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 by adding a new article to be appropriately designated and to read as follows:

"ARTICLE

CORPORATE GOVERNANCE ANNUAL DISCLOSURE

§431: -A Purpose and scope. (a) The purposes of this article are to:

(1) Provide the insurance commissioner a summary of an insurer or insurance group's corporate governance structure, policies, and practices to permit the commissioner to gain and maintain an understanding of the insurer's corporate governance framework;

(2) Outline the requirements for completing a corporate governance annual disclosure with the commissioner; and

(3) Provide for the confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and
sensitive information related to an insurer or
insurance group's internal operations and proprietary
and trade secret information which, if made public,
could potentially cause the insurer or insurance group
competitive harm or disadvantage.

(b) Nothing in this article shall be construed to
prescribe or impose corporate governance standards and internal
procedures beyond those required under applicable state
corporate law. Notwithstanding the foregoing, nothing in this
article shall be construed to limit the commissioner's
authority, or the rights or obligations of third parties, under

(c) The requirements of this article shall apply to all
insurers domiciled in this State.

§431: -B Definitions. For the purposes of this article:
"Commissioner" means the insurance commissioner of this
State.
"Corporate governance annual disclosure" means a
confidential report filed by the insurer or insurance group made
in accordance with the requirements of this article.
"Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in article 11.

"Insurer" has the same meaning as in article 1, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

"Own risk and solvency assessment summary report" means the report filed in accordance with section 431:3D-105.

§431: -C Disclosure requirement. (a) An insurer or the insurance group of which the insurer is a member shall, no later than June 1 of each calendar year, submit to the commissioner a corporate governance annual disclosure that contains the information described in section 431: -E(b). Notwithstanding any request from the commissioner made pursuant to subsection (c), if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to the commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis CCA-01(19)
Handbook adopted by the National Association of Insurance Commissioners.

(b) The corporate governance annual disclosure must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

(c) An insurer not required to submit a corporate governance annual disclosure under this section shall do so upon the commissioner's request.

(d) For purposes of completing the corporate governance annual disclosure, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the corporate governance annual disclosure disclosures at the level at which:
(1) The insurer's or insurance group's risk appetite is determined;

(2) The earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors is coordinated and exercised; or

(3) Legal liability for failure of general corporate governance duties would be placed.

If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the criteria described in paragraphs (1) to (3) was used to determine the level of reporting and explain any subsequent changes in the level of reporting.

(e) The review of the corporate governance annual disclosure and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(f) Insurers providing information substantially similar to the information required by this article in other documents provided to the commissioner, including proxy statements filed in conjunction with Form B requirements, or other state or
federal filings provided to the insurance division shall not be required to duplicate that information in the corporate governance annual disclosure, but shall only be required to cross-reference the document in which the information is included.

§431: -D Rules. The commissioner may adopt rules and issue orders to carry out the provisions of this article.

§431: -E Contents of corporate governance annual disclosure. (a) The insurer or insurance group shall have discretion over the responses to the corporate governance annual disclosure inquiries, provided that the corporate governance annual disclosure shall contain the material information necessary to permit the commissioner to gain an understanding of the insurer's or insurance group's corporate governance structure, policies, and practices. The commissioner may request additional information deemed material and necessary to provide the commissioner with a clear understanding of the corporate governance policies, the reporting or information system, or the controls implementing those policies.

(b) Notwithstanding subsection (a), the corporate governance annual disclosure shall be prepared consistent with the National Association of Insurance Commissioners' Corporate
Governance Annual Disclosure Model Regulation. Documentation and supporting information shall be maintained and made available upon examination or request of the commissioner.

§431: -F Confidentiality. (a) Insofar as it includes information relating to specific insurers or insurance groups, any record or information in the possession or control of the division that was obtained by, created by, or disclosed to the commissioner or any other person under this article, including, but not limited to, corporate governance annual disclosures and the information they contain, communications between the division and insurers or insurance groups, and internal records of the division, shall be confidential by law and privileged, shall not be subject to disclosure pursuant to chapter 92F, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. This section shall not be interpreted to limit the application of exceptions to disclosure under chapter 92F to any records or information not specifically made confidential by this section.

However, the commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

The commissioner shall not otherwise make the documents,
materials, or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the commissioner may share or receive confidential documents, materials, or other information related to the corporate governance annual disclosure pursuant to subsection (c) to assist in the performance of the commissioner's regular duties.

(b) Neither the commissioner nor any person who received documents, materials, or other information related to the corporate governance annual disclosure through examination or otherwise, while acting under the authority of the commissioner, or with whom such documents, materials, or other information are shared pursuant to this article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (a).

(c) In order to assist in the performance of the commissioner's regulatory duties, the commissioner may:

(1) Upon request, share documents, materials, or other information related to the corporate governance annual disclosure, including the confidential and privileged documents, materials, or information subject to
subsection (a), including proprietary and trade secret
documents and materials with other state, federal, and
international financial regulatory agencies, including
members of any supervisory college as defined in
section 431:11-107.5, the National Association of
Insurance Commissioners, and third-party consultants
pursuant to section 431: -G, provided that the
recipient agrees in writing to maintain the
confidentiality and privileged status of the
documents, material, or other information and has
verified in writing the legal authority to maintain
confidentiality; and

(2) Receive documents, materials, or other information
related to the corporate governance annual disclosure,
including otherwise confidential and privileged
documents, materials, or information, including
proprietary and trade-secret information or documents,
from regulatory officials of other state, federal, and
international financial regulatory agencies, including
members of any supervisory college as defined in the
section 431:11-107.5, and from the National
Association of Insurance Commissioners, and shall
maintain as confidential or privileged any documents, materials, 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.

(d) The sharing of information and documents by the commissioner pursuant to this article shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution, and enforcement of this article.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials, or other information related to the corporate governance annual disclosure shall occur as a result of disclosure of any information related to the corporate governance annual disclosure or documents to the commissioner under this section or as a result of sharing as authorized in this article.

§431: National Association of Insurance Commissioners and third-party consultants. (a) The commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants, and other experts not
otherwise a part of the commissioner's staff as may be
reasonably necessary to assist the commissioner in reviewing the
corporate governance annual disclosure and related information
or the insurer's compliance with this article.

(b) Any persons retained under subsection (a) shall be
under the direction and control of the commissioner and shall
act in a purely advisory capacity.

(c) The National Association of Insurance Commissioners
and third-party consultants shall be subject to the same
confidentiality standards and requirements as the commissioner.

(d) As part of the retention process, a third-party
consultant shall verify to the commissioner, with notice to the
insurer, that it is free from any conflict of interest and that
it has internal procedures in place to monitor compliance with a
conflict and to comply with the confidentiality standards and
requirements of this article.

(e) A written agreement with the National Association of
Insurance Commissioners or a third-party consultant governing
sharing and use of information provided pursuant to this article
shall contain the following provisions and expressly require the
written consent of the insurer prior to making public
information provided under this article:
(1) Specific procedures and protocols for maintaining the confidentiality and security of the corporate governance annual disclosure and related information shared with the National Association of Insurance Commissioners or a third-party consultant pursuant to this article;

(2) Procedures and protocols for sharing by the National Association of Insurance Commissioners only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the corporate governance annual disclosure and related documents, materials, or other information and has verified in writing the legal authority to maintain confidentiality;

(3) A provision specifying that ownership of the corporate governance annual disclosure and related information shared with the National Association of Insurance Commissioners or a third-party consultant remains with the insurance division and that the National Association of Insurance Commissioners' or third-party
consultant's use of the information is subject to the
direction of the commissioner;

(4) A provision that prohibits the National Association of
Insurance Commissioners or a third-party consultant
from storing the information shared pursuant to this
article in a permanent database after the underlying
analysis is completed;

(5) A provision requiring the National Association of
Insurance Commissioners or a third-party consultant to
provide prompt notice to the commissioner and to the
insurer or insurance group regarding any subpoena,
request for disclosure, or request for production of
the insurer's corporate governance annual disclosure
or related information; and

(6) A requirement that the National Association of
Insurance Commissioners or a third-party consultant to
consent to intervention by an insurer in any judicial
or administrative action in which the National
Association of Insurance Commissioners or a third-
party consultant may be required to disclose
confidential information about the insurer shared with
the National Association of Insurance Commissioners or a third-party consultant pursuant to this article.

