HOUSE CS FOR CS FOR SENATE BILL NO. 104(FIN)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY THE HOUSE FINANCE COMMITTEE

Offered: 5/7/97
Referred: Rules

Sponsor(s): SENATE RULES COMMITTEE

A BILL

FOR AN ACT ENTITLED

"An Act relating to regulation and examination of insurers and insurance agents; relating to kinds of insurance; relating to payment of insurance taxes and to required insurance reserves; relating to insurance policies; relating to regulation of capital, surplus, and investments by insurers; relating to hospital and medical service corporations; relating to the portability and availability of health care insurance; making amendments to the insurance statutes to conform to federal requirements regarding health insurance; relating to the repeal of certain small employer health care insurance provisions; requiring that uninsured and underinsured motor vehicle insurance apply to claims of an insured even if other policy limits are not exhausted; repealing delayed provisions relating to dental, vision, and hearing insurance in secs. 3 and 4, ch. 101, SLA 1992; repealing delayed provisions relating to small employer health care insurance in

secs. 4, 7, 9, and 12, ch. 39, SLA 1993; repealing the delayed effective date in sec. 5, ch. 101, SLA 1992, and in sec. 13, ch. 39, SLA 1993; and providing for an effective date."

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

*** Section 1.** PURPOSE. The purpose of secs. 3, 11, 12, 31 - 34, 43 - 57, 59 - 90, 99 - 102, 108, 111, 112, 115 - 119, and 122 of this Act is to implement the minimum federal standards for health care insurance enacted under P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996).

*** Sec. 2.** AS 21.06.030 is amended by adding a new subsection to read:

(h) A volunteer member of an advisory committee who has been appointed by the director under a provision of this title to assist and advise the director on issues or matters concerning a specific area of insurance is not entitled to payment of per diem or travel expenses authorized under AS 39.20.180.

*** Sec. 3.** AS 21.06.085 is amended to read:

Sec. 21.06.085. Uniform data and procedures for health claims. (a) The director shall adopt by regulation uniform claims forms, uniform standards, and uniform procedures for the processing of data relating to billing for and payment of health care services provided to state residents. A health **care** insurer shall use the uniform claims forms and comply with the uniform standards and procedures established under this section.

(b) In this section,

(1) "health care services" has the meaning given in AS 21.86.900;

(2) ["HEALTH INSURANCE" HAS THE MEANING GIVEN IN AS 21.12.050;

(3)] "health **care** insurer" **has the meaning given in AS 21.54.500** [MEANS AN INSURER TRANSACTING THE BUSINESS OF HEALTH INSURANCE, A HEALTH MAINTENANCE ORGANIZATION UNDER AS 21.86, A HOSPITAL SERVICE CORPORATION UNDER AS 21.87, A MEDICAL SERVICE CORPORATION UNDER AS 21.87, OR A COMBINED MEDICAL SERVICE AND HOSPITAL SERVICE CORPORATION UNDER AS 21.87].

*** Sec. 4.** AS 21.06.110 is amended to read:

Sec. 21.06.110. Director's annual report. As early in each calendar year as is reasonably possible**,** the director shall prepare and deliver an annual report to the commissioner, who shall notify the legislature that the report is available, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in this state, with a summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose **certificate of authority was surrendered, suspended, or revoked** [BUSINESS WAS CLOSED] during the year **and** [,] the cause of **surrender, suspension, or revocation** [THE CLOSING, AND THE AMOUNT OF ASCERTAINABLE ASSETS AND LIABILITIES OF EACH CLOSED BUSINESS];

(3) the name of each insurer **authorized to do business in this state** against which delinquency or similar proceedings were instituted [,] and**, if against an insurer domiciled in this state,** a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipt and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance [,] or the office of director;

(7) other pertinent information and matters the director considers proper.

*** Sec. 5.** AS 21.06.160(a) is amended to read:

(a) Each person examined, other than [AS TO] examinations under AS 21.06.130, shall pay **a reasonable rate calculated on** [ALL THE COSTS OF, AND EXPENSES INCURRED BY DIVISION STAFF EXAMINERS, INCLUDING] salary**,** [AND] benefit costs, **and estimated division overhead** for time spent directly or indirectly related to the examination**. Each person examined, other than examinations under AS 21.06.130, shall pay actual out-of-pocket business**

expenses, including travel expenses, incurred by division staff examiners [,] and shall pay the compensation of a contract examiner, to be set at a reasonable customary rate, for conducting the examination [,] upon presentation of a detailed account of the charges and expenses by the director or under an order of the director. The accounting may either be presented periodically during the course of the examination or at the termination of the examination. A person may not pay and an examiner may not accept additional compensation for an examination.

*** Sec. 6.** AS 21.09.210(b) is amended to read:

(b) Each insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall pay a tax on the total direct premium income received during the year ending on the preceding December 31 and paid for the insurance of property or risks resident or located in the state**,** other than wet marine and transportation insurance, after deducting from the total direct premium income the applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to their policies. No deductions may be made of cash surrender value of policies. Considerations received on annuity contracts are not included in the direct premium income and are not subject to tax. The tax shall be paid to the director **at least** annually **but not more often than once each quarter** on **the dates specified by the director. The method of payment must be by the electronic or other payment method specified by the director. The tax** [OR BEFORE MARCH 1, AND] is computed at the rate of

(1) for domestic and foreign insurers, except hospital and medical service corporations, 2.7 percent;

(2) for hospital and medical service corporations, six percent of their gross premiums less claims paid.

*** Sec. 7.** AS 21.09.210(d) is amended to read:

(d) An authorized insurer shall, with respect to all wet marine and transportation contracts written in this state during the preceding calendar year, [ON OR BEFORE MARCH 1 OF EACH YEAR,] pay to the director a tax of three-quarters

of one percent on its gross underwriting profit. **The director shall specify the dates that payment is due and the electronic or other method by which payment is to be made.** The gross underwriting profit is computed by deducting**,** from the net premiums on wet marine and transportation insurance contracts, the net losses paid during the calendar year under the contracts. In the case of an insurer issuing participating contracts, the gross underwriting profit may not include, for computation of the tax prescribed by this section, the amounts refunded or paid as participation dividends by the insurers to the holders of the contracts. In this subsection,

(1) "net losses" means gross losses less salvage and recoveries on reinsurance ceded;

(2) "net premiums" means gross premiums less all return premiums and premiums for reinsurance.

*** Sec. 8.** AS 21.09 is amended by adding a new section to read:

Sec. 21.09.245. Required notice. (a) If an insurer intends to change the insurer's name, domicile, or other information provided on the certificate of authority, the insurer shall file a notice of the change with the director within 30 days before or after the intended change takes effect.

(b) If an insurer changes the insurer's articles of incorporation, bylaws, business address, phone number, or other information maintained by the director, the insurer shall file a notice of the change with the director not later than 90 days after the effective date of the change.

(c) Failure by an insurer to provide notification required by this section may result in a civil penalty of up to $1,000 and, additionally, a civil penalty of up to $50 for each day that the information is withheld from the director.

*** Sec. 9.** AS 21.09 is amended by adding a new section to read:

Sec. 21.09.320. Maintenance of records. (a) An insurer domiciled in a jurisdiction other than this state shall keep at its principal place of business a complete record of its assets, transactions, and affairs in accordance with the methods and systems that are customary or suitable to the kind of insurance transacted.

(b) To meet the requirements of (a) of this section, the insurer shall keep the records specified in AS 21.69.390(d) for five years from the date the record was

created or as required by the record maintenance requirements of the insurer's domicile jurisdiction, whichever is longer.

*** Sec. 10.** AS 21.12.020(a)(4)(A)(iii) is amended to read:

(iii) in the case of a single assuming insurer, the trust shall consist of trust money representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, include a trust surplus of not less than $20,000,000; the single assuming insurer shall make available to the director an annual certification of the insurer's solvency [BY THE INSURER'S DOMICILIARY REGULATOR AND] by an independent certified public accountant or an accountant holding a substantially equivalent designation as determined by the director;

*** Sec. 11.** AS 21.12.050 is amended to read:

Sec. 21.12.050. Health and health care insurance defined. Health insurance is insurance of human beings (1) against bodily injury, disablement, or death by accident or accidental means; (2) against the resulting expenses of the injury, disablement, or death; (3) against disablement or expense resulting from sickness or childbirth; (4) against expense incurred in prevention of sickness; (5) for dental care; and (6) **including every insurance** that applies to injury, disablement, or death. Transaction of health insurance includes disability insurance **and stop-loss insurance** but does not include workers' compensation insurance. **Health care insurance described in (b) of this section is a type of health insurance under this subsection.**

*** Sec. 12.** AS 21.15.050 is amended by adding new subsections to read:

(b) Health care insurance means that part of health insurance that provides benefits for medical care whether provided directly, through reimbursement, or other method.

(c) In this section, "stop-loss insurance" means insurance purchased by a self-insured employer to cover benefits the employer incurs in excess of a preset limit.

*** Sec. 13.** AS 21.14.010(a) is amended to read:

(a) A life and health domestic insurer, property and casualty domestic insurer, or other insurer required by the director shall, on or before March 1, submit to the

director a report of its risk based capital covering the previous calendar year [, IF REQUIRED BY THE DIRECTOR]. The report must be in a form and contain the information required by risk based capital instructions. A domestic insurer required to submit a report under this subsection shall file the report with

(1) the National Association of Insurance Commissioners; and

(2) the insurance regulatory agency in each state in which the insurer is authorized to transact business [,] if the insurance regulatory agency has requested the report in writing from the insurer; a report requested under this paragraph shall be delivered

(A) not later than 15 days from the receipt of a request if the report has already been filed with the director; or

(B) at the time the report is filed with the director, if the report has not **yet** been filed with the director.

*** Sec. 14.** AS 21.14.200(18) is amended to read:

(18) "risk based capital instructions" means risk based capital instructions for a life and health insurer or for a property and casualty insurer adopted by **order of** [REGULATION BY] the director **after an open meeting as provided** under **AS 44.62.310** [AS 21.14.010];

*** Sec. 15.** AS 21.18.050 is amended to read:

Sec. 21.18.050. Reserves and liabilities, in general. In a determination of the financial condition of an insurer, capital stock and liabilities to be charged against its assets shall include

(1) the amount of its capital stock outstanding, if any;

(2) the amount, estimated consistent with the provisions of this title, necessary to pay all of its unpaid losses and claims incurred on or before the date of statement, whether reported or unreported, together with the expenses of adjustment or settlement;

(3) with reference to life and health insurance and annuity contracts,

(A) the amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and methods adopted under this title that are applicable;

(B) reserves for disability benefits, for both active and disabled lives;

(C) reserves for accidental death benefits;

(D) additional reserves that may be required by the director, consistent with practice formulated or approved by the National Association of Insurance Commissioners, on account of the insurance;

(4) with reference to health insurance, the amount of reserves required under **AS 21.18.080 - 21.18.086** [AS 21.18.080];

(5) with reference to insurance other than specified in (3) and (4) of this section, and other than title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with this chapter;

(6) taxes, expenses, and other obligations due or accrued at the date of the statement.

*** Sec. 16.** AS 21.18.080 is repealed and reenacted to read:

Sec. 21.18.080. Reserve standards for health insurance. (a) The adequacy of health insurance reserves must be determined based on the sum of policy reserves determined under AS 21.18.082, claim reserves determined under AS 21.18.084, and premium reserves determined under AS 21.18.086.

(b) Reserve adequacy must be determined by a prospective gross premium valuation. For policies in force, in a claims status, or in a continuation of benefits status on the valuation date, the gross premium valuation must take into account the present value of all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, including expected future premium increases.

(c) A gross premium valuation must be performed whenever there is an indication that reserves and future premiums may be insufficient to cover future claims for a particular block of policies or for the entire health insurance block. If a reserve inadequacy is determined to exist, the loss must be immediately recognized and reserves increased to account for the inadequacy. The increased reserves will be considered minimum reserves.

*** Sec. 17.** AS 21.18 is amended by adding new sections to read:

Sec. 21.18.082. Policy reserves for health insurance. (a) Except as provided in (b) of this section, policy reserves are required for all individual and group health insurance policies or groups of policies

(1) with level premiums or with a gross premium pricing structure at time of issue that results in future benefits exceeding the corresponding future valuation net premiums at any time; or

(2) for which gross premiums are restricted by contract, regulation, or another reason that results in future gross premiums, reduced by expenses for administration, commissions, and taxes, being insufficient to cover future claims.

(b) Policy reserves are not required for health insurance policies that cannot be continued after one year from the date of issue.

(c) The structure of valuation net premiums used under a health insurance policy must be consistent with the structure of gross premiums on the date the policy is issued.

(d) For return of premium benefits, deferred cash benefits, policies with premium rates that are not guaranteed, and where the effects of insurer underwriting by policy duration are specifically used in the valuation morbidity standard, termination rates that exceed the mortality rates in the tables required in (g)(2) of this section may be used but may not exceed the lesser of

(1) 80 percent of the total termination rate used in the calculation of gross premiums; or

(2) eight percent.

(e) The methods and procedures used to determine health insurance policy reserves must be consistent with the methods and procedures used to determine claim reserves for a health insurance policy.

(f) Negative reserves on a benefit may be offset against positive reserves for other benefits in the same policy, but the total policy reserve with respect to all benefits combined may not be less than zero.

