved by the commissioner, and that are, except in cases of court ordered conservation or rehabilitation, also approved by the impaired insurer:

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

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

(3) Loan money to the impaired insurer.

[~~(b)(1) If a member insurer is an impaired insurer, whether domestic, foreign, or alien, and the insurer is not paying claims timely, then subject to the preconditions specified in paragraph (2), the association shall, in its discretion, either:~~

~~(A) Take any of the actions specified in subsection (a), subject to the conditions therein, or~~

~~(B) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for: accident and health or sickness claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.~~

~~(2) The association shall be subject to the requirements of paragraph (1) only if:~~

~~(A) The laws of the impaired insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations;~~

~~(i) The delinquency proceeding shall not be dismissed;~~

~~(ii) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management; and~~

~~(iii) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and~~

~~(B) (i) If the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this State, or;~~

~~(ii) If the impaired insurer is a foreign or alien insurer:~~

~~(I) It has been prohibited from soliciting or accepting new business in this State,~~

~~(II) Its certificate of authority has been suspended or revoked in this State, and~~

~~(III) A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.~~

~~(c)~~] (b) If a member insurer is an insolvent insurer, the association shall, in its discretion[~~, either~~]:

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

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

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

(2) [~~With respect only to life and accident and health or sickness insurance policies, provide~~] Provide benefits and coverages in accordance with [~~subsection (d).~~

~~(d) When proceeding under subsection (b)(1)(B) or (c)(2), the association shall, with respect to only life and accident and health or sickness insurance policies:~~

~~(1)~~ ~~Assure~~] the following provisions:

(A) With respect to life and accident and health or sickness insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and renewability) that would have been payable under the policies of the insolvent insurer, for claims incurred:

[~~(A)~~] (i) With respect to group policies[~~,~~] and contracts, not later than the earlier of the next renewal date under [~~such~~] the policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to [~~such~~] the policies;

[~~(B)~~] (ii) With respect to [~~individual~~] non-group policies, contracts, and annuities, not later than the earlier of the next renewal date (if any) under [~~such~~] the policies or contracts or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to [~~such~~] the policies[~~,~~] or contracts.

[~~(2)~~] (B) Make diligent efforts to provide all known insureds or [~~group policyholders~~] annuitants (for non-group policies and contracts), or group policy owners with respect to group policies and contracts, thirty [~~days'~~] days notice of the termination of the benefits provided[~~; and~~].

[~~(3)~~] (C) With respect to [~~individual~~] non-group life and accident and health or sickness insurance policies[~~,~~] and annuities covered by the association, make available to each known insured[~~,~~] or annuitant, or owner if other than the insured[~~,~~] or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with [~~paragraph (4),~~] subparagraph (D), if the insureds or annuitants had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class.

[~~(4) (A)~~] (D) (i) In providing the substitute coverage required under [~~paragraph (3),~~] subparagraph (C), the association may offer either to reissue the terminated coverage or to issue an alternative policy.

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

[~~(C)~~] (iii) The association may reinsure any alternative or reissued policy.

[~~(5) (A)~~] (E) (i) Alternative policies adopted by the association shall be subject to the approval of the domiciliary commissioner[~~.~~] or the receivership court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

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

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

[~~(6)~~] (F) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance commissioner or by a court of competent jurisdiction.

[~~(7)~~] (G) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.

[~~(e)~~] (H) When proceeding under [~~subsections (b)(1)(B) or (c)~~] subsection (b)(2) with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with section 431:16-203(b)(2)(C).

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

[~~(g)~~] (d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

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

[~~(i)~~] (f) In carrying out its duties under [~~subsections (b) and (c),~~] subsection (b), the association may, subject to approval by [~~the~~] a court[~~:~~] in this State:

(1) Impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this part are less than the amounts needed to assure full and prompt performance of the association's duties under this part, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; and

(2) Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of any moratorium or moratorium charge imposed by the receivership court on the payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, except that the association may not defer the payment for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

[~~(j)~~] (g) If the association fails to act within a reasonable period of time as provided in [~~subsections (b)(1)(B), (c) and (d),~~] subsection (b), the commissioner shall have the powers and duties of the association under this part with respect to [~~impaired or~~] the insolvent [~~insurers.~~] insurer.

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

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

[~~a third party~~] any person or property against whom the association may have rights through subrogation [~~of the insurer's policyholders.~~] or otherwise.

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

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

(3) In addition to [~~items~~] paragraphs (1) and (2), the association shall have all common law rights of subrogation and any other equitable or legal remedy [~~which~~] that would have been available to the impaired or insolvent insurer [~~or holder of a policy or contract with respect to such policy or contracts.~~], or owner, beneficiary, or payee of a policy or contract with respect to the policy or contracts.

