SENATE CS FOR CS FOR HOUSE BILL NO. 246(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SECOND LEGISLATURE - SECOND SESSION

BY THE SENATE JUDICIARY COMMITTEE

Offered: 5/11/02
Referred: Rules

Sponsor(s): HOUSE LABOR AND COMMERCE COMMITTEE BY REQUEST

A BILL

FOR AN ACT ENTITLED

"An Act relating to regulation of a person providing insurance for the cost of medical care, to confidentiality of insurance records, to insurance hearings, to insurance fees, to annual and quarterly statements by insurers, to managed care insurance, to taxes on insurance, to insurer certificates of authority, to risk based capital for insurers, to unauthorized and nonadmitted insurers, to surplus lines insurance, to health insurance, to life insurance, to annuity insurance, to consumer credit insurance, to insurer liquidation, to multiple employer welfare arrangements, to title insurance, to the Alaska Insurance Guaranty Association, to hospital and medical service corporations, and to regulation of insurance producers, agents, brokers, managers, and adjusters; and providing for an effective date."

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

*** Section 1.** AS 21.03.021 is amended by adding new subsections to read:

(b) Except as otherwise provided in this title, a person that provides coverage for the cost of medical care in this state is subject to this title unless the person shows that, while providing coverage for medical care, the person is subject to the jurisdiction of another agency of this state or of the federal government by providing the director with the appropriate certificate, license, or other document issued by the other governmental agency that permits or qualifies the person to provide coverage for medical care.

(c) A person described under (b) of this section who is unable to show that the person is subject to the jurisdiction of another governmental agency under (b) of this section and who has not received a certificate of authority under AS 21.85

(1) is subject to all appropriate provisions of this title regarding the conduct of the person's business; and

(2) shall submit to an examination by the director to determine the organization and solvency of the person and to determine whether the person complies with this title.

(d) A person that advertises, administers, sells, or transacts the coverage of medical care under (b) of this section and is required to submit to an examination by the director under (c)(2) of this section shall advise every purchaser, prospective purchaser, or covered person that the person's coverage may not be regulated under Alaska insurance law and may not be covered by the Alaska Life and Health Insurance Guaranty Association under AS 21.79.

*** Sec. 2.** AS 21.06.060 is amended to read:

Sec. 21.06.060. Records. The director shall enter in permanent form records of official transactions, examinations, investigations, and proceedings and keep those records in the office of the director. The records and insurance filings in the office of the director are open to public inspection, except as otherwise provided in **(b) - (g) of this section or other provisions of** this title with respect to particular records or filings.

*** Sec. 3.** AS 21.06.060 is amended by adding new subsections to read:

(b) Information and records, including written documents and electronic data, designated as confidential or not available for public inspection under this section or

other provisions of this title

(1) are not subject to inspection and copying under AS 40.25.110 - 40.25.220;

(2) may not be obtained from the director by subpoena, except for a subpoena issued by a state or federal law enforcement agency or grand jury;

(3) may be used by the director in a regulatory or legal proceeding; and

(4) may be released for public inspection if the person who provided the information or records to the director consents or releases incomplete or misleading information on the same topic to the public.

(c) The director or a person acting under the authority of the director who receives information or records designated in this title as confidential or not available for public inspection may not be permitted or required to testify about the information or records in a civil action not involving the state or a state agency, officer, or employee.

(d) A person required or requested to provide information or records to the director under this title does not waive a claim of privilege that the person may have by providing the information or records to the director.

(e) In the performance of duties under this title, the director may

(1) disclose confidential information or records to the legislature, state, federal, and international regulatory or law enforcement agencies, or the National Association of Insurance Commissioners if the recipient will maintain the confidentiality of the information or records;

(2) receive information or records from state, federal, and international regulatory or law enforcement authorities or the National Association of Insurance Commissioners and maintain the confidentiality of the information or records if requested to do so or given notice that the information or records are confidential under the law of the jurisdiction supplying them; and

(3) enter into agreements consistent with this section governing the sharing of information or records that are confidential under this title with other state, federal, and international regulatory or law enforcement agencies or the National Association of Insurance Commissioners for the purpose of furthering any regulatory

or legal action that may be taken as part of the recipient's official duties.

(f) The following information or records submitted to or obtained by the director are confidential:

(1) personally identifiable consumer information; however, the director may disclose the information or records for the purpose of attempting to resolve a consumer complaint;

(2) information or records established by a showing satisfactory to the director to be a trade secret or proprietary business information, including

(A) detailed health insurance claim cost data; and

(B) justification for usual, customary, and reasonable charge determinations; and

(3) information or records provided by a person not subject to this title at the request of the director if the information or records are identified as confidential by the director; and

(4) financial analysis ratios and examination synopses concerning insurance companies that are submitted to the director by the National Association of Insurance Commissioners.

(g) The director may withhold information or records from public inspection for as long as the director finds the withholding is

(1) necessary to protect a person against unwarranted injury; or

(2) in the public interest.

*** Sec. 4.** AS 21.06.150(g) is repealed and reenacted to read:

(g) Information or records obtained by the director under AS 21.06.120 or 21.06.140 and any related work papers of an examination are confidential. The director may publish an examination report or a summary of it in a newspaper or electronic media in the state if the director determines that the publication is in the public interest.

*** Sec. 5.** AS 21.06.210 is amended by adding a new subsection to read:

(h) The director may close a hearing to the public when the director finds the closure is necessary to protect a person against unwarranted injury or is in the public interest.

*** Sec. 6.** AS 21.07.040(c) is amended to read:

(c) Nothing in this section may be construed to prohibit the exchange of medical information between and among health care providers of an applicant or **a person currently or formerly** [A CURRENT OR FORMER PERSON] covered by a managed care plan for purposes of providing health care services.

*** Sec. 7.** AS 21.09.120(a) is amended to read:

(a) If**,** upon completion of its application**,** the director finds that the insurer has met the requirements for and is entitled to a certificate under this title, the director shall issue to the insurer a proper certificate of authority; if the director does not so find, the director shall issue an order refusing the certificate. The director shall act upon an application for a certificate of authority within **60** [30] days after its completion.