§431: -H Sanctions. Any insurer failing, without just cause, to timely file the corporate governance annual disclosure as required in this article shall be required, after notice and an opportunity for hearing, to pay a penalty of not less than $100 and not more than $500 for each day's delay, to be recovered by the commissioner and paid into the compliance resolution fund. The maximum penalty under this section is $50,000. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

§431: -I Severability. If any provision of this article other than section 431: -F, or the application thereof to any person or circumstance, is held invalid, the determination of invalidity shall not affect those provisions or applications of this article that can be given effect without the invalid provision or application, and to that end, the provisions of this article, except for section 431: -F, are severable."

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

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"§431:2—Trade name. (a) Prior to the use or change of a trade name to sell, solicit, or negotiate insurance in this State, the licensee shall register the trade name with the department of commerce and consumer affairs pursuant to part II of chapter 482.

(b) Upon registration of the trade name with the department of commerce and consumer affairs, the licensee may apply, on a form approved by the commissioner, to add or remove a trade name on a license. The applicant shall provide proof of registration of a trade name to the commissioner.

(c) If the commissioner finds the application for use or change of a trade name is substantially identical to another trade name registered with the department of commerce and consumer affairs, or substantially identical to a legal name or trade name of a revoked license, the commissioner shall deny use of the trade name on a license issued pursuant to chapter 431.

(d) A licensee shall inform the commissioner, by any means acceptable to the commissioner, of any change of status of a trade name registered with the department of commerce and consumer affairs within thirty days of the change."
SECTION 3. Chapter 431, Hawaii Revised Statutes, is amended by adding to part I of article 10A two new sections to be appropriately designated and to read as follows:

"§431:10A-A Required disclaimer. Any limited benefit policy, certificate, application, or sales brochure that provides coverage for accident and sickness, excluding specified disease, long-term care, disability income, medicare supplement, dental, or vision shall disclose in a conspicuous manner and in not less than fourteen-point boldface type the following, or substantially similar, statement:

"THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT."

§431:10A-B Reimbursement to providers. (a) Coverage for services required by this part shall include reimbursement to health care providers who perform services required by this part, or to the insured member, as appropriate.

(b) Notwithstanding any law to the contrary, whenever an individual or group policy, contract, plan, or agreement provides for reimbursement for any service, a health care provider who performs a service shall be eligible for reimbursement for the performed service.
For purposes of this section, "health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u); a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s); and a practitioner licensed by the State and working within the practitioner's scope of practice."

SECTION 4. Chapter 431, Hawaii Revised Statutes, is amended by adding to part VI of article 10A a new section to be appropriately designated and to read as follows:

"§431:10A- Limited benefit health insurance. (a) Except as provided in subsection (b) or elsewhere in this article, when used in this article, the terms "accident insurance", "health insurance", or "sickness insurance" shall not include an accident-only; specified disease; hospital indemnity; long-term care; disability; dental; vision; medicare supplement; short-term, limited-duration health insurance; or other limited benefit health insurance contract that pays benefits directly to the insured or the insured's assigns and in which the amount of the benefit paid is not based upon the actual costs incurred by the insured.

and 431:10A-604, except as otherwise provided, the terms
"accident insurance", "accident and health or sickness
insurance", "health insurance", or "sickness insurance" shall
include an accident-only; specified disease; hospital indemnity;
long-term care; disability; dental; vision; medicare supplement;
short-term, limited-duration health insurance; or other limited
benefit health insurance contract regardless of the manner in
which benefits are paid; provided that if any of the
requirements in the foregoing sections as applied to long-term
care insurance conflict with article 10H, the provisions of
article 10H shall govern and control."

SECTION 5. Chapter 431, Hawaii Revised Statutes, is
amended by adding a new section to article 11 to be
appropriately designated and to read as follows:

"§431:11- Group-wide supervision of internationally
active insurance groups. (a) The commissioner is authorized to
act as the group-wide supervisor for any internationally active
insurance group in accordance with this section; provided that
the commissioner may otherwise acknowledge another regulatory
official as the group-wide supervisor where the internationally active insurance group:

1. Does not have substantial insurance operations in the United States;
2. Has substantial insurance operations in the United States, but not in this State; or
3. Has substantial insurance operations in the United States and this State, but the commissioner has determined pursuant to the factors in subsections (b) and (f) that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

(b) In cooperation with other state, federal, and international regulatory agencies, the commissioner shall identify a single group-wide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial
insurance operations concentrated in this State. However, the
commissioner may acknowledge that a regulatory official from
another jurisdiction is the appropriate group-wide supervisor
for the internationally active insurance group. The
commissioner shall consider the following factors when making a
determination or an acknowledgment under this subsection:

1. The place of domicile of the insurers within the
   internationally active insurance group that holds the
   largest share of the group's written premiums, assets,
   or liabilities;

2. The place of domicile of the top-tiered insurer or
   insurers in the insurance holding company system of
   the internationally active insurance group;

3. The location of the executive offices or largest
   operational offices of the internationally active
   insurance group;

4. Whether another regulatory official is acting or is
   seeking to act as the group-wide supervisor under a
   regulatory system that the commissioner determines to
   be:
   (A) Substantially similar to the system of regulation
   provided under the laws of this State; or
(B) Otherwise sufficient in terms of providing for

group-wide supervision, enterprise risk analysis,

and cooperation with other regulatory officials;

and

(5) Whether another regulatory official acting or seeking
to act as the group-wide supervisor provides the
commissioner with reasonably reciprocal recognition
and cooperation.

However, a commissioner identified under this section as the
group-wide supervisor may determine that it is appropriate to
acknowledge another supervisor to serve as the group-wide
supervisor. The acknowledgment of the group-wide supervisor
shall be made after consideration of the factors in paragraphs
(1) through (5), and shall be made in cooperation with and
subject to the acknowledgment of other regulatory officials
involved with supervising members of the internationally
active insurance group, and in consultation with the
internationally active insurance group.

(c) Notwithstanding any other provision of law to the
contrary, when another regulatory official is acting as the
group-wide supervisor of an internationally active insurance
group, the commissioner shall acknowledge that regulatory

official as the group-wide supervisor; provided that in the
event a material change in the internationally active
insurance group results in:

(1) The internationally active insurance group's insurers
domiciled in this State holding the largest share of
the group's premiums, assets, or liabilities; or

(2) This State being the place of domicile of the top-tiered insurer or insurers in the insurance holding
company system of the internationally active insurance
group,

the commissioner shall make a determination or acknowledgment as
to the appropriate group-wide supervisor for the internationally
active insurance group pursuant to subsection (b).

(d) Pursuant to section 431:11-107, the commissioner is
authorized to collect from any insurer registered pursuant to
section 431:11-105 all information necessary to determine
whether the commissioner may act as the group-wide supervisor of
an internationally active insurance group or if the commissioner
may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an
internationally active insurance group is subject to group-wide
supervision by the commissioner, the commissioner shall notify
the insurer registered pursuant to section 431:11-105 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than thirty days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish on the division's internet website the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.

(e) If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner is authorized to engage in any of the following group-wide supervision activities:

(1) Assess the enterprise risks within the internationally active insurance group to ensure that:

(A) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(B) Reasonable and effective mitigation measures are in place:

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(2) Request, from any member of an internationally active insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:

(A) Governance, risk assessment, and management;

(B) Capital adequacy; and

(C) Material intercompany transactions;

(3) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of the internationally active insurance group that are engaged in the business of insurance;

(4) Communicate with other state, federal, and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality
provisions of section 431:11-108, through supervisory
colleges as set forth in section 431:11-107.5 or
otherwise;
(5) Enter into agreements with or obtain documentation
from any insurer registered under section 431:11-105,
any member of the internationally active insurance
group, and any other state, federal, and international
regulatory agencies for members of the internationally
active insurance group, providing the basis for or
otherwise clarifying the commissioner's role as group-
wide supervisor, including provisions for resolving
disputes with other regulatory officials. These
agreements or documents shall not serve as evidence in
any proceeding that any insurer or person within an
insurance holding company system not domiciled or
incorporated in this State is doing business in this
State or is otherwise subject to jurisdiction in this
State; and
(6) Other group-wide supervision activities, consistent
with the authorities and purposes enumerated above, as
considered necessary by the commissioner.
(f) If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the National Association of Insurance Commissioners is the group-wide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

(1) The commissioner's cooperation is in compliance with the laws of this State; and

(2) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the commissioner is authorized to refuse recognition and cooperation.