(g) Except as provided in (d) and (h) - (k) of this section, policy reserves for policies issued after July 1, 1997, must be determined based on

(1) a maximum interest rate equal to the maximum interest rate allowed

under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the health insurance policy;

(2) a termination assumption equal to the mortality table allowed under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the health insurance policy or equal to a mortality table approved by the director for use in determining the policy reserves;

(3) for long-term care policies issued after July 1, 1997,

(A) a mortality assumption equal to the 1983 Group Annuity Mortality Table without projection;

(B) a lapse assumption for policy durations one through four equal to the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums or eight percent; and

(C) a lapse assumption for policy durations five and later of 100 percent of the voluntary lapse rate used in the calculation of the gross premiums or four percent;

(4) a two-year full preliminary term method under which the terminal reserve is zero on the first and second policy anniversary dates;

(5) a morbidity assumption for

(A) individual disability income insurance issued (i) after December 31, 1997, equal to Tables A or B of the 1985 Commissioners' Individual Disability Tables for policies; and (ii) before January 1, 1998, equal to the 1964 or 1985 Commissioners' Individual Disability Tables; the insurer shall indicate which morbidity table the insurer will use for all individual disability income policies issued in a calendar year;

(B) group disability income insurance issued

(i) after December 31, 1997, equal to the 1987 Commissioners' Group Disability Table; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(C) scheduled or fixed time period hospital, surgical, or maternity benefit policies issued

(i) after December 31, 1997, equal to the 1974 Medical Expense Table A from the Transactions of the Society of Actuaries, Volume XXX; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(D) cancer expense benefits for policies issued

(i) after December 31, 1997, equal to the 1985 National Association of Insurance Commissioners Cancer Claim Cost Tables; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(E) accidental death benefits for policies issued

(i) after December 31, 1997, equal to the 1959 accidental death benefit table; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998; or

(F) all other individual or group policy benefits equal to a morbidity table established for reserve determination by an actuary qualified to determine the morbidity table and approved by the director; the morbidity table must contain a pattern of incurred claims cost that reflects the underlying morbidity and may not be constructed for the primary purpose of minimizing reserves.

(h) The reserve method for return of premium or other deferred cash benefits must be a preliminary term method that is applied only in relation to the issue date of the policy and is a

(1) one-year preliminary term method if benefits are provided before the 20th policy anniversary; or

(2) two-year preliminary term method if the benefits are provided only on or after the 20th policy anniversary.

(i) The reserve method for long-term care insurance must be calculated on a

(1) two-year full preliminary term method for a policy or certificate issued on or before July 1, 1997; and

(2) one-year full preliminary term method for a policy or certificate issued after July 1, 1997.

(j) Reserve adjustments due to rate changes, revised assumptions, or other reasons for return of premium or other deferred cash benefits must be applied on the effective date of the adoption of the reserve adjustment.

(k) An alternative method or basis of determining policy reserves may be used if the aggregate policy reserve is not less than the aggregate policy reserves determined under (c) - (j) of this section.

(l) An insurer shall annually review prospective policy liabilities on policies valued by tabular reserves to determine the continuing adequacy and reasonableness of the tabular reserves given future gross premiums. The insurer shall make adjustments to the tabular reserves if the tests indicate that the basis of the reserves is no longer adequate.

(m) Policy reserves that are valued based on the 1964 or 1985 Commissioners Individual Disability Tables must include a provision for a waiver of premium benefit with the minimum reserve for the benefit equal to the valuation net premium to be waived.

(n) Policy reserves for long-term care insurance may not be less than the net single premium for any nonforfeiture benefits provided by the policy or certificate.

Sec. 21.18.084. Claim reserves for health insurance. (a) Claim reserves are required for all incurred and unpaid claims on all health insurance policies.

(b) Claim expense reserves are required for the estimated expense of settlement of all incurred and unpaid claims.

(c) Claim reserves for prior valuation years must be tested for adequacy and reasonableness using claim runoff schedules in accordance with the statutory annual statement, including consideration of any residual unpaid liability. Claim reserve adequacy must be determined in the aggregate.

(d) Claim reserves must be determined as follows:

(1) for policies that require policy reserves under AS 21.18.082(a), based on a maximum interest rate equal to the maximum interest rate allowed under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the

date the claim was incurred;

(2) for policies that do not require policy reserves under AS 21.18.082(b), based on a maximum interest rate equal to the maximum interest rate allowed under AS 21.18.110 for the valuation of single premium immediate annuities issued on the same date as the date the claim was incurred less 100 basis points;

(3) except as provided in (4) and (5) of this subsection, a morbidity assumption for

(A) individual disability income insurance must be equal to the morbidity assumption used in determining policy reserves under AS 21.18.082(g)(5);

(B) group disability income insurance for policies issued

(i) after December 31, 1997, must be equal to the 1987 Commissioners Group Disability Table; and

(ii) before January 1, 1998, must be equal to the morbidity assumption in use by the insurer before January 1, 1998;

(C) accidental death benefits must be equal to the actual amount of claims incurred; and

(D) all other individual or group policy benefits must be equal to a morbidity table approved by the director and established for reserve determination by an actuary qualified to determine the morbidity table;

(4) for individual or group disability claims with a duration from disablement of less than two years, morbidity assumptions may be based on the insurer's experience if determined credible by the insurer or upon another basis designed to place a sound value on the liabilities as determined by the insurer;

(5) if approved by the director, reserves for group disability income claims with a duration from disablement of more than two years but less than five years may be based on the insurer's experience for which the insurer maintains control of underwriting and claim administration; request for approval to use this modified reserve basis must include

(A) an analysis of the credibility of the experience;

(B) a description of how all the insurer's experience is proposed

to be used in setting the reserves;

(C) a description and quantification of the margins to be included;

(D) a summary of the financial impact that the proposed plan of modification would have on the insurer's last filed annual statement;

(E) a copy of the approval from the state of domicile; and

(F) all other information requested by the director;

(6) any generally accepted actuarial reserving method or other reasonable method approved by the director may be used; the method used to estimate liabilities may be an aggregate method; approximations based on groupings and averages may also be used.

(e) Claim reserves that are valued based on the 1964 or 1985 Commissioners' Individual Disability Tables must include a provision for a waiver of premium benefit with the minimum reserve for the benefit equal to the valuation net premium to be waived.

Sec. 21.18.086. Premium reserves for health insurance. (a) Unearned premium reserves must be established for the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(b) Due and unpaid premiums that are carried as an asset in the annual statement must be treated as premiums in force and are subject to the unearned premium reserve requirements of this section. Unpaid commissions, premium taxes, and costs of collection associated with due and unpaid premiums must be carried in the annual statement as an offsetting liability.

(c) Gross premiums paid in advance for a period of coverage starting after the next premium due date following the valuation date may be discounted to the valuation date and must be held as a separate liability in the annual statement or as an addition to the unearned premium reserve established in this section.

(d) The minimum unearned premium reserve for a policy is the pro rata unearned modal premium that applies to the valuation period beyond the date of valuation. If a policy reserve is required for a policy, the unearned modal premium is the valuation net modal premium on the policy reserve. If no policy reserve is

required for a policy, the unearned modal premium is the gross modal premium for the policy.

(e) The sum of the unearned premium and policy reserves for all policies may not be less than the gross modal unearned premium reserve on all policies as of the date of valuation. The total unearned premium and policy reserves may not be less than the expected claims for the period after the valuation date represented by the unearned premium reserve.

(f) An insurer may use approximations and estimates in determining premium reserves, including groupings, averages, and aggregate estimates. The approximations or estimates must be tested periodically and not less frequently than triennially to determine adequacy.

(g) Premium reserves based on the 1964 or 1985 Commissioners' Individual Disability Tables must include policies on premium waiver as in-force contracts and establish a minimum reserve for a waiver of premium benefit equal to the unearned modal valuation net premium being waived.

*** Sec. 18.** AS 21.21 is amended by adding a new section to read:

Sec. 21.21.410. Custodians. (a) A custodial agreement between an insurer and an institution holding the assets, securities, or investments of the insurer must provide that the custodian is obligated to indemnify the insurer for losses involving an insurance company asset or security in the custodian's custody resulting from the negligence or dishonesty of the custodian's officers, employees, or agents, or caused by burglary, robbery, holdup, theft, or mysterious disappearance, including loss by damage or destruction. The agreement must also provide that, in the event of a loss, an asset or security will be promptly replaced or the value of the asset or security and the value of a loss of rights or privileges resulting from the loss will be promptly replaced.

(b) The custodian for assets, securities, or investments of the insurer may only be a bank, trust company, or securities firm that is properly authorized by the insurer and approved by the director.

*** Sec. 19.** AS 21.27.010(f) is amended to read:

(f) A person who performs management services under a written contract for

an admitted insurer is not required to be licensed as a managing general agent [,] if

(1) either

(A) the person is a United States manager of the United States branch of an alien admitted insurer; or

(B) the person's compensation is not based on the volume of premium written; and

(2) the person

(A) is a wholly-owned subsidiary of the admitted insurer;

(B) wholly owns the admitted insurer; **or**

(C) is a wholly-owned subsidiary of the insurance holding company subject to AS 21.22 that owns or controls the admitted insurer.

*** Sec. 20.** AS 21.27.010(i) is amended to read:

(i) A person licensed under AS 21.75 as an attorney-in-fact**, or a person who meets the requirements for exemption from licensure under AS 21.75,** is not required to be additionally licensed under this chapter while acting on behalf of subscribers and within the scope and authority of a subscribers agreement of a reciprocal insurer or exchange licensed under AS 21.75.

*** Sec. 21.** AS 21.27.040(a) is amended to read:

(a) Application for a license shall be made to the director upon forms prescribed by the director. As a part of or in connection with [,] the application, the applicant shall furnish information concerning the **applicant's** identity, personal history, experience, business record, purposes**,** [OF THE APPLICANT] and other pertinent facts [CONCERNING THE APPLICANT] that the director may reasonably require. The applicant shall declare under **oath and subject to** penalty of denial, nonrenewal, suspension, or revocation of a license issued by the director that the statements made in or in connection with the application are true, correct, and complete to the best of the applicant's knowledge and belief. Payment of an application fee established under AS 21.06.250 must be submitted with the application.

*** Sec. 22.** AS 21.27.370(b) is amended to read:

(b) A **person** [LICENSEE] may not be promised or paid, directly or indirectly, compensation for procuring an application or for placing a kind or class of insurance

for which the **person** [LICENSEE] is not then licensed to procure or place or for insurance that the **person** [LICENSEE] is prohibited by this title from procuring or placing.

*** Sec. 23.** AS 21.27.390(b) is amended to read:

(b) **Except as otherwise provided by law, a** [A] temporary license may not be in effect for more than 90 consecutive days [,] and may not be renewed or reissued for more than one additional 90-day period.

*** Sec. 24.** AS 21.27.405(b) is amended to read:

(b) If the director determines that a person has violated this chapter, the director shall serve an order upon the person charged requiring that person to cease and desist from engaging in the act or practice. [SERVICE REQUIRED UNDER THIS SUBSECTION SHALL BE BY MAIL WITH A CERTIFICATE OF MAILING FROM THE UNITED STATES POSTAL SERVICE.] A person aggrieved by the cease and desist order may demand a hearing under AS 21.06.170 - 21.06.240.

*** Sec. 25.** AS 21.27.440(a) is amended to read:

(a) In addition to any other penalty provided by law, a person that the director determines under AS 21.06.170 - 21.06.240 has violated the provisions of this chapter is subject to

(1) a civil penalty equal to the compensation promised, paid, or to be paid, directly or indirectly, to a **person** [LICENSEE] in regard to each violation;

(2) either a civil penalty of not more than $10,000 for each violation or a civil penalty of not more than $25,000 for each violation if the director determines that the person wilfully violated the provisions of this chapter; and

(3) denial, nonrenewal, suspension, or revocation of a license.

*** Sec. 26.** AS 21.27.640(b)(5) is amended to read:

(5) provide in or with its application

(A) all basic organizational documents of the third-party administrator, including articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement**,** and other applicable documents and all endorsements to the required documents;

(B) the bylaws, rules, regulations**,** or similar documents regulating the internal affairs of the administrator;

(C) the names, mailing addresses, physical addresses, official positions, and professional qualifications of persons who are responsible for the conduct of affairs of the third-party administrator; including the members of the board of directors, board of trustees, executive committee**,** or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of partnership or association; shareholders holding directly or indirectly 10 percent or more of the voting securities of the third-party administrator; and any other person who exercises control or influence over the affairs of the third-party administrator;

(D) certified financial statements for the prior two years**, or for each year and partial year that the applicant has been in business if less than two years,** prepared by an independent certified public accountant **establishing** [THAT ESTABLISH] that the applicant is solvent, that the applicant's system of accounting, internal control, and procedure is operating effectively to provide reasonable assurance that money is promptly accounted for and paid to the person entitled to the money, and any other information that the director may require to review the current financial condition of the applicant; and

(E) a statement describing the business plan, including information on staffing levels and activities proposed in this state and in other jurisdictions and providing details establishing the third-party administrator's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims handling, underwriting, and record keeping;

*** Sec. 27.** AS 21.34.040(c)(4) is amended to read:

(4) a Lloyd's **syndicate** or **an insurer belonging to a** [OTHER] similar group**,** including incorporated and individual unincorporated **insurers** [UNDERWRITERS], may qualify if it maintains a trust fund **jointly and severally with the other members of the group** in an amount not less than $50,000,000, as security to the full amount, for the protection of all **policyholders** [ITS POLICY

HOLDERS] and creditors of each member of the group in the United States; the incorporated members may not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; the trust fund must consist of instruments of substantially the same character and quality as those that are eligible investments for the capital and statutory reserves of admitted insurers authorized to write like kinds of insurance in this state or of irrevocable, clean, and unconditional letters of credit; the trust fund must have an expiration date that at no time is less than five years;

*** Sec. 28.** AS 21.34.040(c)(5) is amended to read:

(5) **each syndicate or insurer belonging to** an insurance exchange created by the laws of individual states may qualify if **the insurance exchange** [IT] maintains capital and surplus, or the substantial equivalent, of not less than $50,000,000 in the aggregate; for insurance exchanges that maintain funds for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the substantial equivalent, of not less than $3,000,000; in the event the insurance exchange does not maintain funds for the protection of all its policyholders, each individual syndicate shall meet the minimum requirements of (1) or (2) of this subsection;

*** Sec. 29.** AS 21.34.180(b) is amended to read:

(b) The surplus lines tax is due on the **date specified by the director and may** [SECOND DAY OF MARCH FOLLOWING THE CALENDAR YEAR IN WHICH THE PREMIUM IS WRITTEN. THE TAX SHALL] be paid **by electronic or other means as specified by the director. The tax shall be** [TO AND] reported on forms prescribed by the director [,] or**,** upon the director's order**,** paid to and reported on forms prescribed by the surplus lines association.

*** Sec. 30.** AS 21.34.190(a) is amended to read:

(a) The fee for filing the statement under AS 21.34.180(b) is an amount equal to one percent on gross premium charged less any return premiums **as reported on the statement** [DURING THE PRECEDING CALENDAR YEAR]. The surplus lines broker shall pay the fee at the time of filing of the statement.