*** Sec. 8.** AS 21.09.130(a) is amended to read:

(a) A certificate of authority issued or renewed under this title continues in force as long as the insurer is entitled to it under this title and until suspended or revoked, or otherwise terminated**,** [;] subject, however, to continuance of the certificate by the insurer each year by payment before June 30 of the continuation fee set under AS 21.06.250. **The method of payment must be by electronic or other payment method specified by the director by regulation under AS 21.06.250.**

*** Sec. 9.** AS 21.09.200(a) is amended to read:

(a) Each authorized insurer shall annually, before March 2, file with the director **or the director's designee** a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The reporting format for a given year is the most recently approved National Association of Insurance Commissioners' annual financial statement blank form and instructions, supplemented for additional information as required by the director. The director may require the statement to be filed on electronic media. The statement shall be verified by the oath of the insurer's president or vice-president, and secretary, or, if a reciprocal insurer, by oath of the attorney-in-fact or its like officers if a corporation unless verification is waived by the director of insurance. **The filing locations must be published by the director at least annually.**

*** Sec. 10.** AS 21.09.200(d) is amended to read:

(d) At the time of filing, the insurer shall pay to the director a fee for filing its statement, set under AS 21.06.250. **The method of payment must be by electronic or other payment method specified by the director by regulation under AS 21.06.250.**

*** Sec. 11.** AS 21.09.200(e) is amended to read:

(e) An insurer shall pay to the division $100 for each day the insurer fails to file the annual statement in the form **and location** required and within the time established in (a) of this section. The authority of the insurer to enter into new obligations or issue new or renewal policies of insurance in this state may be suspended by the director if the annual statement has not been filed by March 1.

*** Sec. 12.** AS 21.09.205(b) is amended to read:

(b) A quarterly financial statement, if required, is due **45** [60] days after the end of the quarter to which it applies.

*** Sec. 13.** AS 21.09.210(g) is amended to read:

(g) **An insurer shall pay to the division a late payment fee of $100 a day or 25 percent of the tax due, whichever is greater, from the date the payment was due to the date paid, and interest at the rate of one percent a month or part of a month from the date the payment was originally due to the date paid for the period the insurer fails to pay the premium tax in this section or in AS 21.09.270 in the form required and within the time established.** The director may suspend or revoke the certificate of authority of an insurer that fails to pay its taxes as required under this section.

*** Sec. 14.** AS 21.09.210(j) is amended to read:

(j) The provisions of AS 21.89.070 **and 21.89.075** apply to a taxpayer who is required to pay a tax due under this section.

*** Sec. 15.** AS 21.09.210(m) is amended to read:

(m) The tax imposed under this section **for an individual policy of life insurance** shall be computed at the rate of

(1) 2.7 percent **of** [FOR A POLICY OF LIFE INSURANCE WITH A] policy year premium up to $100,000; and

(2) one-tenth of **one** [A] percent **of** [FOR A POLICY OF LIFE INSURANCE FOR THE] policy year premium exceeding $100,000.

*** Sec. 16.** AS 21.09.270(b) is amended to read:

(b) This section does not apply to

[(1)] personal income taxes, [OR] to ad valorem taxes on real or personal property**,** or to special purpose obligations or assessments imposed by another state in connection with particular kinds of insurance other than property insurance; except that deductions from premium taxes or other taxes otherwise payable allowed on accounts of real estate or personal property taxes paid shall be taken into consideration by the director in determining the propriety and extent of retaliatory action under this section [; OR

(2) A HEALTH CARE INSURER WHO ISSUES HEALTH CARE INSURANCE TO THE STATE, A MUNICIPALITY, A CITY OR BOROUGH SCHOOL DISTRICT, A REGIONAL EDUCATIONAL ATTENDANCE AREA, THE UNIVERSITY OF ALASKA, OR A COMMUNITY COLLEGE OPERATED BY THE UNIVERSITY OF ALASKA; IN THIS PARAGRAPH, "HEALTH CARE INSURER" HAS THE MEANING GIVEN IN AS 21.54.500].

*** Sec. 17.** AS 21.09.270 is amended by adding a new subsection to read:

(f) For purposes of the application of (a) of this section, a health care insurer may not include taxes, assessments, or other similar obligations on health care insurance premiums received from the state, a municipality, a city or borough school district, a regional educational attendance area, the University of Alaska, or a community college operated by the University of Alaska. In this subsection, "health care insurer" has the meaning given in AS 21.54.500.

*** Sec. 18.** AS 21.09.310(n) is amended to read:

(n) Annual statements under AS 21.09.200 and quarterly statements under AS 21.09.205 (1) may only relate to **and must include all** insurance transactions and affairs within the United States, assets held by or for the United States branch for the protection of policyholders and creditors within the United States, and liabilities incurred against those assets; and (2) may not contain a statement in regard to assets and business transacted in a place not described in this subsection. The annual and

quarterly statements shall be signed and verified by the United States manager, attorney-in-fact, or a duly empowered assistant United States manager of the United States branch.

*** Sec. 19.** AS 21.14.050(a) is amended to read:

(a) If a mandatory control level event occurs **for a domestic insurer**, the director shall take the action necessary to place the insurer under regulatory control under AS 21.78.

*** Sec. 20.** AS 21.27.020(c) is amended to read:

(c) To qualify for issuance or renewal of a license as a firm insurance producer, a firm managing general agent, a firm reinsurance intermediary broker, a firm reinsurance intermediary manager, a firm surplus lines broker, or a firm independent adjuster, an applicant or licensee shall

(1) comply with (b)(4) and (5) of this section;

(2) maintain a lawfully established place of business in this state, except when licensed as a nonresident under AS 21.27.270;

(3) disclose to the director all owners, officers, directors, or partners of the firm;

(4) designate **one or more** [A] compliance **officers** [OFFICER] for the firm;

(5) provide to the director documents necessary to verify the information contained in or made in connection with the application; and

(6) notify the director, in writing, within 30 days of a change in the firm's compliance officer or of the termination of employment of an individual in the firm licensee.

*** Sec. 21.** AS 21.27.140(a) is repealed and reenacted to read:

(a) A firm shall have a firm license, the scope of which includes all lines and classes of authority of each individual employee of the firm.

*** Sec. 22.** AS 21.27.140(b) is repealed and reenacted to read:

(b) A firm may not be licensed as an insurance producer, managing general agent, reinsurance intermediary broker, reinsurance intermediary manager, surplus lines broker, or independent adjuster, or transact insurance unless each individual

employed as an insurance producer, managing general agent, surplus lines broker, trainee insurance producer, trainee independent adjuster, or independent adjuster by the firm is licensed as an individual in the firm. Each compliance officer of the firm shall be licensed as an individual in the firm for a specific line and class of authority. If there is more than one compliance officer, the combined authority of all compliance officers shall cover all the powers conferred by the firm's license.

*** Sec. 23.** AS 21.27.330(b) is amended to read:

(b) If a licensee that is a firm transacts business at more than one place of business [IN THIS STATE], the licensee shall pay a license fee for each place of business **that transacts business in this state or relative to a subject resident, located, or to be performed in this state**.

*** Sec. 24.** AS 21.27.370(c) is amended to read:

(c) An unlicensed person who refers a customer or potential customer to a licensee and who does not discuss specific terms and conditions of a policy [,] or **give** [WHO GIVES] opinions or advice regarding insurance, may be compensated for the referral, if the compensation

(1) for each referral is

(A) nominal;

(B) on a one-time basis; and

(C) fixed in amount by referral;

(2) does not depend on whether the customer or potential customer purchases the insurance; and

(3) is not contingent on the volume of insurance transacted.