(g) The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under section 431:11-105, any affiliate of the insurer, and other state, federal, and international regulatory agencies for members of the internationally active insurance
group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

(h) The commissioner may promulgate rules necessary for the administration of this section.

(i) A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries, and any other professionals, and all reasonable travel expenses."

SECTION 6. Chapter 432, Hawaii Revised Statutes, is amended by adding to part VI of article 1 a new section to be appropriately designated and to read as follows:

"§432:1- Reimbursement to providers. (a) Coverage for services required by this part shall include reimbursement to health care providers who perform services required by this article, or to the insured member, as appropriate.

(b) Notwithstanding any law to the contrary, whenever an individual or group policy, contract, plan, or agreement that provides health care coverage under this article provides for reimbursement for any service, a health care provider who performs a service shall be eligible for reimbursement for the performed service.
(c) For purposes of this section, "health care provider"

has the same meaning as in section 431:10A -B(c)."

SECTION 7. Section 431:3-202, Hawaii Revised Statutes, is
amended to read as follows:

"§431:3-202 Insurer's name. (a) Every insurer shall
conduct its business in its own legal name.

(b) No insurer shall assume or use a name deceptively
similar to that of any other authorized insurer[,-nor-which] or
a name that tends to deceive or mislead as to the type of
organization of the insurer.

(c) An insurer shall apply to the department of commerce
and consumer affairs and the commissioner for approval of the
use or change of a trade name pursuant to section 431:2-

[(e+-)] (d) When a foreign or an alien insurer authorized to
do business in this State wants to change the name under which
its certificate of authority is issued, the insurer shall file a
request for name change with the commissioner at least thirty
days prior to the effective date of the name change. If within
the thirty-day period the commissioner finds the name change
request does not meet the requirements of this chapter or of the
corporation laws of this State, the commissioner shall send to
the insurer written notice of disapproval of the request
specifying in what respect the proposed name change fails to meet the requirements of this chapter or the corporation laws of this State and stating that the name change shall not become effective."

SECTION 8. Section 431:5-307, Hawaii Revised Statutes, is amended by amending subsection (o) to read as follows:

"(o)(1) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (b)(2), except as provided under paragraph (5) or (7) of this subsection;

(2) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(A) The valuation manual has been adopted by the National Association of Insurance Commissioners by an affirmative vote of at least forty-two members, or three-fourths of the members voting, whichever is greater;

(B) The Standard Valuation Law, as amended by the National Association of Insurance Commissioners in 2009, or legislation including substantially
similar terms and provisions, has been enacted by
states representing greater than seventy-five per
cent of the direct premiums written as reported
in the following annual statements submitted for
2008: life, accident and health annual
statements; health annual statements; or
fraternal annual statements; and

(C) The Standard Valuation Law, as amended by the
National Association of Insurance Commissioners
in 2009, or legislation including substantially
similar terms and provisions, has been enacted by
at least forty-two of the following fifty-five
jurisdictions: the fifty states of the United
States, American Samoa, the American Virgin
Islands, the District of Columbia, Guam, and
Puerto Rico;

(3) Unless a change in the valuation manual specifies a
later effective date, changes to the valuation manual
shall be effective on January 1 following the date
when [all of the following have occurred:}
The change to the valuation manual has been adopted by the National Association of Insurance Commissioners by an affirmative vote representing:

(A) At least three-fourths of the members of the National Association of Insurance Commissioners voting, but not less than a majority of the total membership; and

(B) Members of the National Association of Insurance Commissioners representing jurisdictions totaling greater than seventy-five per cent of the direct premiums written as reported in the following annual statements most recently available prior to the vote in clause (A): life, accident and health annual statements; health annual statements; or fraternal annual statements; and

The valuation manual becomes effective pursuant to rules adopted by the commissioner.

The valuation manual shall specify all of the following:

(A) Minimum valuation standards for and definitions of the policies or contracts subject to
subsection (b)(2). These minimum valuation standards shall be:

(i) The commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to subsection (b)(2);

(ii) The commissioner's annuity reserve valuation method for annuity contracts subject to subsection (b)(2); and

(iii) Minimum reserves for all other policies or contracts subject to subsection (b)(2);

(B) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in subsection (p)(1) and the minimum valuation standards consistent with those requirements;

(C) For policies and contracts subject to a principle-based valuation under subsection (p):

(i) Requirements for the format of reports to the commissioner under subsection (p)(2)(C) that shall include information necessary to
determine if the valuation is appropriate 
and in compliance with this section;

(ii) Assumptions shall be prescribed for risks 
over which the company does not have 
significant control or influence; and

(iii) Procedures for corporate governance and 
oversight of the actuarial function, and a 
process for appropriate waiver or 
modification of such procedures;

(D) For policies not subject to a principle-based 
valuation under subsection (p), the minimum 
valuation standard shall either:

(i) Be consistent with the minimum standard of 
valuation prior to the operative date of the 
valuation manual; or

(ii) Develop reserves that quantify the benefits 
and guarantees, and the funding, associated 
with the contracts and their risks at a 
level of conservatism that reflects 
conditions that include unfavorable events 
that have a reasonable probability of 
occuring;
(E) Other requirements including but not limited to those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules, and internal controls; and

(F) The data and form of the data required under subsection (q), with whom the data shall be submitted, and may specify other requirements including data analyses and reporting of analyses;

(5) [In the absence of] Absent a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this section, then the company shall, with respect to these requirements, comply with minimum valuation standards prescribed by the commissioner by rule;

(6) The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the
appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this section. The commissioner may rely upon the opinion[7] regarding provisions contained within this section[7] of a qualified actuary engaged by the commissioner of another state, district, or territory of the United States. As used in this paragraph, "engage" includes employment and contracting; and

(7) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary to comply with the requirements of the valuation manual or this section, and the company shall adjust the reserves as required by the commissioner. The commissioner may take other disciplinary action as permitted pursuant to this chapter."

SECTION 9. Section 431:6-101, Hawaii Revised Statutes, is amended by amending the definition of "cash equivalents" to read as follows:

"Cash equivalents" means highly-rated and highly-liquid investments or securities with a remaining term of ninety days.
or less and rated in the highest short-term category by a
nationally recognized statistical rating organization recognized
by the SVO. Cash equivalents include government money market
mutual funds [and class one money market mutual funds] defined
by the Purposes and Procedures Manual of the SVO, or its
successor publication."

SECTION 10. Chapter 431, part VI, Hawaii Revised Statutes,
is amended by amending its title to read as follows:
"[SECTION VI. ] [SECTION INVESTMENT POOLS. ]"

SECTION 11. Section 431:6-601, Hawaii Revised Statutes, is
amended by amending subsections (a) and (b) to read as follows:
"(a) For purposes of this section:
"Business entity" means a corporation, limited liability
company, association, partnership, joint stock company, joint
venture, mutual fund trust, or other similar form of business
organization, whether organized for-profit or not-for-profit.

["Class one money market mutual funds" means a mutual fund
that at all times qualifies for investment using the bond class
one reserve factor under the Purposes and Procedures of the SVO
or any successor publication.]

"Government money market mutual fund" means a money market
mutual fund that at all times:

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(1) Invests only in obligations issued, guaranteed, or insured by the government of the United States or collateralized repurchase agreements composed of these obligations; and

(2) Qualifies for investment without a reserve under the Purposes and Procedures of the SVO or any successor publication.

"Money market mutual fund" means a mutual fund that meets the conditions of 17 Code of Federal Regulations part 270.2a-7, under the Investment Company Act of 1940 (15 United States Code section 80a-1 et seq.), as amended, or renumbered.

