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CS FOR HOUSE BILL NO. 164(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): HOUSE LABOR AND COMMERCE COMMITTEE

A BILL

FOR AN ACT ENTITLED

"An Act relating to health care insurance, exemption of certain insurers, reporting, notice, and record-keeping requirements for insurers, biographical affidavits, qualifications of alien insurers assuming ceded insurance, risk-based capital for insurers, insurance holding companies, licensing, federal requirements for nonadmitted insurers, surplus lines insurance, insurance fraud, life insurance policies and annuity contracts, rate filings by health care insurers, long-term care insurance, automobile service corporations, guaranty fund deposits of a title insurer, joint title plants, fraternal benefit societies, multiple employer welfare arrangements, hospital and medical service corporations, and health maintenance organizations; 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 a new subsection to read:

(f) If an insurer is not required to obtain a certificate of authority in this state under AS 21.09.020(5), the provisions of the title do not apply to policies or contracts issued by the insurer.

*** Sec. 2.** AS 21.07.010 is amended to read:

Sec. 21.07.010. Patient and health care provider protection. (a) A contract between a participating health care provider and a **health care insurer** [MANAGED CARE ENTITY THAT OFFERS A MANAGED CARE PLAN] must contain a provision that

(1) provides for a reasonable mechanism to identify all medical care services to be provided by the **health care insurer** [MANAGED CARE ENTITY];

(2) clearly states or references an attachment that states the health care provider's rate of compensation;

(3) clearly states all ways in which the contract between the health care provider and **health care insurer** [MANAGED CARE ENTITY] may be terminated; a provision that provides for discretionary termination by either party must apply equitably to both parties;

(4) provides that, in the event of a dispute between the parties to the contract, a fair, prompt, and mutual dispute resolution process must be used; at a minimum, the process must provide

(A) for an initial meeting at which all parties are present or represented by individuals with authority regarding the matters in dispute; the meeting shall be held within 10 working days after the **health care insurer** [PLAN] receives written notice of the dispute or gives written notice to the provider, unless the parties otherwise agree in writing to a different schedule;

(B) that if, within 30 days following the initial meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to the parties and who is not regularly under contract to or employed by either of the parties; each party shall bear its proportionate share of the cost of mediation, including the mediator fees;

(C) that if, after a period of 60 days following commencement

of mediation, the parties are unable to resolve the dispute, either party may seek other relief allowed by law;

(D) that the parties shall agree to negotiate in good faith in the initial meeting and in mediation;

(5) states that a health care provider may not be penalized or the health care provider's contract terminated by the **health care insurer** [MANAGED CARE ENTITY] because the health care provider acts as an advocate for a covered person in seeking appropriate, medically necessary medical care services;

(6) protects the ability of a health care provider to communicate openly with a covered person about all appropriate diagnostic testing and treatment options; and

(7) defines words in a clear and concise manner.

(b) A contract between a participating health care provider and a **health care insurer** [MANAGED CARE ENTITY] that offers a **health care insurance policy** [MANAGED CARE PLAN] may not contain a provision that

(1) has as its predominant purpose the creation of direct financial incentives to the health care provider for withholding covered medical care services that are medically necessary; nothing in this paragraph shall be construed to prohibit a contract between a participating health care provider and a **health care insurer** [MANAGED CARE ENTITY] from containing incentives for efficient management of the utilization and cost of covered medical care services;

(2) requires the provider to contract for all products that are currently offered or that may be offered in the future by the **health care insurer** [MANAGED CARE ENTITY]; or

(3) requires the health care provider to be compensated for medical care services performed at the same rate as the health care provider has contracted with another **health care insurer** [MANAGED CARE ENTITY].

(c) A **health care insurer** [MANAGED CARE ENTITY] may not enter into a contract with a health care provider that requires the provider to indemnify or hold harmless the **health care insurer** [MANAGED CARE ENTITY] for the acts or conduct of the **health care insurer** [MANAGED CARE ENTITY]. An

indemnification or hold harmless clause entered into in violation of this subsection is void.