*** Sec. 25.** AS 21.27.900(4) is amended to read:

(4) "compliance officer" means a licensee **designated for a specific line and class of authority** under this chapter **who** [THAT] is responsible for a firm's compliance with the insurance statutes and regulations of this state;

*** Sec. 26.** AS 21.27.900 is amended by adding a new paragraph to read:

(32) "class of authority" means the authority held by a person under a license as an insurance producer, managing general agent, reinsurance intermediary broker, reinsurance intermediary manager, surplus lines broker, or independent

adjuster, or under registration as a third-party administrator.

*** Sec. 27.** AS 21.33.037(b) is amended to read:

(b) This section does not apply to

(1) matters authorized to be done by the director;

(2) surplus lines insurance effected and written under AS 21.34;

(3) transactions for which a certificate of authority is not required under this title;

(4) reinsurance;

(5) the property and operations of railroads or aircraft **primarily** engaged in interstate or foreign commerce and wet marine and transportation insurance;

(6) life insurance, health insurance, and annuity contracts when solicited solely by mail or when not solicited, negotiated, or procured in this state;

(7) transactions subsequent to issuance of a policy not covering a subject resident, located, or to be performed in this state at time of issuance and lawfully solicited, written, or delivered outside this state.

*** Sec. 28.** AS 21.33.055(a) is amended to read:

(a) Except as to premiums on lawfully procured surplus lines insurance exported under AS 21.34 and premiums on independently procured insurance on which a tax has been paid under AS 21.33.061, every nonadmitted insurer shall pay to the director**,** on or before March 1 following the calendar year in which the insurance was so effectuated, continued, or renewed**,** a premium-receipts tax of three percent of gross premiums charged for the insurance other than wet marine and transportation insurance and a premium-receipts tax of three-fourths of one percent of gross premiums charged for the wet marine and transportation insurance on subjects resident, located, or to be performed in this state. The insurance on subjects resident, located, or to be performed in this state procured through negotiations or an application, in whole or in part occurring or made in or from in or out of this state, or for which premiums in whole or in part are remitted directly or indirectly from in or out of this state, shall be considered to be insurance procured or continued or renewed in this state. The term "premium" includes all premiums, membership fees,

assessments, dues, and any other consideration for insurance. The tax **paid by the insurer** is in lieu of all **insurer** taxes and fire department dues. On default of a nonadmitted insurer in the payment of the tax, the insured shall pay the tax within 30 days of written notice from the director of the default by the nonadmitted insurer. If the tax prescribed by this section is not paid by the nonadmitted insurer within the time stated or by the insured within the time stated after notice of default by the nonadmitted insurer, the tax may be increased by

(1) a late payment fee of $1,000 or 10 percent of the tax due, whichever is greater;

(2) interest at the rate of one percent a month or part of a month from the date the payment was originally due to the date paid; and

(3) a penalty not to exceed $100 a day or 25 percent of the tax due, whichever is greater, from the date the payment was due to the date paid.

*** Sec. 29.** AS 21.33.055(c) is amended to read:

(c) This section does not apply to insurance of risks of the state **or** [,] a political subdivision of the state, or to insurance of aircraft **primarily** [REGULARLY] engaged in interstate or foreign commerce.

*** Sec. 30.** AS 21.33.061(c) is amended to read:

(c) There is levied upon the obligation, chose in action, or right represented by the premium charged for the insurance, a premium receipts tax of three per cent of gross premiums charged for the insurance other than wet marine and transportation insurance and a premium receipts tax of three-fourths of one percent of gross premiums charged for the wet marine and transportation insurance. The term "premium" includes all premiums, membership fees, assessments, dues, and any other consideration for insurance. [THE TAX IS IN LIEU OF ALL TAXES AND FIRE DEPARTMENT DUES.] The insured shall, on or before March 1 following the calendar year in which the insurance was procured, continued, or renewed, pay the amount of the tax to the director. In event of cancellation and rewriting of the insurance contract**,** the additional premium for premium receipts tax purposes is the premium in excess of the unearned premium of the cancelled insurance contract. If the tax prescribed by this section is not paid within the time stated, the tax may be

increased by

(1) a late payment fee of $1,000 or 10 percent of the tax due, whichever is greater;

(2) interest at the rate of one percent a month or part of a month from the date the payment was due to the date paid; and

(3) a penalty not to exceed $100 a day or 25 percent of the tax due, whichever is greater, from the date the payment was due to the date paid.

*** Sec. 31.** AS 21.33.061(g) is amended to read:

(g) This section does not apply to insurance of risks of the state **or** [,] a political subdivision of the state, **to** insurance of aircraft **primarily** [REGULARLY] engaged in interstate or foreign commerce, to life insurance, **to** health insurance, or **to** annuity contracts.

*** Sec. 32.** AS 21.34.180(a) is amended to read:

(a) Gross premiums charged, less any return premium, for surplus lines insurance are subject to a premium receipts tax as outlined in AS 21.09.210, which shall be collected by the surplus lines broker as specified by the director, in addition to the full amount of the gross premium charged by the insurer for the insurance. The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the surplus lines broker shall be returned to the policy holder directly by the surplus lines broker or through the producing broker, if any. The surplus lines broker may not absorb the tax or any part of it, and may not rebate for any reason the tax or any part of it. **However, if, under AS 21.09.210, an admitted insurer is required to collect and pay premium tax on a portion of a subscription policy, the surplus lines broker is not required to collect any amount that would constitute double taxation of that portion of the insurance.**

*** Sec. 33.** AS 21.34.180(d) is amended to read:

(d) This section does not apply to insurance of risks of state government or its political subdivision, to an agency of state government or its political subdivision, or to insurance of aircraft **primarily** [REGULARLY] engaged in interstate or foreign commerce.

*** Sec. 34.** AS 21.34.180 is amended by adding a new subsection to read:

(f) A surplus lines broker shall pay to the division a late payment fee of $100 a day or 25 percent of the tax due, whichever is greater, from the date the payment was due to the date paid and interest at the rate of one percent a month or part of a month from the date the payment was originally due to the date paid for each day the insurer fails to pay the tax in the form required and within the time established

*** Sec. 35.** AS 21.42.020(d) is amended to read:

(d) "Insurable interest**,**" with reference to **life, annuity, or health** [PERSONAL] insurance**,** includes only the following interests:

(1) in the case of persons related closely by blood or by law, a substantial interest engendered by love and affection;

(2) in the case of persons other than those described in (1) of this subsection, a lawful and substantial economic interest in having the life, health, or bodily safety of the person insured continue, as distinguished from an interest **that** [WHICH] would arise only by, or would be enhanced in value by, the death, disablement, or injury of the individual insured;

(3) an individual party to a contract or option for the purchase or sale of an interest in a business partnership or firm, or of shares of stock of a closed corporation or of an interest in the shares, has an insurable interest in the life of each individual party to the contract for the purposes of the contract only, in addition to an insurable interest that may otherwise exist as to the life of the individual.