*** Sec. 31.** AS 21.36.095(a) is amended to read:

(a) **A health care** [AN] insurer may not deny enrollment of a child under the health **care** insurance of the child's parent on the ground that the child

(1) was born out of wedlock;

(2) is not claimed as a dependent on the parent's federal income tax return;

(3) does not reside with the parent; or

(4) does not reside in the **health care** insurer's service area.

*** Sec. 32.** AS 21.36.095(b) is amended to read:

(b) If a parent is required under AS 25.27.020(a)(9) or 25.27.060(c) to provide medical support for a child and the parent is eligible for family health **care insurance** coverage through an insurer, the parent's **health care** insurer

(1) shall allow the parent to enroll the child under the family **health care insurance** coverage without regard to restrictions relating to enrollment periods if the child is otherwise eligible;

(2) shall, if the parent fails to apply for enrollment of a child under (1) of this subsection, enroll the child under the parent's family **health care insurance** coverage upon application by the child's other parent or custodian, the child support enforcement agency, or the Department of Health and Social Services; and

(3) may not disenroll or eliminate **health care insurance** coverage of the child unless the insurer has received written evidence that

(A) the parent with the insurance coverage is no longer required by court order or administrative order to provide the child's medical support; or

(B) the child is or will be enrolled in comparable health **care insurance** coverage through another insurer that will take effect not later than the effective date of the disenrollment or elimination of coverage.

*** Sec. 33.** AS 21.36.095(c) is amended to read:

(c) **A health care** [AN] insurer who provides health **care insurance** coverage of a child through family health **care insurance** coverage of a parent who does not have sole physical custody of the child shall

(1) provide to the child's other parent or custodian the information that may be necessary for the child to obtain benefits through the family health **care insurance** coverage;

(2) allow the child's other parent or custodian, or the child's health care provider with the parent's or custodian's approval, to submit claims for covered services without the approval of the parent whose **health care** insurance covers the child; and

(3) make payment on claims submitted under (2) of this subsection directly to the child's other parent or custodian, the health care provider, or a state agency to which the child's medical support rights have been assigned under AS 25.27.120 or AS 47.07.025.

*** Sec. 34.** AS 21.36.095(e) is repealed and reenacted to read:

(e) In this section, "health care insurer" has the meaning given in AS 21.54.500 and includes the Comprehensive Health Insurance Association as described in AS 21.55.010.

*** Sec. 35.** AS 21.36 is amended by adding a new section to read:

Sec. 21.36.185. Maintenance of complaint handling records. An insurer shall maintain a complete record of all the complaints received by the insurer since the date of the insurer's last market conduct examination under AS 21.06.120 or for four years, whichever occurs first. This record must indicate the total number of complaints, the classification of each complaint by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this section, "complaint" means any written communication primarily expressing a grievance.

*** Sec. 36.** AS 21.36.240 is amended to read:

Sec. 21.36.240. Failure to renew. An insurer may **only** [NOT] fail to renew a personal insurance policy **on the policy's annual anniversary** [IN FORCE FOR LESS THAN 12 MONTHS]. An insurer may not fail to renew a policy unless a written notice of nonrenewal is mailed to the named insured as required by AS 21.36.260 at least 20 days for a personal insurance policy, and at least 45 days for a business or commercial insurance policy, before the expiration date of the policy or

of the anniversary date of a policy written for a term longer than one year or with no fixed expiration date. If notice of nonrenewal is not given as required by this section, the existing policy shall continue until the insurer provides notice for the time period required by this section for that policy. This section does not apply

(1) if the insurer has in good faith manifested its willingness to renew;

(2) in case of nonpayment of premium for the expiring policy; or

(3) if the insured fails to pay the premium as required by the insurer for renewal.

*** Sec. 37.** AS 21.36.290 is amended to read:

Sec. 21.36.290. Policy period. (a) **A** [EXCEPT AS DESCRIBED IN (b) OF THIS SECTION, A] policy with a policy period or term [OF LESS THAN 12 MONTHS SHALL, FOR THE PURPOSES OF AS 21.36.210 - 21.36.310, BE CONSIDERED TO BE WRITTEN FOR A POLICY PERIOD OR TERM OF 12 MONTHS EXCEPT IN CASE OF CANCELLATION UNDER ANY OF THE CIRCUMSTANCES SPECIFIED IN AS 21.36.210, AND A POLICY WRITTEN FOR A TERM] longer than one year or a policy with no fixed expiration date shall be considered to be written for successive policy periods or terms of one year**,** and termination by an insurer effective on an anniversary date of the policy shall be considered a failure to renew.

(b) **The rate for** [FOR DETERMINING THE APPROPRIATE RATE OR PREMIUM,] a personal automobile insurance policy **may not be changed more frequently than once every** [WITH A POLICY PERIOD OR TERM OF LESS THAN SIX MONTHS SHALL, FOR THE PURPOSES OF AS 21.36.210 - 21.36.310, BE CONSIDERED TO BE WRITTEN FOR A POLICY PERIOD OR TERM OF] six months.

*** Sec. 38.** AS 21.36.390 is repealed and reenacted to read:

Sec. 21.36.390. Notice to director. (a) An insurer or licensee that has reason to believe that a fraudulent claim has been made against it shall send the director a report disclosing information that the director may require.

(b) An insurer or licensee that has reason to believe that an insurance producer with which it is doing business is involved in a defalcation, embezzlement, or violation

of the provisions of AS 21.36.360 shall immediately send the director a report disclosing the basis for that belief and any other information that the director may require.

(c) An insurer or licensee, its employee or agent, or another person acting in good faith is not civilly liable for damages resulting from the filing of the report or the furnishing of information required by this section or by the director.

(d) The director shall investigate facts reported under this section and shall refer facts indicating a violation of law to the appropriate prosecutor or agency.

*** Sec. 39.** AS 21.39.045(b) is amended to read:

(b) The director shall accept a rate filing for workers' compensation insurance if the filing includes a reasonable method of recognizing differences in rates of pay **for the construction industry,** and the method uses a credit scale that begins at an amount equal to the average weekly wage in this state **for the construction industry** as determined by the Department of Labor.

*** Sec. 40.** AS 21.42.130 is amended to read:

Sec. 21.42.130. Grounds for disapproval. The director shall disapprove a form filed under AS 21.42.120 or withdraw a previous approval of the form [,] only if the form

(1) is in any respect in violation of or does not comply with this title;

(2) contains or incorporates by reference, where incorporation is permissible, an inconsistent, ambiguous, or misleading clause, or exception and condition that deceptively affects the risk purported to be assumed in the general coverage of the contract;

(3) has a title, heading, or other indication of its provisions that is misleading;

(4) is printed or otherwise reproduced in a manner that renders a provision of the form substantially illegible;

(5) provides benefits for Medicare **supplement** [SUPPLEMENTAL AND INDIVIDUAL HEALTH] insurance that are unreasonable in relation to the premium charged.

*** Sec. 41.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.205. Coordination of benefits. (a) Unless prohibited by federal law, an insurer authorized under AS 21.09 to offer, issue for delivery, deliver, or renew an individual or group health insurance policy for major medical coverage on an expense incurred basis; a health maintenance organization authorized under AS 21.86 to offer a contract to provide major medical health care services on a prepaid basis; or a service corporation authorized under AS 21.87 to offer or renew an individual or group subscriber's contract for major medical coverage shall include a coordination of benefits provision in a major medical policy or contract.

(b) The director may adopt regulations to implement this section.

*** Sec. 42.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.265. Effective date of coverage. Unless otherwise provided by law, the effective date of a change relating to coverage under an insurance contract as a result of a change to this title is the issue date for a new policy or the renewal date for a renewal policy.

*** Sec. 43.** AS 21.42.345 is repealed and reenacted to read:

Sec. 21.42.345. Required provision for coverage of dependents. (a) A health care insurance plan providing coverage for a dependent of a covered individual shall, as to the dependent’s coverage, also provide that the health care insurance benefits applicable for dependents shall be payable with respect to

(1) a newly born child of a covered individual from the moment of birth;

(2) a child adopted by a covered individual from the date of adoption;

(3) a child placed with a covered individual for adoption from the date of placement for adoption; and

(4) a spouse from not later than the first day of the first month beginning after the date the request for enrollment is received, but the insurer may require that a request for enrollment be received within 31 days of the date of marriage.

(b) The coverage for a newly born child under this section shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(c) If payment of a specific charge is required to provide coverage for a child under this section, the policy or contract may require that notification of birth of a newly born child, adopted child, or child placed for adoption and payment of the required premium or fees may be required to be furnished to the health care insurer within 31 days after the date of birth, adoption, or placement for adoption in order to have the coverage continue beyond the 31-day period.

(d) Under (a) - (c) of this section, a health care insurer shall offer coverage for a family member, including a newly born child, adopted child, or child placed for adoption, regardless of the marital status of the covered individual.

*** Sec. 44.** AS 21.42.347(a) is amended to read:

(a) **A health care** [AN] insurer who provides coverage for the costs of childbirth shall also provide coverage for the costs of hospitalization or medical care following childbirth for a period of not less than

(1) 48 hours after a vaginal birth; and

(2) 96 hours after a caesarean birth.

*** Sec. 45.** AS 21.42.347(b) is amended to read:

(b) Except as otherwise required to provide coverage specified under (a) of this section, this section does not affect a payment arrangement entered into between a hospital or **health care provider** [PHYSICIAN] and **a health care** [AN] insurer.

*** Sec. 46.** AS 21.42.347(d)(2) is repealed and reenacted to read:

(2) "health care insurer" has the meaning given in AS 21.54.500; "health care insurer" includes the Comprehensive Health Insurance Association as described in AS 21.55.010.

*** Sec. 47.** AS 21.42.353 is repealed and reenacted to read:

Sec. 21.42.353. Coverage for the costs of acupuncture treatment. Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan may offer coverage for services of an acupuncturist licensed under AS 08.06 if the plan covers acupuncture treatment by a health care provider who is subject to other provisions of AS 08.

*** Sec. 48.** AS 21.42.355 is amended to read:

Sec. 21.42.355. Coverage for cost of services provided by nurse midwives.

(a) If **a health care insurance plan or an excepted benefits policy or contract** [AN INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY, SUBSCRIBER'S CONTRACT, ENROLLEE CONTRACT, OR FRATERNAL BENEFIT SOCIETY CERTIFICATE] provides indemnity for the cost of services of a physician provided to women during pregnancy, childbirth, and the period after childbirth, indemnity in a reasonable amount shall also be provided for the cost of an advanced nurse practitioner who provides the same services. Indemnity may be provided under this subsection only if the advanced nurse practitioner is certified to practice as a nurse midwife in accordance with regulations adopted under AS 08.68.100(a), and the services provided are within the scope of practice authorized by that certification.

(b) If **a health care insurance plan or an excepted benefits policy or contract** [AN INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY, SUBSCRIBER'S CONTRACT, ENROLLEE CONTRACT, OR FRATERNAL BENEFIT SOCIETY CERTIFICATE] provides for furnishing those services required of a physician in the care of women during pregnancy, childbirth, and the period after childbirth, the contract shall also provide that an advanced nurse practitioner may furnish those same services instead of a physician. Services may be provided under this subsection only if the advanced nurse practitioner is certified to practice as a nurse midwife in accordance with regulations adopted under AS 08.68.100(a), and the services provided are within the scope of practice authorized by that certification.

*** Sec. 49.** AS 21.42.365 is repealed and reenacted to read:

Sec. 21.42.365. Coverage for treatment of alcoholism or drug abuse. (a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan, except for catastrophic illness insurance, providing coverage for five or more employees of an employer in the group market shall provide a covered employee or the employee's dependent the following coverage for treatment of alcoholism or drug abuse:

(1) benefits of at least $9,600 over two consecutive benefit years; and

(2) lifetime benefits of at least $19,200.

(b) The benefits described in (a) of this section shall be adjusted January 1, 1999, by the director and every three years thereafter to correspond with the

change in the medical care component of the consumer price index for all urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor Statistics, United States Department of Labor. The base year for the first adjustment shall be calendar year 1996.

(c) A health care insurer that offers a health care insurance plan providing coverage under this section may not

(1) require that a covered employee or the employee's dependent be responsible for a deductible or copayment that is different for the determination of benefits relating to treating alcoholism or drug abuse than for the determination of benefits for treating another covered illness;

(2) use a different claim payment methodology in determining the benefits relating to treating alcoholism or drug abuse than that used in determining the benefits for treating another covered illness;

(3) require prenotification of treatment or a second opinion unless the requirement is applicable to other covered major illnesses;

(4) limit coverage by provisions of the insurance contract that are not applicable to other covered major illnesses, including provisions concerning preexisting illnesses or provisions requiring that the exact date of onset be known;

(5) limit treatment services under the insurance contract to either an inpatient or outpatient service;

(6) exclude from coverage the cost of medically necessary treatment, including medical or psychiatric evaluation, activity or family therapy, counseling, or prescription drugs or supplies received at an approved treatment facility; or

(7) deny reimbursement for actual services rendered solely because treatment was interrupted or not completed.

(d) Notwithstanding (a) of this section, if an employer employs fewer than 20 permanent, full-time employees for each working day during each of at least 20 calendar workweeks in either the current calendar year or the preceding calendar year, a health care insurer is not required to provide the coverage specified in (a) of this section to the employer but shall offer that coverage to the employer as optional coverage.

(e) In this section,

(1) "alcoholism or drug abuse" means an illness characterized by

(A) a physiological or psychological dependency, or both, on alcoholic beverages or controlled substances as defined in AS 11.71.900; or

(B) habitual lack of self-control in using alcoholic beverages or controlled substances to the extent that the person's health is substantially impaired or the person's social or economic function is substantially disrupted;

(2) "approved treatment facility" means treatment in a facility that is either approved under AS 47.37.140 or located and licensed for treatment of alcoholism or drug abuse in another state;

(3) "catastrophic illness insurance" means a health care insurance plan that provides benefits for hospital and medical care with a lifetime maximum benefit per insured of at least $250,000 and that has a deductible of at least $5,000;

(4) "cost" means the least of the following:

(A) the actual charge for the treatment received for alcoholism or drug abuse;

(B) the usual, customary, and reasonable charge for the treatment as determined by the contract of coverage; or

(C) the charged agreed to by contract between the treatment provider and the health care insurer;

(5) "treatment" means medical care, including detoxification, as an inpatient or outpatient at an approved treatment facility.