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

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

[~~(n)~~] (k) The association may:

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

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 431:16-209 and to settle claims or potential claims against it;

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

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

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

(6) Exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic life or accident and health or sickness insurer, but in no case may the association issue

insurance policies or annuity contracts other than those issued to perform its obligations under this part[.];

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

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

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

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

(m) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation or rehabilitation, the association may elect to succeed to the rights of the insolvent insurer arising after the date of the order of liquidation or rehabilitation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that the contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the association shall pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

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

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

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

(q) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under subsection (a) or (b), the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;

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

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

SECTION 8. Section 431:16-209, Hawaii Revised Statutes, is amended to read as follows:

"**§431:16-209 Assessments.** (a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at eighteen per cent per annum on and after the due date.

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

(1) Class A assessments shall be [~~made~~] authorized and called for the purpose of meeting administrative and legal costs, and other expenses and examinations conducted under the authority of section 431:16-212(e). Class A assessments may be [~~made~~] authorized and called whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be [~~made~~] authorized and called to the extent necessary to carry out the powers and duties of the association under section 431:16-208 with regard to an impaired or an insolvent insurer.

(c)(1) The amount of any Class A assessment shall be determined by the board of directors and may be [~~made~~] authorized and called on a pro rata or non-pro rata basis. If pro rata, the board of directors may provide that it be credited against future Class B assessments. A non-pro rata assessment shall not exceed [~~$150~~] $300 per member insurer in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board of directors in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this State by each assessed member insurer [~~]on[~~] policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to [~~such~~] the premiums received on business in this State for [~~such~~] the calendar years by all assessed member insurers.

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

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board of directors, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is

abated, or deferred in whole or in part, the amount by which [~~such~~] the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused the deferral have been removed or rectified, the member shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

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

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

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

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

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses[~~,~~] and claims.

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

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

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

a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

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

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

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

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

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

SECTION 9. Section 431:16-210, Hawaii Revised Statutes, is amended by amending subsections (c) and (d) to read as follows:

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

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

(2) Establish the amount and method of reimbursing members of the board of directors under section 431:16-207(c);

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

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

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

(6) Establish any additional procedures for assessments under section 431:16-209;

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

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

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

(d) The plan of operation may provide that any or all powers and duties of the association, except those under [~~section 431:16-208(n)(3)~~] sections 431:16-208(k)(3) and [~~section~~] 431:16-209, are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. [~~Such a~~] The corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with

the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this part."

SECTION 10. Section 431:16-212, Hawaii Revised Statutes, is amended as follows:

1. By amending subsection (a) to read:

"[~~[~~](a)[~~]~~] To aid in the detection and prevention of insurer insolvencies or impairments, it shall be the duty of the commissioner:

(1) To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when the commissioner takes any of the following actions against a member insurer:
   (A) Revocation of license;
   (B) Suspension of license; or
   (C) Makes any formal order that [~~such~~] the company [~~restricts~~] restrict its premium writing, obtain additional contributions to surplus, withdraw from the State, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors.

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

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

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

(4) To furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. [~~Such~~] The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority."

2. By amending subsection (c) to read:

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

3. By amending subsection (e) to read:

"(e) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of such request, the commissioner shall begin [~~such~~] the examina-

tion. The examination may be conducted as a National Association of Insurance Commissioners' examination or may be conducted by such persons as the commissioner designates. The cost of [~~such~~] the examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall [~~such~~] the examination report be released to the board of directors prior to its release to the public, but this shall not excuse the commissioner from complying with subsection (a). The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it shall not be open to public inspection prior to the release of the examination report to the public."

SECTION 11. Section 431:16-214, Hawaii Revised Statutes, is amended to read as follows:

"**§431:16-214 Miscellaneous provisions.** (a) Nothing in this part shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) [~~All meetings and records of the board of directors shall be open to all member insurers except for those meetings and records pertaining to the solvency, liquidation, rehabilitation, or conservation of any member insurer deemed confidential. A member insurer shall provide written designation of its representative or representatives to the board meetings.~~

~~(c) Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under section 431:16-208.~~] Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under section 431:16-208. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, except:

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

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

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

[~~(d)~~] (c) For the purpose of carrying out its obligations under this part, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to section [~~431:16-208(m).~~] 431:16-208(j). Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this part. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

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

associations having obligations because of the insolvency, the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(e)(1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under section 431:16-208 with respect to such insurer have been fully recovered by the association.

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

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

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

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

(5) If any person liable under [~~[~~]paragraph (3)[~~]~~] is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate."

SECTION 12. Section 431:16-217, Hawaii Revised Statutes, is amended to read as follows:

"**§431:16-217 Stay of proceedings; reopening default judgments.** All proceedings in which the insolvent insurer is a party in any court in this State shall be stayed [~~sixty~~] one-hundred eighty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default the association

may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits."

SECTION 13. Section 431:16-219, Hawaii Revised Statutes, is repealed.

SECTION 14. Statutory material to be repealed is bracketed and stricken.[2] New statutory material is underscored.

SECTION 15. This Act shall take effect on July 1, 2012; provided that sections 4 to 13 of this Act shall not apply to any proceedings in which a member insurer is placed under an order of liquidation prior to July 1, 2012.

(Approved July 6, 2012.)

Notes

1. Should be underscored.
2. Edited pursuant to HRS §23G-16.5.