*** Sec. 36.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.145. Stop-loss insurance provisions. (a) 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, or a multiple employer welfare arrangement may not issue a stop-loss insurance policy that

(1) has an annual attachment point for claims incurred for each individual that is lower than $10,000;

(2) has an annual aggregate attachment point for a small employer that is lower than the greater of

(A) $4,000 times the number of individuals covered under the

health benefit plan;

(B) 120 percent of the expected claims for the health benefit plan for the period covered by the stop-loss insurance policy; or

(C) $20,000;

(3) has an annual aggregate attachment point for a large employer that is lower than 110 percent of expected claims for the health benefit plan for the period covered by the stop-loss insurance policy; or

(4) provides direct coverage of health care expenses of an individual.

(b) The director may, by regulation, change the dollar amounts established under (a) of this section to reflect medical costs in this state, including adjustments to reflect changes 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.

(c) For the purposes of this section,

(1) "attachment point" means the claim amount incurred by an insured group beyond which the insurer incurs a liability for payment;

(2) "expected claims" means the amount of claims that, in absence of a stop-loss insurance policy or other insurance, are projected to be incurred by an insured group through its health benefit plan;

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

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

(5) "small employer" has the meaning given in AS 21.54.500.

*** Sec. 37.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.363. Eye care under health insurance. A policy, contract, or prepaid plan for individual or group health insurance issued or delivered in the state that provides reimbursement for a service within the lawful scope of practice of an optometrist licensed under AS 08.72 must provide for reimbursement to a person covered under the policy, contract, or plan who had the service performed by an optometrist.

*** Sec. 38.** AS 21.42.365(b) is amended to read:

(b) The benefits described in (a) of this section shall be adjusted **July 1, 2004**

[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 adjusted benefits shall be applicable to coverage issued or renewed on or after January 1 of the calendar year following the July 1 adjustment by the director** [THE BASE YEAR FOR THE FIRST ADJUSTMENT SHALL BE CALENDAR YEAR 1996].

*** Sec. 39.** AS 21.42.390(b) is repealed and reenacted to read:

(b) A health care insurer shall provide coverage of not less than $1,500 for a covered person in a year for the cost of diabetes outpatient self-management training or education under (a) of this section.

*** Sec. 40.** AS 21.42.500(5) is amended to read:

(5) "health care insurance plan" has the meaning given in AS 21.54.500; **"health care insurance plan" does not include short-term limited-duration insurance offered to individuals in the individual market;**

*** Sec. 41.** AS 21.42.500 is amended by adding a new paragraph to read:

(8) "individual market" has the meaning given in AS 21.51.500;

*** Sec. 42.** AS 21.51.090 is amended to read:

Sec. 21.51.090. Claim forms. There shall be a provision as follows:

"Claim Forms: The insurer, **within 10 working days after** [UPON] receipt of a notice of claim, will furnish to the claimant forms **that** [WHICH] are usually furnished by it for filing proofs of loss. If the forms are not furnished within **10** [15] days after the giving of notice**,** the claimant shall be considered to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character**,** and the extent of the loss for which claim is made."

*** Sec. 43.** AS 21.51.110 is amended to read:

Sec. 21.51.110. Time of payment of claims. There shall be a provision as follows:

"Time of Payment of Claims: Indemnities payable under this policy for a loss other than loss for which this policy provides a periodic payment [,] will be paid **within 30 days after** [IMMEDIATELY UPON] receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid (insert period for payment**,** which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid **beginning within 30 days after** [IMMEDIATELY UPON] receipt of due written proof."

*** Sec. 44.** AS 21.54.130(c) is amended to read:

(c) A health care insurer may discontinue offering and renewing all health care insurance plans in the **small group market, large group market, or both,** [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.

*** Sec. 45.** AS 21.55.010 is amended to read:

Sec. 21.55.010. Creation; membership. There is established a nonprofit incorporated legal entity to be known as the Comprehensive Health Insurance Association. Membership consists of all licensed hospital or medical service corporations in the state that offer subscriber contracts for major medical coverage, all health maintenance organizations or other managed care arrangements approved by

the director, **all licensed self-funded multiple employer welfare arrangements in the state,** and all insurers licensed to transact health insurance in the state that offer policies for major medical coverage on an expense incurred basis. All members shall maintain membership in the association as a condition of doing health insurance business, or being able to offer subscriber contracts or enrollment in a health maintenance organization**, self-funded multiple employer welfare arrangement,** or managed care arrangement [,] in the state.

*** Sec. 46.** AS 21.56.120(c) is amended to read:

(c) A small employer insurer shall

(1) maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles;

(2) file with the director annually, on or before March 15, an actuarial certification certifying that the insurer is in compliance with this chapter **and AS 21.54.100 - 21.54.500** and that the rating methods of the small employer insurer are actuarially sound; the certification shall be in a form and manner, and must contain information, as specified by the director; a copy of the certification shall be retained by the small employer insurer at its principal place of business;

(3) make the information and documentation described in (1) of this subsection available to the director upon request; the information is confidential and not subject to disclosure, except

(A) as agreed to by the small employer insurer;

(B) as ordered by a court of competent jurisdiction; or

(C) the director may use the information or other discovered information in a judicial or administrative proceeding.

*** Sec. 47.** AS 21.56.140(c) is amended to read:

(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. In applying minimum employee participation requirements, a small employer insurer may not consider employees or dependents who have [SIMILAR] existing **creditable** coverage in determining whether the minimum employee participation level is met.

*** Sec. 48.** AS 21.57.055(a) is amended to read:

(a) Before a debtor elects to purchase consumer credit insurance in connection with a credit transaction, the insurer shall disclose the following in writing to the debtor:

(1) the purchase of consumer credit insurance is optional and not a condition of obtaining credit approval;

(2) if more than one kind of consumer credit insurance is being made available to the debtor, whether the debtor can purchase the insurance separately or the multiple coverage only as a package;

(3) the conditions of eligibility;

(4) if the debtor has other insurance that covers the risk, the debtor may not want or need credit insurance;

(5) if the creditor requires [CONSUMER CREDIT] insurance as additional security for a debt, the debtor has the option of furnishing the required amount of insurance through existing policies owned or procured by the debtor or of procuring and furnishing the required insurance through an insurer authorized to transact insurance business in this state;

(6) the effective date of the coverage;

(7) the debtor may cancel the coverage within the first 30 days after receiving the individual policy or group certificate and have a premium paid by the debtor refunded or credited; thereafter, the debtor may cancel the policy at any time during the term of the loan and receive a refund of unearned premium;

(8) a brief description of the coverage, including

(A) the amount;

(B) the term;

(C) any exceptions, limitations, or exclusions;

(D) the insured event;

(E) any waiting or elimination period;

(F) any deductible;

(G) any applicable waiver of premium provision;

(H) to whom the benefits would be paid; and

(I) the premium rate for a coverage or for multiple coverage in a package;

(9) if the premium or insurance charge is financed, it is subject to finance charges at the rate applicable to the credit transaction or at another specified rate; and

(10) whether or not the benefits provided are sufficient to pay off the debt **existing on the date of death, disability, or unemployment** [IN FULL, INCLUDING FINANCE CHARGES UNEARNED AT THE TIME OF THE CLAIM].