*** Sec. 3.** AS 21.07.020 is amended to read:

Sec. 21.07.020. Required contract provisions for health care insurance policy [MANAGED CARE PLANS]. A **health care insurance policy** [MANAGED CARE PLAN] must contain

(1) a provision that preauthorization for a covered medical procedure on the basis of medical necessity may not be retroactively denied unless the preauthorization is based on materially incomplete or inaccurate information provided by or on behalf of the provider;

(2) a provision for emergency room services if any coverage is provided for treatment of a medical emergency;

(3) a provision that covered medical care services be reasonably available in the community in which a covered person resides or that, if referrals are required by the **policy** [PLAN], adequate referrals outside the community be available if the medical care service is not available in the community;

(4) a provision that any utilization review decision

(A) must be made within 72 hours after receiving the request for preapproval for nonemergency situations; for emergency situations, utilization review decisions for care following emergency services must be made as soon as is practicable but in any event not later than 24 hours after receiving the request for preapproval or for coverage determination; and

(B) to deny, reduce, or terminate a health care benefit or to deny payment for a medical care service because that service is not medically necessary shall be made by an employee or agent of the **health care insurer** [MANAGED CARE ENTITY] who is a licensed health care provider;

(5) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a **health care insurer** [MANAGED CARE ENTITY]; except as provided under (6) of this section, this appeal mechanism must provide for a written decision

(A) from the **health care insurer** [MANAGED CARE

ENTITY] within 18 working days after the date written notice of an appeal is received; and

(B) on the appeal by an employee or agent of the **health care insurer** [MANAGED CARE ENTITY] who holds the same professional license as the health care provider who is treating the covered person;

(6) a provision that provides for an internal appeal mechanism for a covered person who disagrees with a utilization review decision made by a **health care insurer** [MANAGED CARE ENTITY] in any case in which delay would, in the written opinion of the treating provider, jeopardize the covered person's life or materially jeopardize the covered person's health; the **health care insurer** [MANAGED CARE ENTITY] shall

(A) decide an appeal described in this paragraph within 72 hours after receiving the appeal; and

(B) provide for a written decision on the appeal by an employee or agent of the **health care insurer** [MANAGED CARE ENTITY] who holds the same professional license as the health care provider who is treating the covered person;

(7) a provision that discloses the existence of the right to an external appeal of a utilization review decision made by a **health care insurer** [MANAGED CARE ENTITY]; the external appeal shall be [AS] conducted in accordance with AS 21.07.050;

(8) a provision that discloses covered benefits, optional supplemental benefits, and benefits relating to and restrictions on nonparticipating provider services;

(9) a provision that describes the preapproval requirements and whether clinical trials or experimental or investigational treatment are covered;

(10) a provision describing a mechanism for assignment of benefits for health care providers and payment of benefits;

(11) a provision describing availability of prescription medications or a formulary guide, and whether medications not listed are excluded; if a formulary guide is made available, the guide must be updated annually; and

(12) a provision describing available translation or interpreter services,

including audiotape or braille information.

*** Sec. 4.** AS 21.07.030(a) is amended to read:

(a) If a **health care insurer** [MANAGED CARE ENTITY] offers a **health care insurance policy** [MANAGED CARE PLAN] that provides for coverage of medical care services only if the services are furnished through a network of health care providers that have entered into a contract with the **health care insurer** [MANAGED CARE ENTITY], the **health care insurer** [MANAGED CARE ENTITY] shall also offer a non-network option to covered persons at initial enrollment, as provided under (c) of this section. The non-network option may require that a covered person pay a higher deductible, copayment, or premium for the plan if the higher deductible, copayment, or premium results from increased costs caused by the use of a non-network provider. [THE MANAGED CARE ENTITY SHALL PROVIDE AN ACTUARIAL DEMONSTRATION OF THE INCREASED COSTS TO THE DIRECTOR AT THE DIRECTOR'S REQUEST. IF THE INCREASED COSTS ARE NOT JUSTIFIED, THE DIRECTOR SHALL REQUIRE THE MANAGED CARE ENTITY TO RECALCULATE THE APPROPRIATE COSTS ALLOWED AND RESUBMIT THE APPROPRIATE DEDUCTIBLE, COPAYMENT, OR PREMIUM TO THE DIRECTOR.] This subsection does not apply to a covered person who is offered non-network coverage through another **health care insurance policy** [MANAGED CARE PLAN] or through another **health care insurer** [MANAGED CARE ENTITY].

*** Sec. 5.** AS 21.07.030(b) is amended to read:

(b) The amount of any additional premium charged by the **health care insurer** [MANAGED CARE ENTITY] for the additional cost of the creation and maintenance of the option described in (a) of this section and the amount of any additional cost sharing imposed under this option shall be paid by the covered person unless it is paid by an employer or other person through agreement with the **health care insurer** [MANAGED CARE ENTITY].

*** Sec. 6.** AS 21.07.030(c) is amended to read:

(c) A covered person may make a change to the medical care coverage option provided under this section only during a time period determined by the **health care**

insurer [MANAGED CARE ENTITY]. The time period described in this subsection must occur at least annually and last for at least 15 working days.