*** Sec. 50.** AS 21.42.375(a) is repealed and reenacted to read:

(a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan shall provide coverage for low-dose mammography screening under the schedule described in (b) of this section if the plan covers mastectomies and prosthetic devices and reconstructive surgery incident to mastectomies.

*** Sec. 51.** AS 21.42.375(b) is amended to read:

(b) The minimum coverage required under (a) of this section includes

(1) a baseline mammogram for a **covered individual** [PERSON] who

is at least 35 years of age but less than 40 years of age;

(2) one mammogram every two years for a **covered individual** [PERSON] who is at least 40 years of age but less than 50 years of age;

(3) an annual mammogram for a **covered individual** [PERSON] who is at least 50 years of age;

(4) a mammogram at any age for a **covered individual** [PERSON] with a history of breast cancer or whose parent or sibling has a history of breast cancer, upon referral by a physician.

*** Sec. 52.** AS 21.42.375(c) is amended to read:

(c) The coverage required by this section

(1) must be included in the **health care insurance plan** [POLICY OR CONTRACT] on a basis that is not less favorable than for other radiological examinations;

(2) may be subject to standard policy provisions applicable to other benefits**,** such as deductible or copayment provisions.

*** Sec. 53.** AS 21.42.380 is repealed and reenacted to read:

Sec. 21.42.380. Coverage for treatment of phenylketonuria. (a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan shall provide coverage under the plan for the formulas necessary for the treatment of phenylketonuria. This subsection does not apply to a health care insurance plan that the director has determined by order should be excluded from this subsection.

(b) A health care insurer providing coverage under this section may impose reasonable contract limitations but may not refuse coverage based on a preexisting condition of phenylketonuria or require that an individual covered under the plan pay a higher deductible or copayment for the cost of treating phenylketonuria than for the cost of treating another condition or illness.

(c) In this section, "cost" means the lowest of the following:

(1) the actual charge for the treatment received for phenylketonuria;

(2) the usual, customary, and reasonable charge for the treatment as determined by the contract of coverage; or

(3) the charge agreed to by contract between the treatment provider and the health care insurer.

*** Sec. 54.** AS 21.42.385 is repealed and reenacted to read:

Sec. 21.42.385. Dental, vision, and hearing coverage. (a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan, including a Medicare supplement policy to the extent not prohibited by 42 U.S.C. 1395, shall offer to each plan sponsor or individual minimum dental, vision, and hearing coverage described in (b) of this section. Coverage required under this subsection may be offered as a rider or in a separate policy.

(b) The minimum coverage required under (a) of this section may

(1) be provided under contract with another health care insurer; and

(2) not be less than the dental, vision, and hearing coverage provided on January 1, 1992, to an individual entitled to medical benefits under AS 39.35.535 (public employees' retirement system of Alaska).

(c) This section does not apply to a health care insurer that has written less than $300,000 in premiums in the previous calendar year. A health care insurer exempt under this subsection shall disclose the exemption when offering, issuing for delivery, delivering, or renewing a health care insurance plan or an excepted benefits contract, and shall advise the individual covered under the plan that health care insurers that have written more than $300,000 in premiums in the previous calendar year are required to offer coverage under (a) and (b) of this section.

(d) This section does not require an insurer who offers only group insurance coverage under AS 21.54 to offer dental, vision, and hearing coverage to an individual.

*** Sec. 55.** AS 21.42.395(a) is repealed and reenacted to read:

(a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan shall provide coverage for the costs of prostate cancer screening tests as required under the schedule described in (b) of this section and shall provide coverage for the costs of cervical cancer screening tests as required under (c) of this section. The coverage required by this section is subject to standard policy provisions applicable to other

benefits, including deductible or copayment provisions. If a physician recommends that a covered individual undergo prostate cancer screening by taking a prostate antigen blood test, coverage may not be denied because the covered individual has already had a digital rectal examination and the examination results were negative.

*** Sec. 56.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.500. Definitions. In AS 21.42.345 - 21.42.395,

(1) "copayment" means the portion of medical care expenses in excess of the deductible to be paid by a covered individual;

(2) "deductible" means the portion of medical care expenses for which a covered individual must pay before benefits become payable;

(3) "excepted benefits" has the meaning given in AS 21.54.160;

(4) "fraternal benefit society" has the meaning given in AS 21.84.900;

(5) "health care insurance plan" has the meaning given in AS 21.54.500;

(6) "health care insurer" has the meaning given in AS 21.54.500;

(7) "placed for adoption" has the meaning given in AS 21.54.500.

*** Sec. 57.** AS 21.53.090 is amended to read:

Sec. 21.53.090. Required regulations. The director shall adopt regulations regarding

(1) the sale of long-term care insurance that provide **minimum** standards for

(A) [(1)] terms of renewability;

(B) [(2)] initial and subsequent conditions of eligibility;

(C) [(3)] nonduplication of coverage provisions;

(D) [(4)] coverage of dependents;

(E) benefit triggers;

(F) [(5)] preexisting conditions **and recurrent conditions**;

(G) [(6)] termination of insurance;

(H) [(7)] continuation or conversion;

(I) [(8)] probationary periods, limitations, exceptions, reductions, **and** elimination periods**;** [,] and

(J) requirements for replacement**;**

(2) standard definitions of long-term care insurance terms;

(3) nonforfeiture or minimum value requirements; and

(4) consumer protection standards, including standards for full and fair disclosure setting out the manner and content of required disclosures.

*** Sec. 58.** AS 21.54 is amended by adding a new section to read:

Sec. 21.54.015. Rate requirements. Rates charged for a group health insurance policy may not be excessive, inadequate, or unfairly discriminatory.

*** Sec. 59.** AS 21.54 is amended by adding new sections to read:

Article 2. Health Care Insurance Provisions.

Sec. 21.54.100. Unfair discrimination. (a) A health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan in the group market may not establish rules for eligibility, including continued eligibility and waiting periods under the plan, for an individual or dependent of an individual based on

(1) health status;

(2) medical condition, including physical and mental illnesses;

(3) claims experience;

(4) receipt of health care;

(5) medical history;

(6) genetic information;

(7) evidence of insurability, including conditions arising from acts of domestic violence; or

(8) disability.

(b) A health care insurer may not require an individual, as a condition of enrollment or continued enrollment under a health care insurance plan offered in the group market, to pay a premium, contribution, or policy fee greater than a premium, contribution, or policy fee for a similarly situated individual already enrolled in the plan on the basis of a health status factor for the individual or a dependent of the individual.

Sec. 21.54.110. Preexisting condition exclusion. (a) A health care insurance plan offered, issued for delivery, delivered, or renewed in the group market may not

contain a preexisting condition exclusion that

(1) relates to a condition, regardless of cause, for which medical advice, diagnosis, care, or treatment was recommended or received more than six months before the enrollment date;

(2) considers genetic information as a condition for which a preexisting condition exclusion may be imposed in absence of a diagnosis of the condition related to the information;

(3) extends for more than 12 months after the enrollment date of a covered individual; or

(4) excludes a condition relating to pregnancy.

(b) A period of a preexisting condition exclusion permissible under (a) of this section must be reduced by the aggregate of periods of creditable coverage, if any, as determined in AS 21.54.120, applicable to the participant or beneficiary as of the enrollment date. The aggregate of periods of creditable coverage is determined by adding together all periods of creditable coverage before the enrollment date, excluding periods of creditable coverage before a continuous break in coverage of more than 90 days. A waiting period or affiliation period may not be considered in determining the 90-day period. This subsection does not apply if an individual's most recent period of creditable coverage ended on a date more than 90 days before the enrollment date. This subsection does not preclude application of a waiting period to all new enrollees under a health care insurance plan.

(c) A health care insurance plan offered, issued for delivery, delivered, or renewed in this state in the group market may not apply a preexisting condition exclusion to an individual who is (1) a newborn covered under creditable coverage as of the last day of the 30-day period beginning with the date of birth; or (2) adopted or placed for adoption before attaining 18 years of age and who is covered under creditable coverage as of the last day of the 30-day period beginning with the date of adoption or placement for adoption. This subsection does not apply to an individual after the end of the first continuous 90-day period during all of which the individual was not covered under creditable coverage.

(d) A health care insurance plan offered, issued for delivery, delivered, or

renewed in this state in the group market may exclude coverage for late enrollees for the greater of 18 months or an 18-month preexisting condition exclusion. If both a waiting period and a preexisting condition exclusion under (a) of this section are applicable to a late enrollee, the combined period may not exceed 18 months from the date the individual enrolls for coverage under a health care insurance plan.

Sec. 21.54.120. Creditable coverage. (a) A health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan in the group market shall count a period of creditable coverage based on

(1) the standard method authorized by 42 U.S.C. 300gg (Health Insurance Portability and Accountability Act of 1996) for determining creditable coverage without regard to the specific benefits covered during the period; or

(2) an alternative method based on coverage of benefits within each of several classes or categories of benefits specified in federal regulation if

(A) made on a uniform basis for all participants and beneficiaries; and

(B) the insurer counts a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(b) A health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan in the group market shall provide a certification of coverage

(1) at the time an individual ceases to be covered under a health care insurance plan or becomes covered under a federal continuation provision;

(2) at the time an individual ceases to be covered under a federal continuation provision; and

(3) upon request by an individual or on behalf of an individual with 24 months after the date coverage under the health care insurance plan or a federal continuation provision ceases.

(c) A health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan in the group market shall establish periods of creditable coverage with respect to an individual through certification under (b) of this

section or as specified in federal regulation.

(d) A health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan in the group market shall prominently state and describe the effect of the health care insurer's election to count a period of creditable coverage using a permissible alternative method

(1) in any disclosure statement concerning the health care insurance plan or coverage;

(2) to each enrollee at the time of enrollment; and

(3) to each employer at the time of offer or sale of coverage.

(e) A health care insurer issuing a certification under (b) of this section shall disclose information regarding coverage of classes and categories of health benefits available under the health care insurer's plan at the request of an entity that

(1) enrolls an individual who has provided the certification of coverage;

(2) elects to count a period of creditable coverage according to a permissible alternative method under (a)(2) of this section; and

(3) pays the health care insurer for the reasonable cost, if any, of disclosing the information described in this subsection.

Sec. 21.54.130. Renewability, termination, and modification of coverage. (a) Except for a multiple employer welfare arrangement, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan in the group market shall renew or continue in force the coverage under the plan at the option of the plan sponsor unless

(1) the plan sponsor has failed to pay premiums or contributions in accordance with the terms of the health care insurance plan or the health care insurer has not received timely premium payments;

(2) the plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;

(3) the plan sponsor has failed to comply with a material plan provision relating to minimum participation or employer contribution requirements;

(4) the health care insurer ceases to offer coverage in accordance with

(b) and (c) of this section;

(5) the health care insurer offers the plan only through a network plan and there is no longer an enrollee in connection with the plan who lives, resides, or works in the service area of the insurer or in the area for which the insurer is authorized to transact business; or

(6) in the case of a plan that is made available only through a bona fide association, the employer's membership in the association ceases and coverage is terminated uniformly without regard to a health status factor of a covered individual.

(b) A health care insurer may discontinue offering a particular type of health care insurance plan in the group market as permitted by this title if the insurer

(1) provides written notice of the decision to discontinue coverage to all affected plan sponsors, participants, and beneficiaries and to the insurance regulatory official in each state in which an affected covered employee or dependent is known to reside; notice required under this paragraph must be given at least 180 days before the insurer fails to renew the health care insurance plan;

(2) provides written notice of the decision to discontinue coverage to the director and to the insurance regulatory official in each state in which the insurer is licensed at least 30 days before notice is given to the affected plan sponsors, participants, and beneficiaries as described under (1) of this subsection;

(3) offers to each plan sponsor who is provided the particular type of health care insurance plan the option to purchase another health care insurance plan currently being offered by the insurer to plan sponsors in the same market in the state; and

(4) acts uniformly without regard to the claims experience of those plan sponsors or to any health status factor of a covered participant or beneficiary or a new participant or beneficiary who may become eligible for coverage.

(c) A health care insurer may discontinue offering and renewing all health care insurance plans in the group market as permitted by this title if the insurer

(1) provides written notice of the decision to discontinue coverage to all affected plan sponsors, participants, and beneficiaries and to the insurance regulatory official in each state in which an affected covered employee or dependent

is known to reside; notice required under this paragraph must be given at least 180 days before discontinuation of the plans;

(2) provides written notice of the decision to discontinue coverage to the director and to the insurance regulatory official in each state in which the insurer is licensed at least 30 days before the notice is given to the affected plan sponsors, participants, and beneficiaries as described under (1) of this subsection; and

(3) does not issue a health care insurance plan in the group market in this state for five years from the date the last group health care insurance plan was discontinued.

(d) A health care insurer may modify a large employer's health care insurance plan at the time of plan renewal.

(e) Except for coverage available only through a bona fide association, a health care insurer may modify a small employer's health care insurance plan consistent with this title at the time of plan renewal only if the modification is uniform for all small employers with the same health care insurance plan.

(f) If a covered employee or dependent has committed a fraudulent act or made an intentional misrepresentation of a material fact in regard to a health care insurance plan, a health care insurer may terminate the coverage of the employee or the dependent under the plan.

(g) For purposes of this section, a plan sponsor includes an employer member of a bona fide association for a health care insurance plan made available by the health care insurer only through a bona fide association.

Sec. 21.54.140. Renewability of coverage for a multiple employer welfare arrangement. A health benefit plan that is a multiple employer welfare arrangement subject to this title may not deny an employer whose employees are covered under the plan continued access to the same or a different plan according to the terms of the plan, except

(1) for nonpayment of contributions;

(2) for fraud or other intentional misrepresentation of material fact by the employer;

(3) for noncompliance with material plan provisions;

(4) where the plan is ceasing to offer any coverage in a geographic area;

(5) for a health benefit plan that offers benefits through a network plan if

(A) there is no longer an individual enrolled through the employer who lives, resides, or works in the service area of the network plan; and

(B) the multiple employer welfare arrangement applies this paragraph without regard to the claims experience of the employer or a health status factor in relation to an individual or an individual's dependent; and

(6) for failure to meet the terms of an applicable collective bargaining agreement to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan or to employ employees covered by a collective bargaining agreement.