"Obligation" means a bond, note, debenture, trust certificate, including equipment certificate, production payment, negotiable bank certificate of deposit, bankers' acceptance, credit tenant loan, loan secured by financing net leases and other evidence of indebtedness for the payment of money (or participation, certificates, or other evidence of an interest in any of the foregoing), whether constituting a general obligation of the issuer or payable only out of certain revenues or certain funds pledged or otherwise dedicated for payment.
"Qualified bank" means a national bank, state bank, or trust company that at all times is no less than adequately capitalized as determined by the standards adopted by the United States banking regulators and that is either regulated by state banking laws or is a member of the Federal Reserve System.

"Repurchase transaction" means a transaction in which an insurer purchases securities from a business entity that is obligated to repurchase the purchased securities or equivalent securities from the insurer at a specified price, either within a specified period of time or upon demand.

"Reverse repurchase transaction" means a transaction in which an insurer sells securities to a business entity and is obligated to repurchase the sold securities or equivalent securities from the business entity at a specified price, either within a specified period of time or upon demand.

"Securities lending transaction" means a transaction in which securities are loaned by an insurer to a business entity that is obligated to return the loans, securities, or equivalent securities to the insurer, either within a specified period of time or upon demand.

(b) An insurer may acquire investments in investment pools that:
(1) Invest only in:

(A) Obligations that are rated 1 or 2 by the SVO or have an equivalent of an SVO 1 or 2 rating (or, in the absence of a 1 or 2 rating or equivalent rating, the issuer has outstanding obligations with an SVO 1 or 2 or equivalent rating) by a nationally-recognized statistical rating organization recognized by the SVO and have:

(i) A remaining maturity of three hundred ninety-seven days or less or a put that entitles the holder to receive the principal amount of the obligation which put may be exercised through maturity at specified intervals not exceeding three hundred ninety-seven days; or

(ii) A remaining maturity of three years or less and a floating interest rate that resets no less frequently than quarterly on the basis of a current short-term index (federal funds, prime rate, treasury bills, London InterBank Offered Rate or commercial paper) and is subject to no maximum limit, if the
obligations do not have an interest rate
that varies inversely to market interest
rate changes;

(B) Government money market mutual funds [or class
ever money market mutual funds]; or

(C) Securities lending, repurchase, and reverse
repurchase transactions that meet all the
requirements of section 431:6-318; or

(2) Invest only in investments which an insurer may
acquire under this article, if the insurer's
proportionate interest in the amount invested in these
investments does not exceed the applicable limits of
this article."

SECTION 12. Section 431:9-203, Hawaii Revised Statutes, is
amended to read as follows:

"§431:9-203 General qualifications for license. (a) For
the protection of the public, the commissioner shall not issue
or extend any license for an adjuster or independent bill
reviewer:

(1) Except as provided by this article; or

(2) To any individual less than eighteen years of age.
(b) An applicant for a license under this article shall notify the commissioner of the applicant's legal name [and trade name, if applicable. An applicant doing business under any name other than [the] applicant's legal name shall notify the commissioner prior to using the assumed name].

(c) An applicant shall apply to the department of commerce and consumer affairs and the commissioner for approval of the use of a trade name pursuant to section 431:2-__.

[{e+}] (d) 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 II of chapter 482[—]; and

(3) Apply to the department of commerce and consumer affairs and the commissioner for approval to change the status of a trade name pursuant to section 431:2-__.
Failure to timely inform the commissioner or business registration division of a change of status shall result in a penalty pursuant to section 431:2-203.

[(d)] (e) As used in this section, "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, business website address, or home phone number. A licensee shall apply to the department of commerce and consumer affairs and the commissioner for approval to change the status of a trade name pursuant to section 431:2-21.

SECTION 13. Section 431:9A-102, Hawaii Revised Statutes, is amended by adding two new definitions to be appropriately inserted and to read as follows:

"Assumed name" means any fictitious, alias, maiden, or trade name used in the past.

"Trade name" means any name used by an insurance producer to solicit insurance business in this State if the applicant's or licensee's true legal name of an individual or a business entity cannot be used."
SECTION 14. Section 431:9A-110, Hawaii Revised Statutes, is amended to read as follows:

"§431:9A-110 Legal, trade, and assumed names. (a) Every insurance producer doing business in this State shall notify the commissioner in writing of the insurance producer's legal name [and trade name, if applicable].

(b) An insurance producer doing business under any name other than the producer's legal name shall notify the commissioner in writing prior to using the assumed name. An insurance producer shall apply to the department of commerce and consumer affairs and the commissioner for approval of the use or change of a trade name pursuant to section 431:2-__.

(c) An insurance producer doing business under any assumed name in the past, other than the producer's legal name, shall notify the commissioner in a form prescribed by the commissioner."

SECTION 15. Section 431:9N-102, Hawaii Revised Statutes, is amended to read as follows:

"§431:9N-102 License denial, nonrenewal, suspension, or revocation[ ]; trade name bar. In addition to 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, may permanently retire or bar subsequent use of a trade name, 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) Failure to satisfy, pay, or otherwise discharge a bail forfeiture judgment after the bail agent's name 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;

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

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

(5) Continuing execution of bail bonds in any court in this State while on the board, where the bail forfeiture judgment that resulted in placement on the
board has not been paid, stayed, vacated, exonerated, or otherwise discharged; or

(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 unless, at the time the services were performed, the person was duly licensed for the performance of the services."

SECTION 16. Section 431:10-104, Hawaii Revised Statutes, is amended to read as follows:

"§431:10-104 General readability requirements. In addition to any other requirements of law, no contract shall be delivered or issued for delivery in this State unless:

(1) The text is in plain language[,—achieving] and achieves a minimum score of forty on the Flesch reading ease test or an equivalent score on any other comparable test prescribed by the commissioner under section 431:10-105(a);

(2) The contract is printed, except for specification pages, schedules, and tables, in not less than ten-point type[,—one-point leaded];
(3) The style, arrangement, and general appearance of the contract give no undue prominence to any endorsements, riders, or other portions of the text; and

(4) A table of contents or an index of principal sections is provided with the contract when the text consists of more than three thousand words printed on three or less pages or when the text has more than three pages, regardless of the total number of printed words; and

(5) For any short-term health insurance policies that impose preexisting conditions provisions, any policy, application, or sales brochure shall disclose in a conspicuous manner in not less than fourteen point bold face type the following statement:

"THIS POLICY EXCLUDES COVERAGE FOR CONDITIONS FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE, OR TREATMENT WAS RECOMMENDED OR RECEIVED DURING THE [insert exclusion period] IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF COVERAGE.""

SECTION 17. Section 431:10A-116, Hawaii Revised Statutes, is amended to read as follows:

"§431:10A-116 Coverage for specific services. Every person insured under a policy of accident and health or sickness
insurance delivered or issued for delivery in this State shall be entitled to the reimbursements and coverages specified below:

(1) Notwithstanding any provision to the contrary, whenever a policy, contract, plan, or agreement provides for reimbursement for any visual or optometric service, which is within the lawful scope of practice of a duly licensed optometrist, the person entitled to benefits or the person performing the services shall be entitled to reimbursement whether the service is performed by a licensed physician or by a licensed optometrist. Visual or optometric services shall include eye or visual examination, or both, or a correction of any visual or muscular anomaly, and the supplying of ophthalmic materials, lenses, contact lenses, spectacles, eyeglasses, and appurtenances thereto;

(2) Notwithstanding any provision to the contrary, for all policies, contracts, plans, or agreements issued on or after May 30, 1974, whenever provision is made for reimbursement or indemnity for any service related to surgical or emergency procedures, which is within the lawful scope of practice of any practitioner licensed
to practice medicine in this State, reimbursement or indemnification under the policy, contract, plan, or agreement shall not be denied when the services are performed by a dentist acting within the lawful scope of the dentist's license;

(3) Notwithstanding any provision to the contrary, whenever the policy provides reimbursement or payment for any service, which is within the lawful scope of practice of a psychologist licensed in this State, the person entitled to benefits or performing the service shall be entitled to reimbursement or payment, whether the service is performed by a licensed physician or licensed psychologist;

(4) Notwithstanding any provision to the contrary, each policy, contract, plan, or agreement issued on or after February 1, 1991, except for policies that only provide coverage for specified diseases or other limited benefit coverage, but including policies issued by companies subject to chapter 431, article 10A, part II and chapter 432, article 1 shall provide coverage for screening by low-dose mammography for occult breast cancer as follows:
(A) For women forty years of age and older, an annual mammogram; and

(B) For a woman of any age with a history of breast cancer or whose mother or sister has had a history of breast cancer, a mammogram upon the recommendation of the woman's physician.