*** Sec. 7.** AS 21.07.030(d) is amended to read:

(d) If a **health care insurer** [MANAGED CARE ENTITY] that offers a **health care insurance policy** [MANAGED CARE PLAN] requires or provides for a designation by a covered person of a participating primary care provider, the **health care insurer** [MANAGED CARE ENTITY] shall permit the covered person to designate any participating primary care provider that is available to accept the covered person.

*** Sec. 8.** AS 21.07.030(e) is amended to read:

(e) Except as provided in this subsection, a **health care insurer** [MANAGED CARE ENTITY] that offers a **health care insurance policy** [MANAGED CARE PLAN] shall permit a covered person to receive medically necessary or appropriate specialty care, subject to appropriate referral procedures, from any qualified participating health care provider that is available to accept the individual for medical care. This subsection does not apply to specialty care if the **health care insurer** [MANAGED CARE ENTITY] clearly informs covered persons of the limitations on choice of participating health care providers with respect to medical care. In this subsection,

(1) "appropriate referral procedures" means procedures for referring patients to other health care providers as set out in the applicable member **policy** [CONTRACT] and as described under (a) of this section;

(2) "specialty care" means care provided by a health care provider with training and experience in treating a particular injury, illness, or condition.

*** Sec. 9.** AS 21.07.030(f) is amended to read:

(f) If a contract between a health care provider and a **health care insurer** [MANAGED CARE ENTITY] is terminated, a covered person may continue to be treated by that health care provider as provided in this subsection. If a covered person is pregnant or being actively treated by a provider on the date of the termination of the contract between that provider and the **health care insurer** [MANAGED CARE ENTITY], the covered person may continue to receive medical care services from that

provider as provided in this subsection, and the contract between the **health care insurer** [MANAGED CARE ENTITY] and the provider shall remain in force with respect to the continuing treatment. The covered person shall be treated for the purposes of benefit determination or claim payment as if the provider were still under contract with the **health care insurer** [MANAGED CARE ENTITY]. However, treatment is required to continue only while the **health care insurance policy** [MANAGED CARE PLAN] remains in effect and

(1) for the period that is the longest of the following:

(A) the end of the current **policy or** plan year;

(B) up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment;

(C) through completion of postpartum care, if the covered person is pregnant on the date of termination; or

(2) until the end of the medically necessary treatment for the condition, disease, illness, or injury if the person has a terminal condition, disease, illness, or injury; in this paragraph, "terminal" means a life expectancy of less than one year.

*** Sec. 10.** AS 21.07.050(a) is amended to read:

(a) A **health care insurer** [MANAGED CARE ENTITY] offering a **health care insurance policy** [MANAGED CARE PLAN] shall provide for an external appeal process that meets the requirements of this section in the case of an externally appealable decision for which a timely appeal is made in writing either by the **health care insurer** [MANAGED CARE ENTITY] or by the covered person.

*** Sec. 11.** AS 21.07.050(b) is amended to read:

(b) A **health care insurer** [MANAGED CARE ENTITY] may condition the use of an external appeal process in the case of an externally appealable decision upon a final decision in an internal appeal under AS 21.07.020, but only if the decision is made in a timely basis consistent with the deadlines provided under this chapter.

*** Sec. 12.** AS 21.07.050(c) is amended to read:

(c) Except as provided in this subsection, the external appeal process shall be conducted under a contract between the **health care insurer** [MANAGED CARE

ENTITY] and one or more external appeal agencies that **are** [HAVE] qualified under AS 21.07.060. The **health care insurer** [MANAGED CARE ENTITY] shall provide

(1) that the selection process among external appeal agencies qualifying under AS 21.07.060 does not create any incentives for external appeal agencies to make a decision in a biased manner;

(2) for auditing a sample of decisions by external appeal agencies to ensure that decisions are not made in a biased manner; and

(3) that all costs of the process, except those incurred by the covered person or treating professional in support of the appeal, shall be paid by the **health care insurer** [MANAGED CARE ENTITY] and not by the covered person.

*** Sec. 13.** AS 21.07.050(d) is amended to read:

(d) An external appeal process must include at least the following:

(1) a fair, de novo determination based on coverage provided by the **policy** [PLAN] and by applying terms as defined by the **policy** [PLAN]; however, nothing in this paragraph may be construed as providing for coverage of items and services for which benefits are excluded under the **policy** [PLAN] or coverage;

(2) an external appeal agency shall determine whether the **health care insurer's** [MANAGED CARE ENTITY'S] decision is

(A) in accordance with the medical needs of the patient involved, as determined by the **health care insurer** [MANAGED CARE ENTITY], taking into account, as of the time of the **health care insurer's** [MANAGED CARE ENTITY'S] decision, the patient's medical needs and any relevant and reliable evidence the agency obtains under (3) of this subsection**;** [,] and