Sec. 21.54.150. Mental health benefits. (a) Except as provided in (d) of this section, a health care insurance plan sold in the large employer group market that provides both medical and surgical benefits and mental health benefits shall meet the following requirements:

(1) if the plan does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan may not provide for an aggregate lifetime limit on mental health benefits;

(2) if the plan includes an aggregate lifetime limit on substantially all medical and surgical benefits, the plan must

(A) include the mental health benefits within the aggregate lifetime limit and may not distinguish in the application of the limit between medical and surgical benefits and mental health benefits; or

(B) provide an aggregate lifetime limit for mental health benefits that is not less than the aggregate lifetime limit for medical and surgical benefits;

(3) if the plan includes different aggregate lifetime limits or none on different categories of medical and surgical benefits, the plan must provide for

aggregate lifetime limits on mental health benefits consistent with federal law;

(4) if the plan does not include an annual limit on substantially all medical and surgical benefits, the plan may not provide for an annual limit on mental health benefits;

(5) if the plan includes an annual limit on substantially all medical and surgical benefits, the plan must

(A) include the mental health benefits with the annual limit and may not distinguish in the application of the limit between medical and surgical benefits and mental health benefits; or

(B) provide an annual limit for mental health benefits that is not less than the annual limit for medical and surgical benefits; and

(6) if the plan includes different annual limits or none on different categories of medical and surgical benefits, the plan must provide for annual limits on mental health benefits consistent with federal law.

(b) Except as provided otherwise in this title, a health care insurance plan is not required to provide mental health benefits.

(c) Except as otherwise provided in this title, this section does not affect the terms and conditions relating to the amount, duration, or scope of mental health benefits under a health care insurance plan that provides mental health benefits, including cost sharing, limits on number of visits or days of coverage, and requirements relating to medical necessity.

(d) This section does not apply if application of this section would result in an increase in the cost under the health care insurance plan of at least one percent.

Sec. 21.54.160. "Excepted benefits" defined. "Excepted benefits" means benefits under one or more or any combination of the following:

(1) benefits under

(A) coverage only for accident, disability income insurance, or both;

(B) coverage issued as a supplement to liability insurance;

(C) liability insurance, including general liability insurance and automobile liability insurance;

(D) workers' compensation or substantially similar insurance;

(E) automobile medical payment insurance;

(F) credit-only insurance;

(G) coverage for on-site medical clinics; or

(H) other similar insurance coverage, as specified in federal law, under which benefits for medical care are secondary or incidental to other insurance benefits;

(2) if offered as a separate insurance policy and otherwise not an integral part of a health care insurance plan, benefits under

(A) limited scope dental or vision coverage;

(B) coverage for long-term care, nursing home care, home health care, community-based care, or any combination; or

(C) other similar limited benefits as specified in federal law;

(3) if offered as independent noncoordinated benefits, benefits under coverage only for a specified disease or illness, or hospital indemnity or other fixed indemnity insurance; as used in this paragraph, "independent, noncoordinated benefits" means benefits that are provided under a separate policy if

(A) there is no coordination between the provision of the benefits and an exclusion of benefits under a health care insurance plan maintained by the same plan sponsor; and

(B) the benefits are paid with respect to an event without regard to whether benefits are provided for the event under a health care insurance plan maintained by the same plan sponsor;

(4) if offered as a separate insurance policy, benefits under

(A) Medicare supplement health insurance as defined in 42 U.S.C. 1345ss(g)(1) (Social Security Act);

(B) coverage supplemental to the coverage provided under 10 U.S.C. 1071 - 1090; or

(C) similar supplemental coverage provided to coverage under a health benefit plan.

Sec. 21.54.170. Determination of size of employer. The determination of

whether an employer is a large or small employer is subject to the following:

(1) the size of an employer that was not in existence throughout the preceding calendar year must be based on the average number of employees that the employer is reasonably expected to employ on the business days in the current calendar year;

(2) all persons treated as a single employer under 26 U.S.C. 414(b), (c), (m), or (o) must be treated as one employer; and

(3) a reference to a large or small employer includes by reference any predecessor of that employer.

Article 3. Definitions.

Sec. 21.54.500. Definitions. In this chapter,

(1) "aggregate lifetime limit" means a dollar limit on the total amount that may be paid for benefits under a health care insurance plan offered in the group market with respect to an individual or unit of coverage;

(2) "annual limit" means a dollar limit on the total amount that may be paid for benefits in a 12-month period under the plan with respect to an individual or unit of coverage;

(3) "beneficiary" has the meaning given under 29 U.S.C. 1002(8) (Employee Retirement Income Security Act of 1974);

(4) "bona fide association" means an association that

(A) has been actively in existence for five years;

(B) has been formed and maintained in good faith for purposes other than obtaining insurance;

(C) does not condition membership in the association on a health status factor relating to an individual;

(D) makes health care insurance available to all members and dependents of members regardless of a health status factor in relation to the member or dependent;

(E) does not offer a health care insurance plan to an individual other than in connection with a member of the association; and

(F) meets any other requirement established by the director in

regulations;

(5) "certification of coverage" means a written certification of

(A) the period of creditable coverage of an individual under a health benefit plan or health care insurance plan offered in the group market, including coverage under a federal continuation provision; and

(B) the waiting period imposed with respect to the individual for coverage under the health benefit plan or health care insurance plan offered in the group market;

(6) "church plan" has the meaning given under 29 U.S.C. 1002(33) (Employee Retirement Income Security Act of 1974);

(7) "creditable coverage" means, with respect to an individual, coverage, excluding excepted benefits, calculated as required under AS 21.54.120 and applicable under

(A) a health care insurance plan offered in the group market;

(B) a health benefit plan;

(C) 42 U.S.C. 1395c or 1395j (Part A or Part B of Title XVIII of the Social Security Act):

(D) 42 U.S.C. 1396 (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under 42 U.S.C. 1396s;

(E) 10 U.S.C. 1071 - 1090;

(F) a medical care program of the Indian Health Service or of a tribal organization;

(G) AS 21.55;

(H) 5 U.S.C. 8901 - 8914;

(I) a public health plan as defined under federal law; or

(J) a health benefit plan under 22 U.S.C. 2504(e) (Peace Corps Act);

(8) "employee" has the meaning given under 29 U.S.C. 1002(6) (Employee Retirement Income Security Act of 1974);

(9) "employer" has the meaning given under 29 U.S.C. 1002(5) (Employee Retirement Income Security Act of 1974); for purposes of this chapter,

"employer" includes a large or small employer, including a person, firm, corporation, partnership, association, or political subdivision, that is actively engaged in business;

(10) "enrollment date" means the date of enrollment of an individual in a health benefit plan or health care insurance plan offered in the group market or the first day of the waiting period for enrollment, whichever occurs first;

(11) "federal continuation provision" means a "COBRA continuation provision" as defined in 42 U.S.C. 300gg-91(d) (Health Insurance Portability and Accountability Act of 1996);

(12) "federal governmental plan" means a governmental plan established or maintained for employees of the United States government or by an agency or instrumentality of the United States government;

(13) "governmental plan" has the meaning given under 29 U.S.C. 1002(32) Employee Retirement Income Security Act of 1974);

(14) "group market" means the health care insurance market in which individuals obtain health care insurance coverage on behalf of themselves and their dependents through a health benefit plan maintained by a large or small employer; "group market" includes a health benefit plan for a small employer in the group market that includes an arrangement under which

(A) a portion of the premium or benefits is paid by a small employer;

(B) a covered individual or dependent is reimbursed, through wage adjustments or otherwise, by or on behalf of a small employer for all or a portion of the premium; or

(C) the health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of 26 U.S.C. 106 or 26 U.S.C. 162 (Internal Revenue Code);

(15) "health benefit plan" means an employee welfare benefit plan as defined in 29 U.S.C. 1002(1) (Employee Retirement Income Security Act of 1974), and includes a plan, fund, or program established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care, including items and services paid for as medical care to employees, present or former partners, or their

dependents, as defined under the terms of the plan, fund, or program, directly or through insurance, reimbursement, or other method;

(16) "health care insurance plan" means a health care insurance policy or contract provided by a health care insurer but does not include an excepted benefits policy or contract;

(17) "health care insurer" means a person transacting the business of health care insurance, including an insurance company licensed under AS 21.09, a hospital or medical service corporation licensed under AS 21.87, a fraternal benefit society licensed under AS 21.84, a health maintenance organization licensed under AS 21.86, a multiple employer welfare arrangement, a church plan, and a governmental plan, except for a nonfederal governmental plan that elects to be excluded under 40 U.S.C. 300gg-21(b)(2) (Health Insurance Portability and Accountability Act of 1996);

(18) "health status factor" means any of the factors described in AS 21.54.100(a);

(19) "large employer" means an employer that employed an average of at least 51 employees on the business days during the preceding calendar year and that employs at least two employees on the first day of a health benefit plan year;

(20) "late enrollee" means a participant or beneficiary who requests enrollment in an employer's health care insurance plan following the initial enrollment period for which the participant or beneficiary was eligible to enroll under the terms of a health care insurance plan, except that a participant or beneficiary may not be considered a late enrollee if

(A) the individual requests enrollment within 30 days after the termination of the creditable coverage or the exhaustion of coverage and

(i) was covered under creditable coverage at the time of the initial enrollment;

(ii) has lost creditable coverage as a result of the termination of employer contributions toward coverage or the termination of eligibility, including death, divorce, dissolution of marriage, legal separation, or a reduction in number of hours of

employment; or

(iii) had coverage under a federal continuation provision and the coverage under that provision was exhausted;

(B) the individual is employed by an employer who offers multiple health care insurance plans and the individual elects a different health care insurance plan during an open enrollment period; or

(C) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made within 30 days after issuance of the court order;

(21) "medical and surgical benefits" means benefits provided for medical or surgical services, but does not include mental health benefits;

(22) "mental health benefits" means benefits provided for mental health services as defined under the terms of the health care insurance plan, but does not include benefits for treatment of substance abuse or chemical dependency;

(23) "network plan" means a health care insurance plan offered in the group market or by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided in whole or in part through a defined set of providers under contract with the insurer;

(24) "participant" has the meaning given under 29 U.S.C. 1002(7) (Employee Retirement Income Security Act of 1974); "participant" includes a

(A) partner in relation to a partnership; or

(B) self-employed individual if the individual or the individual's beneficiaries are or may become eligible to receive benefits under a health benefit plan maintained by the self-employed individual;

(25) "placed for adoption" means the assumption and retention by an individual of a legal obligation for total or partial support of a child in anticipation of adopting the child;

(26) "plan sponsor" has the meaning given under 29 U.S.C. 1002(16)(B) (Employee Retirement Income Security Act of 1974);

(27) "preexisting condition exclusion" means a limitation or exclusion of benefits relating to a physical or mental condition that was present before the

enrollment date, regardless of whether medical advice, diagnosis, care, or treatment was recommended or received before the enrollment date;

(28) "small employer" means an employer that employed an average of at least two but not more than 50 employees on the business days during the preceding calendar year and that employs at least two employees on the first day of a health benefit plan year;

(29) "waiting period" means the period that must pass before an individual who is a potential participant or beneficiary in a health care insurance plan offered in the group market is eligible to be covered for benefits under the terms of the plan.

*** Sec. 60.** AS 21.55.100(a) is amended to read:

(a) The association shall make available to residents who are high risks **or to federally defined eligible individuals** an individual state plan of health insurance. The association shall offer three alternatives related to deductibles as described in AS 21.55.120 and may offer additional deductible alternatives.

*** Sec. 61.** AS 21.55.100(c) is amended to read:

(c) The association may not refuse to offer coverage under a state plan to residents who are high risks**, or to federally defined eligible individuals,** [AND] who are eligible under this chapter. The association may not refuse coverage under a state plan to residents who are high risks**, or to federally defined eligible individuals, who** [,] are eligible under this chapter, apply for coverage, and pay the required premium.

*** Sec. 62.** AS 21.55.100(d) is amended to read:

(d) The association may make available to residents who are high risks **and to federally defined eligible individuals** coverage through a health maintenance organization or other managed care arrangement as approved by the director.

*** Sec. 63.** AS 21.55.130 is amended by adding a new subsection to read:

(d) A state plan issued to a federally defined eligible individual may not impose a preexisting condition exclusion.

*** Sec. 64.** AS 21.55.300(a) is amended to read:

(a) Except as provided in this section, a state resident who is a high risk **or a federally defined eligible individual** is eligible to enroll in a state plan described

in AS 21.55.100.

*** Sec. 65.** AS 21.55.300(b) is amended to read:

(b) **Except for a federally defined eligible individual, a** [A] person may not be covered by the state plan

(1) while covered by another health insurance policy or subscriber contract; or

(2) if the person is eligible to be covered by a plan subject to the requirements of AS 21.56.110 - 21.56.250.

*** Sec. 66.** AS 21.55.310 is amended to read:

Sec. 21.55.310. Enrollment by an eligible person. A person may enroll in a state plan by applying to the writing carrier. The application must include the following:

(1) name, address, age, and length of residency of the applicant;

(2) a designation of the plan desired, including deductible option chosen;

(3) information relevant to whether the person is a high risk **or a federally defined eligible individual**; and

(4) payment of the first premium.

*** Sec. 67.** AS 21.55.500(9) is repealed and reenacted to read:

(9) "resident" means

(A) except for a federally defined eligible individual and an individual who is absent from the state for more than 90 consecutive days for reasons other than for medical treatment or education, an individual who

(i) is physically present in the state, has lived in the state for at least the 12 consecutive months immediately preceding the application for a state plan, and intends to remain permanently in the state; or

(ii) is not physically present in the state if the person lived in the state for at least nine of the 12 months immediately preceding application for a state plan and the person's absence from the state is for medical treatment or education;

(B) for a federally defined eligible individual, an individual who is legally domiciled in this state.