The services provided in this paragraph are subject to any coinsurance provisions that may be in force in these policies, contracts, plans, or agreements.

For the purpose of this paragraph, the term "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. An insurer may provide the services required by this paragraph through contracts with providers; provided that the contract is determined to be a cost-effective means of delivering the services.
without sacrifice of quality and meets the approval of
the director of health; and

(5) (A) (i) Notwithstanding any provision to the
contrary, whenever a policy, contract, plan,
or agreement provides coverage for the
children of the insured, that coverage shall
also extend to the date of birth of any
newborn child to be adopted by the insured;
provided that the insured gives written
notice to the insurer of the insured's
intent to adopt the child prior to the
child's date of birth or within thirty days
after the child's birth or within the time
period required for enrollment of a natural
born child under the policy, contract, plan,
or agreement of the insured, whichever
period is longer; provided further that if
the adoption proceedings are not successful,
the insured shall reimburse the insurer for
any expenses paid for the child; and

(ii) Where notification has not been received by
the insurer prior to the child's birth or
within the specified period following the
child's birth, insurance coverage shall be
effective from the first day following the
insurer's receipt of legal notification of
the insured's ability to consent for
treatment of the infant for whom coverage is
sought; and

(B) When the insured is a member of a health
maintenance organization [(HMO)], coverage of an
adopted newborn is effective:

(i) From the date of birth of the adopted
newborn when the newborn is treated from
birth pursuant to a provider contract with
the health maintenance organization, and
written notice of enrollment in accord with
the health maintenance organization's usual
enrollment process is provided within thirty
days of the date the insured notifies the
health maintenance organization of the
insured's intent to adopt the infant for
whom coverage is sought; or
(ii) From the first day following receipt by the health maintenance organization of written notice of the insured's ability to consent for treatment of the infant for whom coverage is sought and enrollment of the adopted newborn in accord with the health maintenance organization's usual enrollment process if the newborn has been treated from birth by a provider not contracting or affiliated with the health maintenance organization.

(6) Notwithstanding any provision to the contrary, any policy, contract, plan, or agreement issued or renewed in this State shall provide reimbursement for services provided by advanced practice registered nurses licensed pursuant to chapter 457. Services rendered by advanced practice registered nurses are subject to the same policy limitations generally applicable to health care providers within the policy, contract, plan, or agreement."

SECTION 18. Section 431:10A-116.6, Hawaii Revised Statutes, is amended to read as follows:
§431:10A-116.6 Contraceptive services. (a)

Notwithstanding any provision of law to the contrary, each employer group accident and health or sickness policy, contract, plan, or agreement issued or renewed in this State on or after January 1, 2000, shall cease to exclude contraceptive services or supplies for the subscriber or any dependent of the subscriber who is covered by the policy, subject to the exclusion under section 431:10A-116.7 and the exclusion under section 431:10A-102.5.

(b) Except as provided in subsection (c), all policies, contracts, plans, or agreements under subsection (a) that provide contraceptive services or supplies or prescription drug coverage shall not exclude any prescription contraceptive supplies or impose any unusual copayment, charge, or waiting requirement for such supplies.

(c) Coverage for oral contraceptives shall include at least one brand from the monophasic, multiphasic, and the progestin-only categories. A member shall receive coverage for any other oral contraceptive only if:

(1) Use of brands covered has resulted in an adverse drug reaction; or
(2) The member has not used the brands covered and, based on the member's past medical history, the prescribing health care provider believes that use of the brands covered would result in an adverse reaction.

(d) Coverage required by this section shall include reimbursement to a prescribing health care provider or dispensing entity for prescription contraceptive supplies intended to last for up to a twelve-month period for an insured.

{(e)} Coverage required by this section shall include reimbursement to a prescribing and dispensing pharmacist who prescribes and dispenses contraceptive supplies pursuant to section 461--.

{(f)} For purposes of this section:

"Contraceptive services" means physician-delivered, physician-supervised, physician assistant-delivered, advanced practice registered nurse-delivered, nurse-delivered, or pharmacist-delivered medical services intended to promote the effective use of contraceptive supplies or devices to prevent unwanted pregnancy.

"Contraceptive supplies" means all United States Food and Drug Administration-approved contraceptive drugs or devices used to prevent unwanted pregnancy.
Nothing in this section shall be construed to extend the practice or privileges of any health care provider beyond that provided in the laws governing the provider's practice and privileges."

SECTION 19. Section 431:10A-118.3, Hawaii Revised Statutes, is amended by amending subsection (e) to read as follows:

"(e) As used in this section unless the context requires otherwise:

"Actual gender identity" means a person's internal sense of being male, female, a gender different from the gender assigned at birth, a transgender person, or neither male nor female.

"Gender transition" means the process of a person changing the person's outward appearance or sex characteristics to accord with the person's actual gender identity.

"Perceived gender identity" means an observer's impression of another person's actual gender identity or the observer's own impression that the person is male, female, a gender different from the gender [assigned designed] assigned at birth, a transgender person, or neither male nor female.

"Transgender person" means a person who has gender identity disorder or gender dysphoria, has received health care services
related to gender transition, adopts the appearance or behavior of the opposite sex, or otherwise identifies as a gender different from the gender assigned to that person at birth."

SECTION 20. Section 431:11-102, Hawaii Revised Statutes, is amended by adding two new definitions to be appropriately inserted and to read as follows:

""Group-wide supervisor" means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the commissioner under section 431:11- to have sufficient significant contacts with the internationally active insurance group.

"Internationally active insurance group" means an insurance holding company system that:

(1) Includes an insurer registered under section 431:11-105; and

(2) Meets the following criteria:

(A) Premiums written in at least three countries;

(B) The percentage of gross premiums written outside the United States is at least ten percent of the insurance holding company system's total gross written premiums; and
Based on a three-year rolling average, the total assets of the insurance holding company system are at least $50,000,000,000 or the total gross written premiums of the insurance holding company system are at least $10,000,000,000."

SECTION 21. Section 431:11-108, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Documents, materials, or other information in the possession or control of the insurance division that are obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to section 431:11-107 and all information reported or provided to the insurance division pursuant to sections 431:11-104(b)(12) and (13), 431:11-105, [and] 431:11-106, and 431:11-__, shall be confidential by law and privileged, shall not be disclosable under chapter 92F, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner may use the documents, materials, or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials, or other information public without prior
written consent of the insurer to which it pertains unless the
commissioner, after giving the insurer and its affiliates who
would be affected thereby notice and opportunity to be heard,
determines that the interest of the policyholders, shareholders,
or the public will be served by the publication thereof, in
which event the commissioner may publish all or any part in such
manner as may be deemed appropriate."

SECTION 22. Section 431:14-104, Hawaii Revised Statutes,
is amended as follows:

(1) By amending subsections (a) and (b) to read as
follows:

"(a) Every insurer shall file with the commissioner every
manual of classifications, rules, and rates, every rating plan,
every other rating rule, and every modification of any of the
foregoing that it proposes to use; provided that filings with
regard to specific inland marine risks, which by general custom
of the business are not written according to manual rate or
rating plans, and bail bonds, subject to section 804-62, shall
not be required pursuant to this subsection.

Every filing shall:

(1) State its proposed effective date;
(2) Indicate the character and extent of the coverage contemplated;
(3) Include a report on investment income; and
(4) Be accompanied by a $50 fee[...payable to the commissioner...] to be deposited in the commissioner's education and training fund.