*** Sec. 49.** AS 21.57.060(b) is amended to read:

(b) The individual policy or group certificate must, in addition to other requirements of law, set out

(1) the name and home office address of the insurer;

(2) the name of the debtor;

(3) the premium to be paid by the debtor disclosed separately for each kind of coverage or for all coverage in a package, except that, for open-ended loans, the premium rate and the basis of premium calculation must be specified;

(4) a full description of the coverage, including the amount, the term, and any exceptions, limitations, or exclusions;

(5) a statement that the benefits shall be paid to the creditor to reduce or extinguish the unpaid debt and that, whenever the amount of insurance benefit exceeds the unpaid debt, the excess is payable to the debtor, a beneficiary other than the creditor named by the debtor, or the debtor's estate;

(6) an explanation of how refunds are calculated in the event of policy termination; and

(7) if the benefit is not adequate to completely pay off the debt existing

on the date of death**,** [OR] disability, **or unemployment,** a statement to that effect on the face of the individual policy or group certificate in not smaller than 10 point, bold face type.

*** Sec. 50.** AS 21.66.110 is amended by adding a new subsection to read:

(c) A title insurance company shall pay to the division a late payment fee of $100 a day or 25 percent of the tax due, whichever is greater, from the date the payment was due to the date paid and interest at the rate of one percent a month or part of a month from the date the payment was originally due to the date paid for each day the insurer fails to pay the premium tax in the form required and within the time established.

*** Sec. 51.** AS 21.66.210(a) is amended to read:

(a) Two or more title insurance companies or two or more title insurance limited producers, or a combination of title insurance companies and title insurance limited producers, may apply to the director of insurance to form an association, corporation, or other legal entity, for the purpose of engaging in the business of preparing abstracts of title searches from public records or from records to be owned by the entity, upon the basis of which a title insurance limited producer or a title insurance company will issue title policies. The owners or participants are considered to be in compliance with the provisions of this section **and AS 21.66.200** if the title plant of the association, corporation, or other legal entity complies with the provisions of this section. The application must contain

(1) a copy of the proposed articles of incorporation or association and the bylaws or agreement governing the operation of the entity;

(2) a list of the owners or participants;

(3) the names and addresses of the persons who will operate the entity, with a description of their experience and qualifications;

(4) the conditions under which ownership or participation in the entity may be sold or acquired;

(5) a statement of whether or not title information will be compiled and sold to persons other than owners of or participants in the entity;

(6) a pro forma balance sheet and other financial information to

indicate the sufficiency of financing the entity.

*** Sec. 52.** AS 21.66.380(b) is amended to read:

(b) The statement and justification provided for in this section shall be open to public inspection**; however, information that can be used to identify the experience of a particular title insurance limited producer is confidential**.

*** Sec. 53.** AS 21.78.260(5) is amended to read:

(5) class 5: claims of the federal or a state or local government, other than claims under (3) of this section; claims, including those of a government body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, along with reasonable and actual costs attributable to it; the remaining portion of the claims are in the class of claims set out in **(7)** [(8)] of this section;

*** Sec. 54.** AS 21.80.060 is amended to read:

Sec. 21.80.060. Powers and duties of the association. (a) The association

(1) is obligated to pay covered claims existing before the order of liquidation and arising within 30 days after the order of liquidation, or before the policy expiration date if less than 30 days after the order of liquidation, or before the insured replaces the policy or causes its cancellation if the insured does so within 30 days after the order of liquidation, but this obligation includes only that amount of each covered claim that is less than $500,000, except that a covered claim for return of unearned premium may not exceed $10,000 for each policy, and except that the association shall pay the full amount of any covered claim arising out of a workers' compensation policy; the association is not obligated

(A) to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises; or

(B) to pay a claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer;

(2) is considered the insurer to the extent of its obligation on the covered claims and to that extent has all rights, duties, and obligations of the insolvent

insurer as if the insurer had not become insolvent;

(3) shall allocate claims paid and expenses incurred among the three accounts separately, and assess member insurers separately for each account amounts necessary to pay the obligation of the association under (1) of this subsection subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and other expenses authorized by this chapter; under this paragraph,

(A) the assessments of each member insurer must **initially** be **based on a uniform percentage, as determined by the association, of** [IN THE PROPORTION THAT] the net direct written premiums of **each** [THE] member insurer for the **last year for which annual statements have been filed** [CALENDAR YEAR PRECEDING THE ASSESSMENT] on the kinds of insurance in the account**; this initial assessment shall be adjusted by applying the same uniform percentage as initially used to each member insurer's net direct written premiums for the calendar year following the year in which the initial assessment was issued; any difference between the initial assessment amount and the adjusted assessment amount allocated to a member insurer shall be levied against or credited back to the member insurer, as appropriate, by the association; the association shall calculate and issue all appropriate levies and credits as soon as practical after all member insurers have filed their annual statements for the calendar year following the year in which the initial assessment was issued** [BEARS TO THE NET DIRECT WRITTEN PREMIUMS OF ALL MEMBER INSURERS FOR THE CALENDAR YEAR PRECEDING THE ASSESSMENT ON THE KINDS OF INSURANCE IN THE ACCOUNT; EACH MEMBER INSURER SHALL BE NOTIFIED OF THE ASSESSMENT NOT LATER THAN 30 DAYS BEFORE IT IS DUE];

(B) **on an annual basis, the association shall determine if funding is required for any of the three accounts; based on this determination, the association shall, during November of each year, issue initial assessments as may be necessary to cover the projected reasonable costs of claims and expenses to administer the association for the following**

year; the association shall use the services of an independent actuary to assist the association to evaluate and make the projection; an initial assessment may be made at any other time if the association determines funding is necessary, except that a member insurer may not be assessed **initial assessments** [IN ANY YEAR] on any account **in** an amount greater than two percent of the member insurer's net direct written premiums for the **applicable** calendar year [PRECEDING THE ASSESSMENT ON THE KINDS OF INSURANCE IN THE ACCOUNT];