*** Sec. 68.** AS 21.55.500 is amended by adding new paragraphs to read:

(14) "creditable coverage" has the meaning given in AS 21.54.500;

(15) "federal continuation provision" has the meaning given in AS 21.54.500;

(16) "federally defined eligible individual" means an individual

(A) with an aggregate of all periods of creditable coverage as provided under AS 21.54.110(b) that is greater than 18 months as of the date that the individual seeks coverage under this chapter;

(B) whose most recent prior creditable coverage was under a health benefit plan or health care insurance plan offered in the group market;

(C) who is not eligible for coverage under a health benefit plan, 42 U.S.C. 1395c or 42 U.S.C. 1395j (Part A or Part B of Title XVIII of the Social Security Act), or a state plan under 42 U.S.C. 1396 (Title XIX of the Social Security Act), and who does not have other health care insurance coverage;

(D) whose most recent coverage within the period of aggregate creditable coverage as provided under AS 21.54.110(b) was not terminated based on a factor relating to nonpayment of premiums or fraud;

(E) who, having been offered and having elected continuation coverage under a federal continuation provision or a similar state program, has exhausted coverage under the continuation provision or program;

(17) "group market" has the meaning given in AS 21.54.500;

(18) "health benefit plan" has the meaning given in AS 21.54.500;

(19) "health care insurance plan" has the meaning given in AS 21.54.500;

(20) "health care insurer" has the meaning given in AS 21.54.500;

(21) "preexisting condition exclusion" has the meaning given in AS 21.54.500.

*** Sec. 69.** AS 21.56.010 is amended to read:

Sec. 21.56.010. Creation; membership. A nonprofit incorporated legal entity to be known as the Small Employer Health Reinsurance Association is established. Membership consists of all **health care** insurers [LICENSED TO TRANSACT HEALTH INSURANCE IN THE STATE THAT OFFER A HEALTH BENEFIT PLAN]. All members shall maintain membership in the **reinsurance** association as a condition of **transacting** [DOING] health **care** insurance business [, OR BEING ABLE TO OFFER SUBSCRIBER CONTRACTS,] in the state.

*** Sec. 70.** AS 21.56.020(a) is amended to read:

(a) The board of directors of the **reinsurance** association consists of nine individuals selected by participating members, subject to approval by the director. The director shall endeavor to appoint at least six board members who are also small employer insurers. If the director is unable to appoint six board members who are also small employer insurers, the director may fill the remaining seats with any insurer. In selecting members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented.

*** Sec. 71.** AS 21.56.020(b) is amended to read:

(b) To the extent possible, one board member shall represent a health maintenance organization, one board member shall represent a hospital or medical service corporation, one board member's principal health insurance business shall be in the small employer **group** market, and one board member's principal health insurance business shall be in the large employer **group** market. Members of the board may be reimbursed from the **reinsurance** association for expenses incurred by them as members, but may not otherwise be compensated by the **reinsurance** association for their services. The costs of conducting meetings of the **reinsurance** association and its board of directors shall be borne by the **reinsurance** association.

*** Sec. 72.** AS 21.56.030 is amended to read:

Sec. 21.56.030. General powers. The **reinsurance** association may

(1) exercise the powers granted to insurers under the laws of the state, except that the **reinsurance** association may not issue insurance;

(2) sue or be sued;

(3) enter into contracts with insurers, similar **reinsurance** associations

in other states, or with other persons for the performance of administrative functions;

(4) establish administrative and accounting procedures for the operation of the **reinsurance** association;

(5) take legal action as necessary to avoid the payment of improper claims against the **reinsurance** association;

(6) define the array of health coverage products for which reinsurance will be provided and issue reinsurance policies;

(7) establish rules, conditions, and procedures pertaining to the reinsurance of members' risks by the **reinsurance** association;

(8) establish actuarial functions appropriate to the operation of the **reinsurance** association;

(9) assess members under the provisions of this chapter and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses; interim assessments shall be credited as offsets against regular assessments due following the close of the calendar year;

(10) appoint appropriate legal, actuarial, and other committees as are necessary to provide technical assistance in the operation of the **reinsurance** association, design of a policy or contract, or to assist in other functions of the **reinsurance** association;

(11) borrow money to accomplish the purposes of the **reinsurance** association; notes or other evidence of indebtedness of the **reinsurance** association that are not in default are investments for insurers and may be carried as admitted assets.

*** Sec. 73.** AS 21.56.040 is amended to read:

Sec. 21.56.040. Plan of operation. (a) The **reinsurance** association shall submit to the director a plan of operation and amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the **reinsurance** association. The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure the fair, reasonable, and equitable administration of the program on a proportionate basis under the provisions of this section and it does not shift program costs to other insured persons or the state. The plan of operation and amendments become effective upon approval in writing by the director.

(b) All members of the **reinsurance** association shall comply with the plan of operation.

(c) The plan of operation must establish procedures for

(1) handling and accounting of program assets and money of the **reinsurance** association and for an annual fiscal report to the director;

(2) reinsuring risks under the provisions of this section;

(3) collecting assessments from all members to provide for claims reinsured by the **reinsurance** association and for administrative expenses incurred or estimated to be incurred by the **reinsurance** association;

(4) selection of an administering insurer and establishing the administering insurer's powers and duties;

(5) effectuating a methodology for applying the dollar thresholds contained in this section for insurers that pay or reimburse health care providers by capitation or salary; and

(6) provisions necessary or proper for the execution of the powers and duties of the **reinsurance** association.

*** Sec. 74.** AS 21.56.050 is amended to read:

Sec. 21.56.050. Health care reinsurance. (a) A member may reinsure health care coverage of an eligible employee of a small employer or a dependent of an eligible employee of a small employer with the **reinsurance** association only under the following provisions:

(1) regarding a small employer basic or standard health **care insurance** [BENEFIT] plan, the **reinsurance** association shall reinsure the level of coverage provided;

(2) regarding a health care plan other than a small employer health **care insurance** [BENEFIT] plan, the **reinsurance** association shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in a small employer basic or standard health benefit plan;

(3) a small employer insurer may reinsure an entire employer group within 60 days of the commencement of the group's coverage under a health **care insurance** [BENEFIT] plan;

(4) a small employer insurer may reinsure an eligible employee or dependent within a period of 60 days following the commencement of the coverage with the small employer; a newly eligible employee or dependent of a reinsured small employer may be reinsured within 60 days of the commencement of coverage;

(5) the **reinsurance** association may not reimburse a reinsuring insurer regarding the claims of a reinsured employee or dependent until the insurer has paid an initial level of claims for the employee or dependent of $5,000 in a calendar year for benefits covered by the **reinsurance** association;

(6) a small employer insurer may terminate reinsurance for one or more of the reinsured employees or dependents of a small employer on any plan anniversary.

(b) Premium rates charged for coverage reinsured by the **reinsurance** association shall be established as required under (e) of this section and adjusted as follows:

(1) for whole group small employer reinsurance coverage, 1.5 multiplied by the base premium rate established by the **reinsurance** association for eligible employees, and dependents of eligible employees, of a small employer all of whose health insurance coverage is reinsured with the **reinsurance** association;

(2) for eligible employee or dependent health reinsurance coverage, 5.0 multiplied by the base premium rate established by the **reinsurance** association.

(c) If a health **care insurance** [BENEFIT] plan coverage for a small employer is entirely or partially reinsured with the **reinsurance** association, the premium charged to the small employer for a rating period for the coverage issued under this section shall meet the premium rate requirements established under AS 21.56.120.

(d) On or before March 1 of each year, the board shall determine and report to the director the **reinsurance** association's net loss for the previous calendar year, including administrative expenses and incurred losses for the year, taking into account investment income and other appropriate gains and losses. A net loss for the year shall be recovered by assessments collected from reinsuring insurers. The board shall establish, as part of the plan of operation, a formula by which to make assessments against reinsuring insurers. The assessment formula must be based on each reinsuring insurer's share of the total premiums earned in the preceding calendar year from health

care insurance [BENEFIT] plans delivered or issued for delivery to small employers in this state by reinsuring carriers and each reinsuring insurer's share of the premiums earned in the preceding calendar year from newly issued health **care insurance** [BENEFIT] plans delivered or issued for delivery during the calendar year to small employers in this state by reinsuring insurers. In determining an assessment, if any, that is collected from a member, the following provisions apply:

(1) the formula established under this subsection may not result in a reinsuring insurer having an assessment share that is less than 50 percent or more than 150 percent of an amount that is based on the proportion of the reinsuring insurer's total premiums earned in the preceding calendar year from health **care insurance** [BENEFIT] plans delivered or issued for delivery to small employers in this state by reinsuring insurers to total premiums earned in the preceding calendar year from health **care insurance** [BENEFIT] plans delivered or issued for delivery to small employers in this state by all reinsuring carriers;

(2) the board may, with approval of the director, change the assessment formula established under this section from time to time**,** as appropriate; the board may provide for the shares of the assessment base attributable to premiums from all health **care insurance** [BENEFIT] plans and to premiums from newly issued health **care insurance** [BENEFIT] plans to vary during a transition period;

(3) subject to the approval of the director, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved health maintenance organizations that are federally qualified under 42 U.S.C. 300, to the extent, if any, that restrictions are imposed on those organizations that are not imposed on other small employer **insurers** [CARRIERS];

(4) annually before March 1, the board shall determine and file with the director an estimate of the assessments needed to fund losses incurred by the **reinsurance** association in the previous calendar year;

(5) if the board determines that the assessments needed to fund the losses incurred by the **reinsurance** association in the previous calendar year will exceed five percent of total premiums earned in the previous year from health **care insurance** [BENEFIT] plans delivered or issued for delivery to small employers in this

state by reinsuring insurers, the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the director within 90 days following the end of the calendar year in which the losses were incurred; the evaluation must include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged, and the level of insurer retention under the program and the costs of coverage for small employers; if the board fails to file a report with the director within 90 days following the end of the applicable calendar year, the director may evaluate the operations of the program and implement amendments to the plan of operation the director determines necessary to reduce future losses and assessments;

(6) if assessments exceed net losses of the **reinsurance** association, the excess shall be held in an interest bearing account and used by the board to offset future losses or to reduce **reinsurance** association premiums; in this paragraph, "future losses" include a reserve for incurred but not reported claims;

(7) the board shall annually determine a member's proportion of participation in the **reinsurance** association based on annual statements and other reports determined necessary by the board and filed by the member with the board; an insurer shall report to the board a claim payment made and administrative expense incurred in this state on a semi-annual basis on a form prescribed by the director;

(8) the plan of operation must include a provision for the imposition of an interest penalty for late payment of assessments;

(9) a member may request a deferment from the director, in whole or in part, from an assessment issued by the board; the director may defer, in whole or in part, the assessment of a member if, in the opinion of the director payment of the assessment would endanger the ability of the member to fulfill the member's contractual obligations;

(10) in the event an assessment against a member is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessments set out in this subsection; the member receiving a deferment shall remain liable to the **reinsurance** association for the amount deferred; the director may attach conditions to a deferment;

a member receiving a deferment may not reinsure an individual or group as provided under this section until the assessment is paid.

(e) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals under this section. The methodology must include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer insurers in the state. The methodology must provide for the development of base reinsurance premium rates that shall be multiplied by the factors set out in (b) of this section to determine the premium rates for the **reinsurance** association. The base reinsurance premium rates shall be established by the board, subject to the approval of the director, and shall be set at levels that reasonably approximate gross premiums charged to small employers by small employer insurers for health **care insurance** [BENEFIT] plans with benefits similar to the standard health **care insurance** [BENEFIT] plan. The board shall review the methodology established under this subsection to ensure that the methodology reasonably reflects the claims experience of the program. Changes to the methodology may be proposed by the board [,] and are subject to approval by the director. In this subsection, "gross premiums" means the premium charged for insurance before reducing the premium for a dividend or rate credit.

*** Sec. 75.** AS 21.56.060 is amended to read:

Sec. 21.56.060. Health care insurance [BENEFIT] plan committee. (a) The health **care insurance** [BENEFIT] plan committee is established in the **reinsurance** association. The committee is composed of seven members selected by the director as follows:

(1) three members who are representatives of participating insurers;

(2) one member who represents small employers;

(3) one member who represents employees of small employers;

(4) one member who represents health care providers; and

(5) one member who represents agents or brokers.

(b) The committee shall recommend benefit levels, cost sharing levels, exclusions and limitations for the basic and standard health **care insurance**

[BENEFIT] plan offered under AS 21.56.140. The committee shall also design a basic health **care insurance** [BENEFIT] plan and a standard health **care insurance** [BENEFIT] plan that contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including restrictions imposed by federal law. The plans recommended by the committee may include the following cost containment features:

(1) utilization review of health care services, including review of the medical necessity of hospital and physician services;

(2) case management;

(3) selective contracting with hospitals, physicians, and other health care providers;

(4) reasonable benefit differentials applicable to providers that participate or do not participate in arrangements using restricted network provisions; and

(5) other managed care provisions.

*** Sec. 76.** AS 21.56.070 is amended to read:

Sec. 21.56.070. Required report. The board shall study and report at least once every two years to the director on the effectiveness of this chapter. The report must analyze the effectiveness of the chapter in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the small group health **care** insurance marketplace. The report must address whether insurers, agents, brokers, managing general agents, and third-party administrators are fairly and actively marketing or issuing health **care insurance** [BENEFIT] plans to small employers in fulfillment of the purposes of the chapter. The report may contain recommendations for market conduct or other regulatory standards or action. The board shall notify the legislature that the report is available.

*** Sec. 77.** AS 21.56 is amended by adding a new section to read:

Sec. 21.56.075. Premium report. A member shall file not later than March 15 of each year in a form prescribed by the director a report of total premiums earned in the preceding calendar year and other information required by the director

for health care insurance plans delivered or issued for delivery to small employers in this state.

*** Sec. 78.** AS 21.56.080 is amended to read:

Sec. 21.56.080. Administrative Procedure Act. The **reinsurance** association is exempt from AS 44.62 (Administrative Procedure Act).

*** Sec. 79.** AS 21.56.090 is amended to read:

Sec. 21.56.090. Tax exemption. The **reinsurance** association is exempt from the payment of fees and taxes levied by the state or any of its political subdivisions except taxes levied on real or personal property.

*** Sec. 80.** AS 21.56.100 is amended to read:

Sec. 21.56.100. Limitation of liability. A member of the **reinsurance** association is not liable for civil damages resulting from an act or omission of the member on behalf of the **reinsurance** association unless the member acts with gross negligence or intentional misconduct.

*** Sec. 81.** AS 21.56.110(a) is repealed and reenacted to read:

(a) A health care insurance plan offered, issued for delivery, delivered, or renewed to small employers in this state is subject to the provisions of this chapter.