(b) [For each] Each filing[...an insurer] shall [submit] be submitted to the commissioner[...]
   (1) An electronic copy of the filing; or
   (2) Two printed copies of the filing.

The commissioner may also request a printed version of an electronic filing to be submitted pursuant to paragraph (1)."

(2) By amending subsection (k) to read as follows:
"(k) The following rates shall become effective when filed:
(1) Specific inland marine [rates] rate filings on risks specially rated by a rating organization or an advisory organization;
(2) Any special filing with respect to a surety or guaranty bond required by law [or] court or executive order or order or rule of a public body, not covered by a previous filing; and

(3) Any special filing with respect to any class of insurance, subdivision, or combination thereof that is subject to individual risk premium modification and has been agreed to by an insured under a formal or an informal bid process.

The filed rates shall be deemed [to meet the requirements of this article until the time the commissioner reviews the filing and] approved so long as the filing remains in effect."

SECTION 23. Section 431:14-104.5, Hawaii Revised Statutes, is amended to read as follows:

"§431:14-104.5 Loss cost filings. When required by the commissioner, the rating organization or advisory organization shall file for approval all prospective loss costs, [and all] supplementary rating information, and every change [or] amendment, or modification [of any of the foregoing] thereto proposed for use in this State. The filings shall be subject to [section] sections 431:14-104 [and section], 431:14-105, and
431:14-106 and other provisions of article 14 relating to 
filings made by insurers."

SECTION 24. Section 431:14-105, Hawaii Revised Statutes, 
is amended to read as follows:

"§431:14-105 Policy revisions that alter coverage.
(a) Any policy revisions that alter coverage in any manner 
shall be filed with the commissioner and shall include an 
analysis of the impact [of] each revision has on rates[− 
(b) A filing shall consist of either:
   (1) An electronic copy of the filing; or 
   (2) Two printed copies of the filing.

The commissioner may also request a printed version of an 
electronic filing to be submitted pursuant to paragraph (1). [or 
loss costs.

(b) After review by the commissioner, the 
commissioner shall determine whether a rate filing for the 
policy revision must be submitted in accordance with section 
431:14-104."

SECTION 25. Section 431:14-108, Hawaii Revised Statutes, 
is amended to read as follows:

"§431:14-108 Deviations. (a) Except for those lines of 
insurance for which the commissioner determines [that]
individual rate filings shall be made, every member of or 
subscriber to a rating organization shall adhere to the filings 
the organization made on its behalf [by the organization, except 
that]; provided that any insurer may [make written application] 
submit a rate filing to the commissioner to file a deviation 
from the class rates, schedules, rating plans, or rules 
respecting any class of insurance, [or] class of risk within a 
class of insurance, or combination thereof. The [application] 
rate filing shall specify the basis for the deviation and shall 
be accompanied by the data upon which the applicant relies. [A] 
The filer shall simultaneously send a copy of the [application] 
development and data [shall be sent simultaneously] to the rating 
organization.

[(b) The commissioner shall set a time and place for a 
hearing at which the insurer and the rating organization may be 
heard, and shall give them not less than ten days' written 
notice thereof. In the event the commissioner is advised by the 
rating organization that it does not desire a hearing, the 
commissioner may, upon the consent of the applicant, waive the 
hearing.

{(e)} (b) In considering the [application to file a] 
development, the commissioner shall [give consideration to]
consider the available statistics and the principles for
ratemaking [as provided] in section 431:14-103. The
commissioner shall [issue an order permitting] approve the
filing of the deviation [to be filed] if the commissioner finds
that it [to be] is justified. The deviation shall become
effective upon [issuance of] the commissioner's [order.]
approval of the proposed effective date of the filing. The
commissioner shall [issue an order denying] disapprove the
[application] rate filing if the commissioner finds [that] the
deviation is not justified or [that] the resulting premiums
would be excessive, inadequate, or unfairly
discriminatory. Each deviation [permitted to be] filed shall be
effective for a period of one year from the date of [the order]
approval, unless terminated sooner with [the] approval [of] by
the commissioner."

SECTION 26. Section 431:14G-105, Hawaii Revised Statutes,
is amended by amending subsections (a) and (b) to read as
follows:

"(a) Every managed care plan shall file with the
commissioner every rate, charge, classification, schedule,
practice, or rule and every modification of any of the foregoing
that it proposes to use. Every filing shall:

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(1) State its proposed effective date;

(2) Indicate the character and extent of the coverage contemplated;

(3) Include a report on investment income; and

(4) Be accompanied by a $50 fee payable to the commissioner which shall be deposited in the commissioner's education and training fund.

(b) Each filing, an insurer shall be submitted to the commissioner:

(1) An electronic copy of the filing; or

(2) Two printed copies of the filing;

provided that the commissioner may request that an insurer that submits an electronic copy of the filing pursuant to paragraph (1) to also submit a printed copy of the electronic filing.) via the National Association of Insurance Commissioners' System for Electronic Rates and Forms Filing or an equivalent service approved by the commissioner."

SECTION 27. Section 431:19-103, Hawaii Revised Statutes, is amended to read as follows:

"§431:19-103 Names of companies. (a) No captive insurance company shall adopt a name that is the same, deceptively similar, or likely to be confused with or mistaken..."
for any other existing business name registered in the State except that the commissioner may allow a branch captive insurance company to be licensed in this State under a different trade name if the normal name of the branch captive insurance company is not available for use in this State].

(b) A captive insurance company shall apply to the department of commerce and consumer affairs and the commissioner for approval of the use or change of a trade name pursuant to section 431:2-__.

SECTION 28. Section 431:19-115, Hawaii Revised Statutes, is amended by amending subsections (a), (b), and (c) to read as follows:

"(a) No insurance laws of this State, other than those contained in this article, article 15, or [contained in specific references contained] specifically referenced in this section [except article, or article 15, shall apply to captive insurance companies.

(b) Sections 431:3-302 to 431:3-304.5, 431:3-307, 431:3-401 to 431:3-409, 431:3-411, 431:3-412, and 431:3-414; articles 1, 2, 4A, 5, 6, 9A, 9B, 9C, 11, and 11A[__, and __]; and chapter 431K shall apply to risk retention captive insurance companies.
(c) Articles 1, 2, and 6[. and 15] shall apply to class 5 companies."

SECTION 29. Section 431:26-103, Hawaii Revised Statutes, is amended by amending subsection (e) to read as follows:

"(e) A health carrier shall meet the following access plan requirements:

(1) Beginning on July 1, 2017, a health carrier shall file with the commissioner for approval, prior to or at the time it files a newly offered network plan, in a manner and form defined by rule or order of the commissioner, an access plan that meets the requirements of this article;

(2) The health carrier may request the commissioner to deem sections of the access plan as proprietary, competitive, or trade secret information that shall not be made public. Information is proprietary, competitive, or a trade secret if disclosure of the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the access plans, absent proprietary, competitive, or trade secret
information, available online, at the health carrier's
business premises, and to any person upon request; and
(3) The health carrier shall prepare an access plan prior
to offering a new network plan and shall notify the
commissioner of any material change to any existing
network plan within fifteen business days after the
change occurs. The carrier shall include in the notice
to the commissioner a reasonable [time frame] timeframe
within which the carrier will submit to the
commissioner for approval or file with the
commissioner, as appropriate, an update to an existing
access plan."

SECTION 30. Section 431:26-104, Hawaii Revised Statutes,
is amended by amending subsection (f) to read as follows:
"(f) Selection standards shall be developed pursuant to
the following:
(1) Health carrier selection standards for selecting and
tiering, as applicable, participating providers shall
be developed for providers and each health care
professional specialty;
(2) The standards shall be used in determining the
selection of participating providers by the health

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carrier and the intermediaries with which the health carrier contracts. The standards shall meet requirements relating to health care professional credentialing verification developed by the commissioner by order or through rules adopted pursuant to chapter 91;

(3) Selection criteria shall not be established in a manner:

(A) That would allow a health carrier to discriminate against high risk populations by excluding providers because the providers are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses, or health care services utilization;

(B) That would exclude providers because the providers treat or specialize in treating populations presenting a risk of higher than average claims, losses, or health care services utilization; or

(C) That would discriminate with respect to participation under the health benefit plan

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against any provider who is acting within the
scope of the provider's license or certification
under applicable state law or regulations;
provided that this subparagraph shall not be
construed to require a health carrier to contract
with any provider who is willing to abide by the
terms and conditions for participation
established by the carrier;

(4) Notwithstanding paragraph (3), a carrier shall not be
prohibited from declining to select a provider who
fails to meet the other legitimate selection criteria
of the carrier developed in compliance with this
article; and

(5) This article does not require a health carrier, its
intermediaries, or the provider networks with which the
carrier and its intermediaries contract, to employ
specific providers acting within the scope of the
providers' license or certification under applicable
state law that may meet the selection criteria of the
carrier, or to contract with or retain more providers
acting within the scope of the providers' license or
certification under applicable state law than are
necessary to maintain a sufficient provider network."