(C) the association may pay claims in any order that it determines reasonable, including the payment of claims as they are received from claimants or in groups or categories of claims; however, if the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be prorated, and the unpaid portion shall be paid as soon thereafter as funds become available;

(D) the association may defer, in whole or in part, an assessment of any member insurer if the assessment would endanger the ability of the member insurer to fulfill the insurer's contractual obligations or cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; however, during the period of deferment, the member insurer may not pay dividends to shareholders or policyholders; a deferred assessment may only be paid when the payment does not reduce capital or surplus below minimums required by law; a member insurer who pays a larger assessment as a result of a deferment given to another member insurer shall receive a refund when the deferment ends or, at the election of the member insurer, receive a credit against future assessments;

(E) each member insurer may set off against an assessment authorized payments made on covered claims and expenses incurred in the

payment of these claims by the member insurer if they are chargeable to the account for which the assessment is made;

(4) shall investigate claims brought against the association, adjust, compromise, settle, and pay covered claims to the extent of the association's obligation, and deny all other claims, and may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which settlements, releases, and judgments may be properly contested;

(5) may, subject to AS 21.89.100, appoint, substitute, or direct legal counsel retained under an insurance policy for the defense of a covered claim;

(6) shall handle claims through its employees or through one or more insurers or other persons designated as servicing facilities; a servicing facility shall operate and maintain its principal office in this state unless the use of a servicing facility located outside of the state would result in operating cost savings of at least 10 percent and would not result in material delay in claim payments; designation of a servicing facility is subject to the approval of the director, but designation may be declined by a member insurer;

(7) shall reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this chapter.

(b) The association may

(1) employ or retain those persons necessary to handle claims and perform other duties of the association;

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

(3) sue or be sued;

(4) negotiate and become a party to those contracts that are necessary to carry out the purposes of this chapter;

(5) perform all other acts necessary or proper to carry out the purposes of this chapter;

(6) **retain amounts excess of claims, expenses, credits, and other**

liabilities in any account to be applied to reduce future assessments in that account, except that, if, in any year, the association determines that significant funds in excess of projected claims, expenses, credits, and other liabilities exist in an account, the association shall return amounts to policyholders, through procedures established by the association, whereby the association reimburses member insurers for providing uniform credits against rates and premiums charged for all policies applicable to the account issued during the next calendar year [REFUND TO THE MEMBER INSURERS IN PROPORTION TO THE CONTRIBUTION OF EACH MEMBER INSURER TO THAT ACCOUNT THAT AMOUNT BY WHICH THE ASSETS OF THE ACCOUNT EXCEED THE LIABILITIES IF, AT THE END OF ANY CALENDAR YEAR, THE BOARD OF GOVERNORS FINDS THAT THE ASSETS OF THE ASSOCIATION IN ANY ACCOUNT EXCEED THE LIABILITIES OF THAT ACCOUNT AS ESTIMATED BY THE BOARD OF GOVERNORS FOR THE COMING YEAR].

*** Sec. 55.** AS 21.80.070(c) is amended to read:

(c) The plan of operation must

(1) establish the procedures whereby all the powers and duties of the association under AS 21.80.060 will be performed;

(2) establish procedures for handling assets of the association, including procedures for handling assets received from the estate of an insolvent insurer;

(3) establish the amount and method of reimbursing members of the board of governors under AS 21.80.050;

(4) establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims; notice of claims to the receiver or liquidator of the insolvent insurer is considered notice to the association or its agent, and a list of these claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator;

(5) establish regular places and times for meetings of the board of governors;

(6) establish procedures for records to be kept of all financial

transactions of the association, its agents, and the board of governors;

(7) provide that any member insurer aggrieved by a final action or decision of the association may appeal to the director within 30 days after the action or decision;

(8) establish the procedures whereby selections of the board of governors will be submitted to the director;

(9) provide for a member insurer serving on the board of governors to appoint an individual to represent the member insurer on the board, including appointment of an alternate or substitute representative for the appointed person;

(10) contain additional provisions necessary or proper for the execution of the powers and duties of the association**;**

(11) establish procedures whereby the association shall, concurrent with making any initial assessments for the following year under AS 21.80.060(a)(3)(B), determine uniform surcharge percentages that may be applied by member insurers to all policies related to an account;

(12) establish procedures whereby the association shall determine surcharge percentages related to an account so that adjusted assessments match, as closely as possible, the amounts that would be collected by member insurers, in the aggregate, if the surcharge percentages were applied to all new and renewal policies issued by member insurers during the applicable 12-month period; any estimated or actual difference between the aggregate assessment and maximum allowable surcharge amounts related to an account shall be taken into account by the association in determining future surcharge percentages.

*** Sec. 56.** AS 21.80.140 is amended to read:

Sec. 21.80.140. Recognition of assessments in surcharge rates. The rates and premiums charged for insurance policies to which this chapter applies may include **surcharge rates** [AMOUNTS] sufficient to offset the **adjusted assessments** [ASSESSMENT] made under this chapter and paid to the association by [THE] member **insurers** [INSURER LESS AMOUNTS RETURNED TO THE MEMBER INSURER BY THE ASSOCIATION], and these **surcharge** rates may not be considered excessive because they contain an amount reasonably calculated to offset

the full amounted of adjusted assessments paid by [THE] member **insurers. The association shall notify the director of each surcharge percentage determined by the association, and this surcharge percentage shall be the maximum surcharge rate that may be applied by member insurers related to the assessment, except that a member insurer may make application to the director to apply a higher surcharge rate** [INSURER]. The amount charged on a policy shall be shown separate from the premium for coverage on the policy. [A RATING ORGANIZATION MAY MAKE A PROVISION IN ITS RATE FILING TO RECOVER AN ASSESSMENT UNDER THIS CHAPTER FOR THE ORGANIZATION'S MEMBER AND SUBSCRIBER INSURERS.] The **surcharge rate** [ASSESSMENT CHARGE] is not considered a premium and is not subject to the premium tax imposed under AS 21.09.210.

*** Sec. 57.** AS 21 is amended by adding a new chapter to read:

Chapter 85. Regulation of Multiple Employer Welfare Arrangements.

Sec. 21.85.010. Certificate of authority required. (a) A person may not establish or maintain a self-funded multiple employer welfare arrangement except as authorized by a subsisting certificate of authority issued to the arrangement by the director.

(b) A self-funded multiple employer welfare arrangement is established or maintained in this state if

(1) one or more of the employer members participating in the arrangement is domiciled or maintains its principal place of business in the state; or

(2) the multiple employer welfare arrangement solicits an employer that is domiciled in this state or has its principal headquarters or principal administrative offices in this state.

Sec 21.85.020. Name. A self-funded multiple employer welfare arrangement may not use a name that includes the words "insurance," "casualty," "surety," "health and accident," "mutual," or other terms descriptive of an insurer or insurance business. A self-funded multiple employer welfare arrangement may not have or use a name that is the same as or so similar to that of another self-funded multiple employer welfare arrangement or insurer that the name is likely to mislead the public.