*** Sec. 82.** AS 21.56.110(c) is amended to read:

(c) Except as provided in this subsection, for purposes of this chapter**,** insurers that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one insurer and a restriction or limitation imposed under this chapter shall apply as if all health **care insurance** [BENEFIT] plans delivered or issued for delivery to a small employer in this state by an affiliated insurer were issued by one insurer. An affiliated insurer that is a health maintenance organization having a certificate of authority under AS 21.86 may be considered to be a separate insurer for the purposes of this chapter.

*** Sec. 83.** AS 21.56.120(a) is amended to read:

(a) A premium rate for a health **care insurance** [BENEFIT] plan subject to this chapter is subject to the following provisions:

(1) the premium rate charged or offered during a rating period to small employers with similar case characteristics as determined by the insurer for the same

or similar coverage may not vary from the applicable index rate by more than 35 percent of the applicable index rate;

(2) regarding a health **care insurance** [BENEFIT] plan issued before July 1, 1993, if premium rates charged or offered for the same or similar coverage under a health **care insurance** [BENEFIT] plan covering a small employer with similar case characteristics as determined by the insurer exceeds the applicable index rate by more than 35 percent, an increase in premium rates for a new rating period may not exceed the sum of

(A) a percentage change in the base premium rate measured from the first day of the prior rating period to the first day of the new rating period; plus

(B) adjustments due to changes in case characteristics or plan design of the small employer, as determined by the insurer;

(3) the percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) the percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period; in the case of a health benefit plan into which the small employer insurer is no longer enrolling new small employers, the small employer insurer shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health **care insurance** [BENEFIT] plan into which the small employer insurer is actively enrolling new small employers;

(B) any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less than one year, due to the claim experience, health status, or duration of coverage of the employees or dependents of the small employer as determined from the small employer insurer's rate manual; and

(C) any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small

employer insurer's rate manual;

(4) adjustments in rates for claim experience, health status, and duration of coverage may not be charged to individual employees or dependents; any adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer;

(5) a premium rate for a health **care insurance** [BENEFIT] plan shall comply with the requirements of this section notwithstanding an assessment paid or payable by small employer insurers under AS 21.56.050(d);

(6) a small employer insurer may **use** [UTILIZE] industry as a case characteristic in establishing premium rates, provided that the rate factor associated with an industry classification may not vary by more than 15 percent from the arithmetic average of the highest and lowest rate factors associated with all industry classifications;

(7) a small employer insurer shall

(A) apply rating factors, including case characteristics, consistently with respect to all small employers; rating factors must produce premiums for identical groups that differ only by amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health **care insurance** [BENEFIT] plans; and

(B) treat all health **care insurance** [BENEFIT] plans issued or renewed in the same calendar month as having the same rating period;

(8) for the purposes of this subsection, a health **care insurance** [BENEFIT] plan that contains a restricted provider network may not be considered similar coverage to a health **care insurance** [BENEFIT] plan that does not **use** [UTILIZE] a restricted provider network if the restriction of benefits to network providers results in substantial differences in claim costs;

(9) a small employer insurer may not use case characteristics, other than age, sex, industry, geographic area, family composition, and group size without prior approval of the director.

*** Sec. 84.** AS 21.56.120(b) is amended to read:

(b) In connection with the offering for sale of a health **care insurance**

[BENEFIT] plan to a small employer, a small employer insurer shall [MAKE A REASONABLE DISCLOSURE], as part of its solicitation and sales materials, **disclose in a manner understandable by the average small employer and sufficient to reasonably inform small employers of their rights and obligations under the health care insurance plan** [OF THE FOLLOWING:]

(1) the extent that premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents; and

(2) the provisions of the health **care insurance** [BENEFIT] plan

(A) concerning the small employer insurer's right to change premium rates and factors [, OTHER THAN CLAIM EXPERIENCE] that affect changes in premium rates;

(B) relating to renewability of policies and contracts; [AND]

(C) relating to any preexisting condition provision**; and**

(D) concerning the benefits and premiums available under all health care insurance plans for which the small employer qualifies.

*** Sec. 85.** AS 21.56.120(d) is amended to read:

(d) The director may adopt regulations to implement the provisions of this section and to ensure that rating practices used by small employer insurers are consistent with the purposes of this chapter, including ensuring that differences in rates charged for health **care insurance** [BENEFIT] plans by small employer insurers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health **care insurance** [BENEFIT] plans.

*** Sec. 86.** AS 21.56.140 is repealed and reenacted to read:

Sec. 21.56.140. Required offer of coverage. (a) Except as provided under AS 21.56.160, a small employer insurer shall, as a condition of transacting business in this state with small employers, offer to small employers all health care insurance plans the small employer actively markets to small employers in this state, including a basic health care insurance plan and a standard health care insurance plan.

(b) A small employer insurer shall issue a health care insurance plan to a small employer that applies for a plan and shall accept for enrollment under the health care insurer coverage all eligible employees and their dependents who apply for enrollment during the period in which the employee first becomes eligible to enroll under the terms of the plan. A small employer insurer may not place a restriction on an eligible employee or dependent with respect to being a participant or beneficiary that is inconsistent with AS 21.54.100.

(c) A small employer insurer may not increase a requirement for minimum employee participation or for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, except that a small employer insurer may vary application of minimum participation and employer contribution requirements by the size of the small employer group.

(d) If a small employer insurer offers coverage to a small employer, the small employer insurer shall offer coverage to all of the eligible employees of the small employer and their dependents. A small employer insurer may not offer coverage to only certain individuals in a small employer group or to only part of the group, except in the case of late enrollees as provided in AS 21.54.110(d).

(e) The small employer insurer shall apply this section uniformly to all small employers without regard to the claims experience of the small employers and their employees and dependents or a health status factor of an employee or dependent.

(f) A small employer insurer may not, directly or indirectly, encourage or direct small employers to refrain from filing an application for coverage with a small employer insurer or to seek coverage from another insurer because of a health status factor, the claims experience, the industry, the occupation, or the geographic location of the small employer.

(g) Except as provided in AS 21.54.110, a small employer insurer may not, by a rider or amendment applicable to a specific individual, restrict or exclude coverage or benefits by type of illness, treatment, medical condition, or service otherwise covered by the plan.

(h) This section does not apply to health care insurance plans offered by a small employer insurer if the insurer makes the health care insurance plans available

in the small employer market only through a bona fide association.

*** Sec. 87.** AS 21.56.160 is repealed and reenacted to read:

Sec. 21.56.160. Exemption from required offer of coverage. (a) A small employer insurer offering health care insurance through a network plan is not required to offer or renew coverage or accept applications under AS 21.56.140(a) if

(1) the small employer does not have eligible employees or dependents who live, work, or reside in the service area for the network plan; or

(2) the small employer insurer demonstrates to the director that the small employer insurer

(A) will not have the capacity to deliver services adequately to eligible employees or dependents of additional groups because of the small employer insurer's obligation to existing group contract holders and covered employees or dependents; and

(B) applies this subsection uniformly without regard to the claims experience of the employers and their employees and dependents or to a health status factor relating to the employees and dependents.

(b) A small employer insurer offering health care insurance is not required to offer or accept applications under AS 21.56.140(a) if

(1) the small employer insurer is only maintaining in-force business and has ceased enrolling new employer groups on or before January 1, 1993; or

(2) the certificate of authority or bylaws of an insurer does not permit the insurer to issue coverage on a marketwide basis; however, an insurer described in this paragraph shall comply with AS 21.56.140 regarding small employers that meet the requirements of the insurer's certificate of authority or bylaws.

(c) A small employer insurer who denies health care insurance coverage in a service area under (a) of this section may not offer coverage in the small employer market within that service area for a period of 180 days after the date the coverage is denied.

(d) If a small employer insurer demonstrates or the director determines under AS 21.09.175 that a small employer insurer does not have the financial reserves necessary to underwrite additional coverage, the small employer insurer may not offer

or renew health care insurance coverage in the small employer group market. The small employer insurer may not reenter the small employer group market until the director has determined that the insurer has sufficient financial reserves to underwrite additional coverage.

*** Sec. 88.** AS 21.56.180 is repealed and reenacted to read:

Sec. 21.56.180. Fair marketing standards. (a) A small employer insurer may not, directly or indirectly, enter into a contract, agreement, or arrangement with an insurance producer, a managing general agent, or a third-party administrator that provides for or results in the compensation paid to an insurance producer for the sale of a health care insurance plan to vary based on the health status, claims experience, industry, occupation, or geographic location of the small employer. This subsection does not apply to a compensation arrangement that provides compensation to an insurance producer, a managing general agent, or a third-party administrator on the basis of a percentage of premium that does not vary based on the health status, claims experience, industry, occupation, or geographic area of the small employer.

(b) A small employer insurer shall provide reasonable compensation, as provided under the plan of operation of the program, to an insurance producer, a managing general agent, or a third-party administrator, if any, for the sale of a basic or standard health care insurance plan.

(c) A small employer insurer, an insurance producer, a managing general agent, or a third-party administrator may not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(d) A small employer insurer may only deny an application for coverage from a small employer in writing, and the writing must state the reasons for the denial.

(e) The director may establish by regulation additional standards to provide for the fair marketing of health care insurance plans to small employers in this state.

(f) A person who enters into a contract, agreement, or other arrangement with a small employer insurer to provide administrative, marketing, or other services related to the offering of health care insurance plans to small employers in this state is subject to this section as if it were a small employer insurer.

(g) A violation of this section by a person is an unfair trade practice for purposes of AS 21.36.

*** Sec. 89.** AS 21.56.190 is amended to read:

Sec. 21.56.190. Mandatory reissue of coverage. The director may adopt regulations to require small employer insurers, as a condition of transacting business with small employers in this state after July 1, 1993, to reissue a health **care insurance** [BENEFIT] plan to a small employer who has had its health **care insurance** [BENEFIT] plan terminated or not renewed by the insurer after January 1, 1993. The director may prescribe the terms for the reissue of coverage that the director determines are reasonable and necessary to provide continuity of coverage to small employers.

*** Sec. 90.** AS 21.56.250 is repealed and reenacted to read:

Sec. 21.56.250. Definitions. In this chapter,

(1) "actuarial certification" means a written statement by a member of the American Academy of Actuaries or another individual acceptable to the director indicating that, based on the person's examination, including a review of the appropriate records, actuarial assumptions, and methods used by the insurer in establishing premium rates for applicable health insurance plans, a small employer insurer is in compliance with the provisions of AS 21.56.120;

(2) "affiliated" means a person who directly or indirectly, through one or more intermediaries, controls or is controlled by or is under common control with a specified person;

(3) "base premium rate" means the lowest premium rate charged or that could have been charged under the rating system by the small employer insurer to small employers with similar case characteristics for health care insurance plans with the same or similar coverage;

(4) "basic health care insurance plan" means a lower cost plan offered under AS 21.56.140;

(5) "beneficiary" has the meaning given in AS 21.54.500;

(6) "board" means the board of directors of the Small Employer Health Reinsurance Association;

(7) "bona fide association" has the meaning given in AS 21.54.500;

(8) "case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer insurer in the determination of premium rates for the small employer, except that claim experience, health status, and duration of coverage may not be case characteristics for the purposes of this chapter;

(9) "committee" means the health benefit plan committee established in AS 21.56.060;

(10) "eligible employee" means an employee who works on a full-time basis, with a normal work week of 30 or more hours; "eligible employee" includes a sole proprietor, a partner of a partnership, or an independent contractor if the sole proprietor, partner, or contractor is included as an employee under a health care insurance plan of a small employer, but does not include an employee who works on a part-time, temporary, or substitute basis;

(11) "employee" has the meaning given in AS 21.54.500;

(12) "group market" has the meaning given in AS 21.54.500;

(13) "health care insurance plan" has the meaning given in AS 21.54.500;

(14) "health care insurer" has the meaning given in AS 21.54.500;

(15) "health status factor" has the meaning given in AS 21.54.500;

(16) "index rate" means, for small employers with similar case characteristics and plan designs as determined by the insurer for a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate,

(17) "large employer" has the meaning given in AS 21.54.500;

(18) "late enrollee" has the meaning given in AS 21.54.500;

(19) "member" means a health care insurer;

(20) "network plan" has the meaning given in AS 21.54.500;

(21) "new business premium rate" means the lowest premium rate charged or offered, or that could have been charged or offered, by the small employer insurer to small employers with similar case characteristics for newly issued health

care insurance plans with the same or similar coverage;

(22) "plan of operation" means the plan of operation of the reinsurance association adopted by the board under AS 21.56.040;

(23) "rating period" means the calendar period for which premium rates established by a small employer insurer are assumed to be in effect;

(24) "reinsurance association" means the Small Employer Health Reinsurance Association created in AS 21.56.010;

(25) "reinsuring insurer" means a small employer insurer participating in the reinsurance association created in AS 21.56.010;

(26) "small employer" has the meaning given in AS 21.54.500;

(27) "small employer insurer" means a health care insurer offering, issuing for delivery, delivering, or renewing health care insurance to small employers in the state;

(28) "standard health care insurance plan" means a health care insurance plan offered under AS 21.56.140 that includes more comprehensive benefits than under a basic health care insurance plan.

*** Sec. 91.** AS 21.66.110(a) is amended to read:

(a) **Each** [ANNUALLY EACH] title insurance company shall pay [ON OR BEFORE MARCH 1,] a tax of one percent of the amount of gross title insurance premiums received by it**,** including as premium income received from guaranteed certificates of title and other guarantees of title [DURING THE PRECEDING CALENDAR YEAR] covering property in this state, as shown by its annual statement to the director. **The director shall specify the due dates and the method of payment.**

*** Sec. 92.** AS 21.66.390(a) is amended to read:

(a) A title insurance company shall make rates that are not excessive or inadequate**,** [AND] that do not unfairly discriminate between risks in this state that involve essentially the same exposure to loss and expense elements, and that give due consideration to

(1) the desirability for stability of rate structures;

(2) the necessity of assuring the financial solvency of title insurance

companies in periods of economic depression by encouraging growth in assets of title insurance companies in periods of high business activity; [AND]

(3) the necessity for assuring a reasonable margin of underwriting and operating profit**; and**

(4) investment income.