SECTION 31. Section 431:30-112, Hawaii Revised Statutes, is
amended by amending subsection (d) to read as follows:

"(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
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. 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-
genration populace which facilitates flexibility and
innovation in the development of long-term care
insurance coverage."

SECTION 32. Section 432:1-604.5, Hawaii Revised Statutes,
is amended to read as follows:

"§432:1-604.5 Contraceptive services. (a)
Notwithstanding any provision of law to the contrary, each
employer group health policy, contract, plan, or agreement
issued or renewed in this State on or after January 1, 2000,
shall cease to exclude contraceptive services or supplies, and
contraceptive prescription drug coverage for the subscriber or
any dependent of the subscriber who is covered by the policy,
subject to the exclusion under section 431:10A-116.7.

(b) Except as provided in subsection (c), all policies,
contracts, plans, or agreements under subsection (a), that
provide contraceptive services or supplies, or prescription drug
coverage, shall not exclude any prescription contraceptive
supplies or impose any unusual copayment, charge, or waiting
requirement for such drug or device.

(c) Coverage for contraceptives shall include at least one
brand from the monophasic, multiphasic, and the progestin-only
categories. A member shall receive coverage for any other oral
contraceptive only if:

(1) Use of brands covered has resulted in an adverse drug
reaction; or

(2) The member has not used the brands covered and, based
on the member's past medical history, the prescribing
health care provider believes that use of the brands
covered would result in an adverse reaction.

(d) Coverage required by this section shall include
reimbursement to a prescribing health care provider or
dispensing entity for prescription contraceptive supplies
intended to last for up to a twelve-month period for a member.

[(e) Coverage required by this section shall include
reimbursement to a prescribing and dispensing pharmacist who
prescribes and dispenses contraceptive supplies pursuant to
section 461-11.6.]

CCA-01(19)
(e) For purposes of this section:

"Contraceptive services" means physician-delivered, physician-supervised, physician assistant-delivered, advanced practice registered nurse-delivered, nurse-delivered, or pharmacist-delivered medical services intended to promote the effective use of contraceptive supplies or devices to prevent unwanted pregnancy.

"Contraceptive supplies" means all Food and Drug Administration-approved contraceptive drugs or devices used to prevent unwanted pregnancy.

(f) Nothing in this section shall be construed to extend the practice or privileges of any health care provider beyond that provided in the laws governing the provider's practice and privileges."

SECTION 33. Section 432:1-607.3, Hawaii Revised Statutes, is amended by amending subsection (e) to read as follows:

"(e) As used in this section unless the context requires otherwise:

"Actual gender identity" means a person's internal sense of being male, female, a gender different from the gender assigned at birth, a transgender person, or neither male nor female."
"Gender transition" means the process of a person changing the person's outward appearance or sex characteristics to accord with the person's actual gender identity.

"Perceived gender identity" means an observer's impression of another person's actual gender identity or the observer's own impression that the person is male, female, a gender different from the gender assigned at birth, a transgender person, or neither male nor female.

"Transgender person" means a person who has gender identity disorder or gender dysphoria, has received health care services related to gender transition, adopts the appearance or behavior of the opposite sex, or otherwise identifies as a gender different from the gender assigned to that person at birth."

SECTION 34. Section 432D-26.3, Hawaii Revised Statutes, is amended by amending subsection (e) to read as follows:

"(e) As used in this section unless the context requires otherwise:

"Actual gender identity" means a person's internal sense of being male, female, a gender different from the gender assigned at birth, a transgender person, or neither male nor female.
"Gender transition" means the process of a person changing the person's outward appearance or sex characteristics to accord with the person's actual gender identity.

"Perceived gender identity" means an observer's impression of another person's actual gender identity or the observer's own impression that the person is male, female, a gender different from the gender [designated] assigned at birth, a transgender person, or neither male nor female.

"Transgender person" means a person who has gender identity disorder or gender dysphoria, has received health care services related to gender transition, adopts the appearance or behavior of the opposite sex, or otherwise identifies as a gender different from the gender assigned to that person at birth."

SECTION 35. Section 431:10A-102.5, Hawaii Revised Statutes, is repealed.

"§431:10A-102.5 Limited-benefit health insurance. (a) Except as provided in subsection (b) or elsewhere in this article, when used in this article, the terms "accident insurance", "health insurance", or "sickness insurance" shall not include an accident only, specified disease, hospital indemnity, long-term care, disability, dental, vision, medicare supplement, short-term, limited-duration health
insurance, or other limited benefit health insurance contract
that pays benefits directly to the insured or the insured's
assigns and in which the amount of the benefit paid is not based
upon the actual costs incurred by the insured.

(b) When used in sections 431:10A-104, 431:10A-105,
431:10A-604, except as otherwise provided, the terms "accident
insurance", "accident and health or sickness insurance", "health
insurance", or "sickness insurance" shall include an accident-
only; specified disease; hospital indemnity; long-term care;
disability; dental; vision; medicare supplement; short-term
limited-duration health insurance; or other limited benefit
health insurance contract regardless of the manner in which
benefits are paid; provided that if any of the requirements set
forth in the foregoing sections as applied to long-term care
insurance conflict with the provisions of article 10H, the
provisions of article 10H shall govern and control.
]

SECTION 36. Section 432:1-611, Hawaii Revised Statutes, is
repealed.
H.B. NO. 984

["5432:1-611—Reimbursement for services of advanced practice-registered nurses. All individual and group hospital and medical service plan contracts and medical service corporation contracts under this article shall provide reimbursement for health plan covered services provided by advanced practice-registered nurses licensed pursuant to chapter 457-3."

SECTION 37. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.


SECTION 39. In codifying the new sections added by sections 1, 2, 3, 4, 5, and 6 of this Act, the revisor of statutes shall substitute appropriate section numbers for the letters used in designating and referring to the new sections in this Act.

SECTION 40. This Act shall take effect upon its approval; provided that sections 1, 5, 20, and 21 shall become effective
on January 1, 2020, and the first filing of the corporate
governance annual disclosure shall be in 2020.

INTRODUCED BY: 

BY REQUEST
JAN 22 2019
Report Title:
Insurance; Health Insurance; Corporate Governance; National Association of Insurance Commissioners; Corporate Governance Annual Disclosure Model Act; Trade Name; Assumed Name; Pre-Existing Disclosure; Provider Reimbursement; Reimbursement By Provider; Medical Service Provider; Pharmacist; Contraceptive; Advanced Practice Registered Nurses; Insurance Holding Company System Regulatory Act; Group-Wide Supervisor; Group-Wide Supervision; Internationally Active Insurance Group; Holding Company; Standard Valuation Model Law; Gender Identity; Captive; Network Adequacy; Network Adequacy Model Act; Health Carrier; Participating Provider; Health Insurance; Vehicle Protection Product Warrantor; Service Contract Provider; Chapter 431; Article 2; Article 3; Article 5; Article 6; Article 9; Article 9A; Article 9N; Article 10; Article 10A; Article 11; Article 14, Article 14G, Article 15; Article 19; Article 26; Article 30; Chapter 432

Description:
Amends various portions of the Hawaii Insurance Code under Hawaii Revised Statutes title 24 to update and improve existing Insurance Code provisions.

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

TITLE: A BILL FOR AN ACT RELATING TO INSURANCE.