Sec. 21.85.030. Qualifications for a certificate of authority. (a) The director may not issue a certificate of authority to a self-funded multiple employer welfare arrangement unless the arrangement establishes to the satisfaction of the director that

(1) employers participating in the arrangement are members of a bona fide association or group of two or more businesses in the same or a closely related trade, profession, or industry that provide support, services, or supplies primarily to that trade, profession, or industry;

(2) employers or employees participating in the arrangement exercise direct control over the arrangement; as described in this paragraph,

(A) subject to (B) of this paragraph, direct control exists if the employers or employees participating in the arrangement have the right to elect at least 75 percent of the individuals designated in the arrangement's organizational documents as having control over the operations of the arrangement and the individuals designated in the arrangement's organizational documents in fact exercise control over the operation of the arrangement;

(B) use of a third-party administrator to process claims and to assist in the administration of the arrangement is not evidence of the lack of exercise of control over the operations of the arrangement;

(3) the arrangement is a nonprofit organization;

(4) the arrangement provides only allowable benefits, except the arrangement may provide life insurance coverage to its participants if the life insurance coverage is provided under contracts that comply with this title;

(5) the arrangement has adequate facilities and competent personnel, as determined by the director, to service the health benefit plan or has contracted with a third-party administrator licensed under AS 21.27 to service the health benefit plan;

(6) the arrangement provides allowable benefits to not less than two employers and not less than 75 employees;

(7) the arrangement does not solicit participation in the arrangement from the general public, except the arrangement may employ or independently contract with a licensed insurance producer who may be paid a commission or other

remuneration to enroll employers in the arrangement;

(8) the arrangement is not organized or maintained solely as a conduit for the collection of premiums and the forwarding of premiums to an insurance company, except that the arrangement may act as a conduit for the collection and forwarding of premiums for life insurance coverage under (4) of this subsection;

(9) the arrangement

(A) has deposited $200,000 with the director to be used for the payment of claims in the event the arrangement becomes insolvent and has submitted to the director a written plan of operation that, in the discretion of the director, ensures the financial integrity of the arrangement; and

(B) is able to remain financially solvent; the director may consider the following in determining the ability of the arrangement to remain financially solvent:

(i) pro forma financial statements;

(ii) types and levels of stop-loss insurance coverage, including attachment points of the coverage;

(iii) whether a deposit is required for each employee covered under the arrangement equal to at least one month's cost of providing benefits under the arrangement;

(iv) the experience of the individuals who will be involved in the management of the arrangement, including employees, independent contractors, and consultants; and

(v) other factors the director considers relevant to determining the ability of the arrangement to remain financially solvent.

(b) The director may require that the articles, bylaws, agreements, trusts, or other documents or instruments describing the rights and obligations of the employers, employees, and beneficiaries of the arrangement require that employers participating in the arrangement are liable for a pro rata share of all liabilities of the arrangement that are unpaid.

(c) The arrangement shall maintain stop-loss insurance coverage covering 100

percent of claims in excess of the attachment point recommended by a qualified actuary.

Sec. 21.85.040. Application for a certificate of authority. To apply for an original certificate of authority, a self-funded multiple employer welfare arrangement shall file with the director its application, accompanied by the applicable fees set under AS 21.06.250, showing its name, the location of its home office, its date of organization, its state of domicile, and additional information that the director may reasonably require. The application shall be submitted together with

(1) a copy of all articles, bylaws, agreements, trusts, or other documents or instruments describing the rights and obligations of the employers, employees, and beneficiaries of the arrangement;

(2) a copy of each summary plan description of the arrangement filed or required to be filed with the United States Department of Labor, including any amendments to each description;

(3) evidence of coverage of or letter of intent to participate executed by at least two employers providing allowable benefits to at least 75 employees;

(4) a copy of the arrangement's most recent financial statement in compliance with AS 21.85.080 or, if the arrangement has been in existence for less than one year, pro forma financial statements, including a balance sheet, an income statement, a statement of changes in financial condition, and an actuarial opinion that the unpaid claim liability of the arrangement satisfies the standards in AS 21.18.080 - 21.18.086;

(5) proof that the arrangement maintains and will continue to maintain fidelity bonds required by the United States Department of Labor under 29 U.S.C. 1001 - 1461 (Employee Retirement Income Security Act of 1974);

(6) a copy of any stop-loss insurance policies maintained or proposed to be maintained by the arrangement;

(7) biographical reports, on forms prescribed by the National Association of Insurance Commissioners, evidencing the general trustworthiness and competence of each individual who is serving or who will serve as a managing employee or fiduciary of the arrangement;

(8) a notarized statement executed by an officer of the arrangement certifying, to the best knowledge and belief of the officer, that the information provided in the application is true and correct and that the arrangement is in compliance with the requirements in

(A) AS 21.85.020;

(B) 29 U.S.C. 1001 - 1461 (Employee Retirement Income Security Act of 1974) or a statement of any requirements with which the arrangement is not in compliance and a statement of proposed corrective action; and

(C) AS 21.85.050;

(9) base contribution rates for participation under the arrangement for its initial year of operations.

Sec. 21.85.050. Minimum reserves. A self-funded multiple employer welfare arrangement shall establish and maintain reserves equal to the greater of

(1) 30 percent of the unpaid claim liability of the arrangement; or

(2) the amount recommended and certified by a qualified actuary.

Sec. 21.85.060. Investments. A multiple employer welfare arrangement shall maintain an amount at least equal to 85 percent of net unpaid claim liability in

(1) cash and cash equivalents;

(2) the fully insured portion of a bank deposit when the insurance is provided by a solvent agency of the United States government or by collateral;

(3) a bank certificate of deposit, subject to review by the director; if the director determines that the amount of the certificate of deposit purchased by an insurer in any one bank is not a sound investment, the director may require the insurer to liquidate that portion found to be an unsound investment;

(4) a share or savings account of a savings and loan or building and loan association, to the extent that an account is insured by the Federal Deposit Insurance Corporation; or

(5) a rated credit instrument that is issued, assumed, guaranteed, or insured by the United States or Canada or by a government-sponsored enterprise of the United States or Canada if the instrument is assumed, guaranteed, or insured by the

United States or Canada or is otherwise backed or supported by the full faith and credit of the United States or Canada.

Sec. 21.85.070. Contribution rates. (a) A self-funded multiple employer welfare arrangement shall establish and maintain contribution rates that

(1) fund the greater of

(A) the amount recommended and certified by a qualified actuary in order for the self-funded multiple employer welfare arrangement to remain financially solvent; or

(B) the sum of projected claims liability for the year, plus all projected costs of operation of the arrangement for the year, plus an amount equal to any deficiency in the reserves of the arrangement for the prior year, minus an amount equal to the reserves of the arrangement in excess of the minimum required level of reserves; and

(2) are not excessive, inadequate, or unfairly discriminatory.