*** Sec. 93.** AS 21.69.310(a) is amended to read:

(a) Meetings of stockholders or members of a domestic insurer shall be held in the city or town of its principal office or place of business in this state. **The meetings may be held, for good cause, in another location within the state upon approval of the director.**

*** Sec. 94.** AS 21.69.520(a) is amended to read:

(a) **Subject to the director's prior written approval, a** [A] domestic stock or mutual insurer may borrow money to defray the expenses of its organization **or** [,] provide it with surplus funds [, OR FOR ANY PURPOSE OF ITS BUSINESS,] upon a written agreement that the money is required to be repaid only out of the insurer's surplus in excess of that stipulated in the agreement. The agreement may provide for interest not exceeding six per cent a year, which interest may or may not constitute a liability of the insurer as to its funds other than the excess of surplus, as stipulated in the agreement. A commission or promotion expense may not be paid in connection with the loan.

*** Sec. 95.** AS 21.75.045(a) is amended to read:

(a) A person may not act in the capacity of attorney-in-fact for a subscriber regarding a subject that is resident, located, or to be performed in this state or for a reciprocal insurer licensed to do business in this state unless the person is licensed under this chapter. The director may adopt regulations that establish qualifications for being licensed as an attorney-in-fact. The attorney-in-fact for a [DOMESTIC] reciprocal insurer [TRANSACTING ALL OF ITS INSURANCE ACTIVITIES ON A SUBJECT RESIDENT, LOCATED, AND TO BE PERFORMED IN THIS STATE] is exempt from licensing under this title if the attorney-in-fact

(1) is a wholly-owned subsidiary of the reciprocal; and

(2) does not act as attorney-in-fact for another unaffiliated reciprocal

insurer.

*** Sec. 96.** AS 21.76.020(b) is amended to read:

(b) By October 1 of each year**,** the administrator of a joint insurance arrangement shall prepare and deliver to the Legislative Budget and Audit Committee **and the director** a report showing the true and correct financial condition of the joint insurance arrangement. The report must

(1) be attested to by the administrator and the board of directors;

(2) include an analysis**,** certified by a member of the American Academy of Actuaries, of the sufficiency of the loss reserves; and

(3) be certified by a certified public accountant.

*** Sec. 97.** AS 21.76.080(e) is amended to read:

(e) Within **150** [60] days of the end of the fiscal year, the administrator shall furnish a detailed report of the operation and condition of the fund to the board of directors and the director of **the division of** insurance. [THE REPORT FURNISHED TO THE DIRECTOR OF INSURANCE SHALL BE

(1) FILED IN THE GENERAL FORM AND CONTEXT ACCEPTABLE TO THE DIRECTOR;

(2) IN ACCORDANCE WITH ACCOUNTING PRINCIPLES ESTABLISHED UNDER THIS TITLE; AND

(3) AVAILABLE FOR PUBLIC INSPECTION.]

*** Sec. 98.** AS 21.78.293(b) is amended to read:

(b) The court **shall review and adopt** [MAY APPROVE, DISAPPROVE, OR MODIFY] the receiver's report on claims **by approving those claims that are supported by substantial evidence and disapproving allowed claims that are not supported by substantial evidence**. Claims in a report that are not **disapproved** [MODIFIED] by the court within a period of **120** [60] days following submission by the receiver shall be treated by the receiver as allowed claims.

*** Sec. 99.** AS 21.84.590 is amended to read:

Sec. 21.84.590. Other provisions applicable. In addition to the provisions contained in this chapter, the following provisions of this title apply to fraternal benefit societies to the extent applicable and not in conflict with the express provisions of this

chapter and the reasonable implications of this chapter:

(1) AS 21.03;

(2) AS 21.06;

(3) AS 21.09.050 and 21.09.100;

(4) AS 21.09.200 and 21.09.205;

(5) AS 21.18;

(6) AS 21.21;

(7) AS 21.27;

(8) AS 21.33;

(9) AS 21.36;

(10) AS 21.42.290**, 21.42.347,** and 21.42.355;

(11) AS 21.53;

(12) **AS 21.54;**

(13) AS 21.56;

(14) AS 21.69.370 and 21.69.640;

(15) [(13)] AS 21.78;

(16) [(14)] AS 21.89.060.

*** Sec. 100.** AS 21.86.150 is amended by adding new subsections to read:

(g) A health maintenance organization that offers, renews, issues for delivery, or delivers in this state a health care insurance plan in the group market that does not impose a preexisting condition exclusion with respect to a particular coverage option under the plan may impose an affiliation period for that coverage option only if the affiliation period

(1) is applied uniformly without regard to a health status factor;

(2) does not exceed two months for new enrollees and three months for late enrollees;

(3) begins on the enrollment date; and

(4) runs concurrently with any waiting period under the plan.

(h) A health maintenance organization may use a method other than a preexisting condition exclusion or an affiliation period to lessen the risk of adverse selection only with prior written approval of the director.

*** Sec. 101.** AS 21.86.260(a) is amended to read:

(a) Except as provided in **AS 21.36, AS 21.42, AS 21.54,** AS 21.56 and in this chapter, this title does not apply to a health maintenance organization that obtains a certificate of authority under this chapter. This subsection does not apply to an insurer licensed under AS 21.09 or a hospital or medical service corporation licensed under AS 21.87 except with respect to its health maintenance organization activities authorized by and regulated under this chapter.

*** Sec. 102.** AS 21.86.900 is amended by adding new paragraphs to read:

(10) "affiliation period" means a period of time under a contract with a health maintenance organization

(A) that must expire before coverage becomes effective;

(B) during which the health maintenance organization is not required to provide health care services or benefits; and

(C) for which no premium is charged to the participant or beneficiary for coverage during the period;

(11) "beneficiary" has the meaning given in AS 21.54.500;

(12) "enrollment date" has the meaning given in AS 21.54.500;

(13) "group market" has the meaning given in AS 21.54.500;

(14) "health status factor" has the meaning given in AS 21.54.500;

(15) "participant" has the meaning given in AS 21.54.500;

(16) "preexisting condition exclusion" has the meaning given in AS 21.54.500;

(17) "waiting period" has the meaning given in AS 21.54.500.

*** Sec. 103.** AS 21.87.140(c) is amended to read:

(c) Each service agreement shall further effectively provide in substance that

(1) the participant provider shall be compensated for services rendered to a subscriber in accordance with **terms** [A SCHEDULE OF FEES] contained in the agreement or attached to and made a part of the agreement [,] and that the participant provider may not request or receive from the service corporation compensation for the services **that** [WHICH] is not in accord with the **terms** [SCHEDULE];

(2) compensation for services may be prorated and settled under the

circumstances and in the manner referred to in AS 21.87.300;

(3) if the participant provider withdraws from the agreement, the withdrawal may not be effective as to a subscriber's contract in force on the date of the withdrawal until the termination of the subscriber's contract or the next anniversary of the subscriber's contract, whichever date is the earlier.

*** Sec. 104.** AS 21.87.150(c) is amended to read:

(c) Each service agreement must further effectively in substance provide that

(1) the participant hospitals shall be compensated for services rendered to a subscriber in accordance with **terms** [A SCHEDULE OF CHARGES] contained in the agreement or attached to and made a part of the agreement [,] and that the hospital may not request or receive from the service corporation compensation for the services that is not in accord with the **terms** [SCHEDULE];

(2) compensation for services may be prorated and settled under the circumstances and in the manner referred to in AS 21.87.300;

(3) if the participant hospital withdraws from the agreement, the withdrawal may not be effective as to a subscriber's contract in force on the date of the withdrawal until the termination of the subscriber's contract or the next anniversary of the subscriber's contract, whichever date is the earlier.

*** Sec. 105.** AS 21.87.180(a) is amended to read:

(a) A service corporation may not issue or use a basic form of service agreement or subscriber's contract, or application, identification, supplement, or endorsement to be connected with the agreement or contract, until the form has been filed with and approved by the director. This provision does not apply to **riders** [AGREEMENTS, CONTRACTS, APPLICATIONS, IDENTIFICATION SUPPLEMENTS], endorsements, or other forms of unique character designed for and used with relation to a particular **subject** [SET OF CIRCUMSTANCES].

*** Sec. 106.** AS 21.87.190(b) is amended to read:

(b) The service corporation shall, before use, file with the director **(1)** a schedule of subscription rates, fees, or payments of any kind to be charged subscribers**; (2) every rating manual, schedule, plan, rule, or formula;** and **(3)** [SHALL FILE] before use**, any modification to the rating manual, schedule, plan, rule, or formula.**

Each filing must state the effective date and must provide a comprehensive description of the coverage. The director may withhold the rating formula from public inspection for as long as the director determines that withholding the rating formula is necessary to protect the service corporation against unwarranted injury or is in the public interest [EVERY PROPOSED CHANGE OR MODIFICATION IN THE RATES, FEES, OR PAYMENTS].

*** Sec. 107.** AS 21.87.200 is repealed and reenacted to read:

Sec. 21.87.200. Reserves. In addition to the surplus fund provided for in AS 21.87.210, each service corporation shall establish and maintain unimpaired reserves and liabilities required under AS 21.18.050.

*** Sec. 108.** AS 21.87.340 is amended to read:

Sec. 21.87.340. Other provisions applicable. In addition to the provisions contained or referred to previously in this chapter, the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions, and**,** for the purposes of the application**,** the corporations shall be considered to be mutual "insurers":

(1) AS 21.03;

(2) AS 21.06;

(3) AS 21.09, except AS 21.09.090;

(4) AS 21.18.010;

(5) AS 21.18.030;

(6) AS 21.18.040;

(7) AS 21.18.120;

(8) AS 21.21.321;

(9) AS 21.36;

(10) AS 21.42.345 - 21.42.365 **and 21.42.375 - 21.42.395** [, 21.42.375, 21.42.380, AND 21.42.385];

(11) AS 21.51.120;

(12) AS 21.53;

(13) **AS 21.54** [AS 21.54.020];

(14) AS 21.56;

(15) AS 21.69.400;

(16) AS 21.69.520;

(17) AS 21.69.600, 21.69.620, and 21.69.630;

(18) AS 21.78;

(19) AS 21.89.040;

(20) AS 21.89.060;

(21) AS 21.90.

*** Sec. 109.** AS 21.89.020(f) is amended to read:

(f) An automobile liability insurance policy must provide

(1) that all expenses and fees, not including counsel fees or adjuster fees, incurred because of arbitration or mediation shall be paid as determined by the arbitrator;

(2) liability coverage in the amount set out in AS 28.22.101(d) for motor vehicles rented in the United States or Canada by a person insured under the policy;

(3) physical damage coverage for motor vehicles rented in the United States or Canada, if the policy provides physical damage coverage; if the insured declines physical damage coverage**,** the insurer shall offer physical damage coverage for rented vehicles**;**

(4) that payments from applicable coverage provided under (2) and (3) of this subsection will be made in the following order of priority:

(A) from a policy or coverage purchased by the operator from the person who has the vehicle available for rent;

(B) from a policy or coverage covering the operator of a rented vehicle but not purchased from the person who has the vehicle available for rent; and

(C) from a policy or coverage of the person who has the vehicle available for rent.

*** Sec. 110.** AS 21.89.020(g) is amended to read:

(g) An insurance company offering automobile liability insurance in this state

shall offer a short term policy valid for no more than seven days. The coverage available for the short term policy must be comparable to coverage available for longer term policies. **The provisions of AS 21.36.210 - 21.36.310 do not apply to short term policies issued under this subsection.**

*** Sec. 111.** AS 21.90.900(29) is amended to read:

(29) "policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements, and papers attached to it and a part of it; **for a group, trust, association, or similar entity, "policy" also means a certificate or other evidence of insurance that establishes the written contract of or written agreement for or effecting insurance for an insured or other beneficiary of the entity;**

*** Sec. 112.** AS 21.90.900 is amended by adding new paragraphs to read:

(41) "certified financial statement" means a financial statement upon which an independent certified public accountant, or an accountant holding a substantially equivalent designation as determined by the director, renders or disclaims an opinion after performance of an audit;

(42) "medical care" means amounts paid for

(A) diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(B) transportation primarily for and essential to medical care described in (A) of this paragraph; and

(C) insurance covering medical care described in (A) and (B) of this paragraph.

*** Sec. 113.** AS 28.20.440 is amended by adding a new subsection to read:

(l) Notwithstanding any other provisions of law, a person who resides in the same household as the person named as insured or a person who is a relative of the person named as insured shall be excluded from coverage under a motor vehicle liability policy if the person named as insured requests that that person be excluded from coverage.

*** Sec. 114.** AS 28.40.100(a)(22) is amended to read:

(22) "underinsured motor vehicle" means a motor vehicle licensed for highway use with respect to ownership, operation, maintenance, or use for which there is a bodily injury or property damage insurance policy or a bond applicable at the time of an accident and the amount of insurance or bond

[(A)] is less than the **amount the covered person is legally entitled to recover for bodily injury or property damage from the owner or operator of the underinsured motor vehicle** [LIMIT FOR UNINSURED AND UNDERINSURED COVERAGE OF THE INSURED'S POLICY; OR

(B) HAS BEEN REDUCED BY PAYMENTS TO PERSONS OTHER THAN AN INSURED, INJURED IN AN ACCIDENT, TO LESS THAN THE LIMIT FOR UNINSURED AND UNDERINSURED COVERAGE OF THE INSURED'S POLICY];

*** Sec. 115.** AS 21.42.375(d), 21.42.395(d); AS 21.56.110(b), 21.56.110(d), 21.56.130, 21.56.150, 21.56.170; AS 21.81; AS 28.20.445(h); and AS 28.22.211 are repealed.

*** Sec. 116.** AS 21.54.150, enacted by sec. 59 of this Act, is repealed.

*** Sec. 117.** Sections 3, 4, and 5, ch. 101, SLA 1992, are repealed.

*** Sec. 118.** Sections 4, 7, 9, 12, and 13, ch. 39, SLA 1993, are repealed.

*** Sec. 119.** AS 21.54.150, enacted by sec. 59 of this Act, takes effect January 1, 1998.

*** Sec. 120.** Sections 6, 7, 27 - 30, and 91 of this Act take effect January 1, 1998.

*** Sec. 121.** Except as provided in secs. 119, 120, and 122 of this Act, this Act takes effect July 1, 1997.

*** Sec. 122.** Section 116 of this Act takes effect September 20, 2001.