PURPOSE: To amend various portions of the Hawaii Insurance Code under title 24 (Code), Hawaii Revised Statutes (HRS), and to update and improve existing Code provisions, including:

(1) Adopting new corporate governance and annual disclosure requirements in the National Association of Insurance Commissioners' (NAIC) Corporate Governance Annual Disclosure Model Act (section 1 of bill);

(2) Requiring any person seeking to add or change a trade name or an assumed name to submit a written request to the Department of Commerce and Consumer Affairs (DCCA) and the Insurance Commissioner (Commissioner) to determine whether the proposal satisfies the Code or corporation laws, and providing notice of this new requirement to insurers, producers, adjusters, independent bill reviewers, licensees, and captives (sections 2, 7, 12, 13, 14, 15 and 27);

(3) Moving the short-term health insurance pre-existing disclosure requirement from section 431:10-104(5) to a new section in chapter 431, article 10A, part I, and amending section 431:10-104(5) by removing the disclosure requirement (sections 3 and 16);

(4) Requiring that coverage for services mandated by chapter 431, article 10A and chapter 432, article 1 includes reimbursement to providers who deliver those services, repealing reimbursement mandates to pharmacists who prescribe and dispense birth control medication.
under an expansion of the pharmacist practice act, and removing reimbursement mandates to advanced practice registered nurses that Act 222, Session Laws of Hawaii 1999, created (sections 3, 6, 17, 18, 32, and 36);

(5) Moving the limited benefit health insurance provision from section 431:10A-102.5 to a new section in chapter 431, article 10A, part VI (sections 4 and 35);

(6) Adopting 2014 revisions to the NAIC's Insurance Holding Company System Regulatory Act (sections 5, 20, and 21);

(7) Removing optional language in the NAIC's Standard Valuation Model Law that requires the Commissioner to adopt a rule to make effective any changes to the valuation manual (section 8);

(8) Removing references to class 1 money market mutual funds (sections 9 and 11);

(9) Amending the title to part VI of article 6 by removing brackets to reflect amendments to this part (section 10);

(10) Amending the definition of "perceived gender identity" in sections 431:10A-118.3(e), 432:1-607.3(e), and 432D-26.3(e) (sections 19, 33, and 34);

(11) Removing obsolete language and clarifying existing language in sections 431:14-104, 431:14-104.5, 431:14-105, and 431:14-108 (sections 22, 23, 24, and 25);
(12) Removing obsolete language and clarifying existing language in section 431:14G-105 (section 26);

(13) Applying chapter 431, article 15 to all captives (section 28);

(14) Amending network adequacy provisions based on the NAIC's Network Adequacy Model Act that currently require implementation by rule to instead be temporarily carried out by order of the Commissioner (sections 29 and 30);

(15) Removing the opt-out provision for long-term care insurance under the Interstate Insurance Product Regulation Commission (IIPRC) (section 31); and

(16) Making technical, nonsubstantive amendments for clarity and consistency.

Means:

Add a new article to chapter 431; add a new section to chapter 431, article 2; add two new sections to chapter 431, article 10A, part I; add a new section to chapter 431, article 10A, part VI; add a new section to chapter 431, article 11; and add a new section to chapter 432, article 1, part VI, HRS.

Amend sections 431:3-202, 431:5-307(o), 431:6-101, 431:6-601(a) and (b), 431:9-203, 431:9A-102, 431:9A-110, 431:9N-102, 431:10-104, 431:10A-116, 431:10A-116.6, 431:10A-118.3(e), 431:11-102, 431:11-108(a), 431:14-104(a), (b), and (k), 431:14-104.5, 431:14-105, 431:14-108, 431:14G-105(a) and (b), 431:19-103, 431:19-115(a), (b), and (c), 431:26-103(e), 431:26-104(f), 431:30-112(d), 432:1-604.5, 432:1-607.3(e), and 432D-26.3(e), HRS.

Repeal sections 431:10A-102.5 and 432:1-611, HRS.
JUSTIFICATION:  

(1) This bill adopts the NAIC's Corporate Governance Annual Disclosure Model Act to maintain the State's accreditation with the NAIC. This bill provides more information on an annual basis to regulators regarding insurers' corporate governance practices. Currently, regulators obtain a significant amount of information on insurers' corporate governance practices during full-scope examinations, which typically occur once every three to five years. However, information on governance practices, including changes that can substantially impact current and prospective solvency, is not widely available to regulators in the period between onsite examination. Through the adoption of standards in this area, regulators can ensure that sufficient information on governance practices is available to assess insurer solvency on an annual basis. (Section 1)

(2) This bill allows DCCA and the Commissioner to determine whether an applicant's request to add or change a trade name or an assumed name satisfies both Code and corporation law requirements. This will ensure that both the DCCA and the Commissioner will receive notice of a proposed name change and that both have express authority to permanently retire or bar the use of a trade name or an assumed name associated with a revoked license. (Sections 2, 7, 12, 13, 14, 15, and 27)

(3) This bill moves the short-term health insurance pre-existing disclosure requirement from article 10 to article 10A, which is the more appropriate location for this requirement. (Sections 3 and 16)
(4) This bill clearly provides for reimbursement to providers who deliver coverage managed by chapter 431, article 10A and chapter 432, article 1 and deletes reimbursement mandates added to the Code in conjunction with medical service provider practice acts. These amendments will clarify that coverage for services mandated by chapter 431, article 10A and chapter 432, article 1 should include reimbursement to providers and will discourage the practice of creating reimbursement mandates in the Code to accompany expansions in provider practice acts. (Sections 3, 6, 17, 18, 32, and 36)

(5) This bill moves the limited benefit health insurance provision from part I to part VI of article 10A, which is the more appropriate location for this provision, and to clarify that this provision applies to both individual and group policies. (Sections 4 and 35)

(6) This bill adopts 2014 revisions to the NAIC's Insurance Holding Company System Regulatory Act to maintain the State's accreditation with the NAIC. This bill provides clear legal authority to a designated state to act as the group-wide supervisor for an internationally active insurance group. (Sections 5, 20, and 21)

(7) This bill streamlines the process of making changes to the valuation manual by eliminating optional language in the NAIC's Standard Valuation Model Law. (Section 8)

(8) This bill removes references to class 1 money market mutual funds to conform with the NAIC Securities Valuation Office Purposes and Procedures Manual.
of the NAIC Investment Analysis Office.
(Sections 9 and 11)

(9) This bill amends the title to part VI of article 6 to reflect amendments to this part.
(Section 10)

(10) This bill replaces "designed" with "assigned" in the definition of "perceived gender identity" to correct a technical drafting error and to conform state law to federal guidance on gender identity.
(Sections 19, 33, and 34)

(11) This bill removes obsolete language and clarifies existing language in chapter 431, article 14 to avoid ambiguity for insurers submitting rate filings.
(Sections 22, 23, 24, and 25)

(12) This bill removes obsolete language and clarifies existing language in chapter 431, article 14G to avoid ambiguity for managed care plans submitting rate filings.
(Section 26)

(13) This bill applies article 15 to all captives to give the Commissioner additional regulatory authority to supervise or liquidate a captive, rather than simply suspending or revoking its insurance license.
(Section 28)

(14) This bill amends network adequacy provisions to temporarily allow DCCA's Insurance Division to create stopgap measures to implement the NAIC's Network Adequacy Model Act and promulgate rules.
(Sections 29 and 30)

(15) This bill removes the opt-out provision for long-term care insurance under the
IIPRC to give states the option of using the IIPRC's proven stricter standards for substantive rate review or conducting their own review. (Section 31)

Impact on the public: This bill enhances consumer protection by making title 24, HRS, provisions more understandable, technically correct, and consistent.

Impact on the department and other agencies: None.

GENERAL FUNDS: None.

OTHER FUNDS: Compliance Resolution Fund.

PPBS PROGRAM DESIGNATION: CCA-106.

OTHER AFFECTED AGENCIES: None.

EFFECTIVE DATE: Upon approval, provided that sections 1, 5, 20, and 21 shall become effective on January 1, 2020, and the first filing of the corporate governance annual disclosure shall be in 2020.