(b) A self-funded multiple employer welfare arrangement shall, before use, file with the director

(1) a rate or fee of any kind to be charged a participating employer or employee;

(2) every rating manual, schedule, plan, rule, or formula; and

(3) any modification to the rating manual, schedule, plan, rule or formula.

(c) The director shall disapprove by order a contribution rate or fee submitted under (b) of this section that does not meet the requirements of (a) of this section or is in any respect not in compliance with or in violation of law.

(d) A filing under (b) of this section must state the effective date and must provide a comprehensive description of the coverage. The director may withhold the information provided under (b)(2) and (3) of this section from public inspection for as long as the director determines that withholding the information is necessary to protect the arrangement against unwarranted injury or is in the public interest.

Sec. 21.85.080. Reporting requirements. (a) A self-funded multiple employer welfare arrangement shall annually, before March 2, file with the director on

forms prescribed by the director, a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31, including

(1) a statement of financial condition;

(2) a statement of change in financial condition for the year accompanied by an actuarial opinion by a qualified actuary that includes

(A) a certification that the unpaid claim liability of the arrangement meets the requirements of AS 21.18.080 - 21.18.086;

(B) the recommended level of specific and aggregate stop-loss insurance the arrangement should maintain;

(C) a description of the actuarial soundness of the arrangement, including any recommended actions the arrangement should take to improve its actuarial soundness;

(3) a statement of the arrangement's contribution rates for the next year;

(4) if the total payments to the arrangement for participation during the prior year of operations exceeded the sum of $2,000,000, certified financial statements for the prior two years, or for each year and partial year that the self-funded multiple employer welfare arrangement has been in business if less than two years;

(5) a report showing the number of participating employers and number of covered lives at the end of the year and contributions received during the year in the state;

(6) additional information the director determines is necessary in order to determine the financial integrity of the arrangement.

(b) A self-funded multiple employer welfare arrangement shall, within 60 days after the end of each quarter, file with the director, on forms prescribed by the director, a full and true statement of its financial condition, transactions, and affairs as of the preceding quarter, including

(1) a statement of financial condition;

(2) a statement of change in financial condition for the period since the end of the prior year;

(3) a report showing the number of participating employers and

number of covered lives at the end of the quarter and contributions received during the quarter in the state;

(4) additional information the director determines is necessary in order to determine the financial integrity of the arrangement.

(c) A self-funded multiple employer welfare arrangement shall file with the director a copy of the arrangement's Internal Revenue Service form 5500, including all attachments to the form.

Sec. 21.85.090. Consumer information notice. A self-funded multiple employer welfare arrangement must provide a written notice to each participating employee at the time that coverage becomes effective. The notice must

(1) be clear and conspicuous;

(2) be in at least 10-point type;

(3) state that

(A) the coverage is issued by a self-funded multiple employer welfare arrangement;

(B) coverage and benefits provided under a self-funded multiple employer welfare arrangement are not protected by the Alaska Life and Health Insurance Guaranty Association; and

(C) if the self-funded multiple employer welfare arrangement does not pay expenses that are eligible for payment under the plan for any reason, the employer or employee covered by the plan may be responsible for the payment of those expenses.

Sec. 21.85.100. Applicability of other provisions. In addition to the provisions contained or referred to in this chapter, the following chapters and provisions of this title also apply with respect to self-funded multiple employer welfare arrangements 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 arrangements shall be considered to be a mutual insurer:

(1) AS 21.03;

(2) AS 21.06;

(3) AS 21.07;

(4) AS 21.09.100, 21.09.120, 21.09.130, 21.09.140 - 21.09.200, 21.09.210, 21.09.245 - 21.09.270, 21.09.300, and 21.09.320;

(5) AS 21.18.010 - 21.18.050, 21.18.080 - 21.18.086, and 21.18.100;

(6) AS 21.33;

(7) AS 21.36;

(8) AS 21.42.120, 21.42.130, 21.42.345 - 21.42.365, and 21.42.375 - 21.42.500;

(9) AS 21.48;

(10) AS 21.54;

(11) AS 21.55;

(12) AS 21.56;

(13) AS 21.78;

(14) AS 21.89.060;

(15) AS 21.90.

Sec. 21.85.500. Definitions. In this chapter,

(1) "allowable benefit" means a benefit for medical care;

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

(3) "claims liability" means the total of all incurred and unpaid claims for allowable benefits under a self-funded multiple employer welfare arrangement that are not reimbursed or reimbursable by stop-loss insurance, subrogation, or other sources;

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

(5) "multiple employer welfare arrangement" has the meaning given in 29 U.S.C. 1002; "multiple employer welfare arrangement" does not include a group that the director designates under AS 21.54.060(5) as subject to issuance of a group health insurance policy;

(6) "qualified actuary" means an individual who

(A) is a member in good standing of the American Academy of Actuaries;

(B) meets the qualification standards of the American Academy

of Actuaries to sign statements of actuarial opinion;

(C) is familiar with the valuation requirements under AS 21.18; and

(D) has not been disqualified by the director, after notice and hearing under AS 21.06.180, for

(i) a violation of this title or other law pertinent to the duties or responsibilities of a qualified actuary;

(ii) conviction of a fraudulent act;

(iii) conduct considered by the director to reflect incompetence or untrustworthiness;

(iv) resignation or removal as an actuary with a company or a consulting firm within the past five years due to acts or omissions indicated in a report of examination or due to failure to adhere to generally accepted actuarial standards; or

(v) failure to notify the director of an action taken against the actuary by an insurance regulator of another state for grounds that are substantially the same as a provision under this paragraph;

(7) "reserves" means the excess of assets of a self-funded multiple employer welfare arrangement minus the liabilities of the arrangement;

(8) "self-funded multiple employer welfare arrangement" or "arrangement" means a multiple employer welfare arrangement that does not provide for payment of benefits under the arrangement solely through a policy of insurance issued by one or more authorized insurance companies.

*** Sec. 58.** 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) [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. **A detailed rate justification, including a rate formula,**

is confidential [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].

*** Sec. 59.** AS 21.87.340 is amended by adding new paragraphs to read:

(22) AS 21.07;

(23) AS 21.18.080 - 21.18.086.

*** Sec. 60.** AS 21.33.045(d); AS 21.87.340(17); and AS 21.89.040 are repealed.

*** Sec. 61.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REVISOR'S INSTRUCTION. The revisor of statutes is instructed to change the catchline of AS 21.42.020 from "Insurable interest: personal insurance" to "Insurable interest: life, annuity, or health."

*** Sec. 62.** This Act takes effect July 1, 2002.