(B) in accordance with the scope of the covered benefits under the **policy** [PLAN]; if the agency determines the decision complies with this paragraph, the agency shall affirm the decision, and, to the extent that the agency determines the decision is not in accordance with this paragraph, the agency shall reverse or modify the decision;

(3) the external appeal agency shall include among the evidence taken into consideration

(A) the decision made by the **health care insurer** [MANAGED CARE ENTITY] upon internal appeal under AS 21.07.020 and any guidelines or standards used by the **health care insurer** [MANAGED CARE ENTITY] in reaching a decision;

(B) any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed;

(C) the opinion of the individual's treating physician or health care provider; and

(D) the **health care insurance policy** [MANAGED CARE PLAN];

(4) the external appeal agency may also take into consideration the following evidence:

(A) the results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals;

(B) the results of professional consensus conferences conducted or financed in whole or in part by one or more government agencies;

(C) practice and treatment guidelines prepared or financed in whole or in part by government agencies;

(D) government-issued coverage and treatment policies;

(E) generally accepted principles of professional medical practice;

(F) to the extent that the agency determines **them** [IT] to be free of any conflict of interest, the opinions of individuals who are qualified as experts in one or more fields of health care that are directly related to the matters under appeal;

(G) to the extent that the agency determines **them** [IT] to be free of any conflict of interest, the results of peer reviews conducted by the **health care insurer** [MANAGED CARE ENTITY] involved;

(H) the community standard of care; and

(I) anomalous utilization patterns;

(5) an external appeal agency shall determine

(A) whether a denial of a claim for benefits is an externally appealable decision;

(B) whether an externally appealable decision involves an expedited appeal; and

(C) for purposes of initiating an external review, whether the internal appeal process has been completed;

(6) a party to an externally appealable decision may submit evidence related to the issues in dispute;

(7) the **health care insurer** [MANAGED CARE ENTITY] involved shall provide the external appeal agency with access to information and to provisions of the **policy** [PLAN OR HEALTH INSURANCE COVERAGE] relating to the matter of the externally appealable decision, as determined by the external appeal agency; and

(8) a determination by the external appeal agency on the decision must

(A) be made orally or in writing and, if it is made orally, shall be supplied to the parties in writing as soon as possible;

(B) be made in accordance with the medical exigencies of the case involved, but in no event later than 21 working days after the appeal is filed, or, in the case of an expedited appeal, 72 hours after the time of requesting an external appeal of the **health care insurer's** [MANAGED CARE ENTITY'S] decision;

(C) state, in layperson's language, the basis for the determination, including, if relevant, any basis in the terms or conditions of the **policy** [PLAN OR COVERAGE]; and

(D) inform the covered person of the individual's rights, including any time limits, to seek further review by the courts of the external appeal determination.

*** Sec. 14.** AS 21.07.050(e) is amended to read:

(e) If the external appeal agency reverses or modifies the denial of a claim for

benefits, the **health care insurer** [MANAGED CARE ENTITY] shall

(1) upon receipt of the determination, authorize benefits in accordance with that determination;

(2) take action as may be necessary to provide benefits, including items or services, in a timely manner consistent with the determination; and

(3) submit information to the external appeal agency documenting compliance with the agency's determination.

*** Sec. 15.** AS 21.07.050(h) is amended to read:

(h) In this section, "externally appealable decision"

(1) means

(A) a denial of a claim for benefits that is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental, or in which the decision as to whether a benefit is covered involves a medical judgment; or

(B) a denial that is based on a failure to meet an applicable deadline for internal appeal under AS 21.07.020;

(2) does not include a decision based on specific exclusions or express limitations on the amount, duration, or scope of coverage that do not involve medical judgment, or a decision regarding whether an individual is a participant, beneficiary, or other covered person under the **policy** [PLAN] or coverage.

*** Sec. 16.** AS 21.07.060 is amended to read:

Sec. 21.07.060. Qualifications of external appeal agencies. (a) An external appeal agency qualifies to consider external appeals if, with respect to a **health care insurance policy** [MANAGED CARE PLAN], the agency is certified by a qualified private standard-setting organization approved by the director or by a health insurer operating in this state as meeting the requirements imposed under (b) of this section.

(b) An external appeal agency is qualified to consider appeals of **health care insurance policy** [MANAGED CARE PLAN] health care decisions if the agency meets the following requirements:

(1) the agency meets the independence requirements of this section;

(2) the agency conducts external appeal activities through a panel of

two clinical peers, unless otherwise agreed to by both parties; and

(3) the agency has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the **health care insurer** [MANAGED CARE ENTITY] on a timely basis consistent with this chapter.

(c) A clinical peer or other entity meets the independence requirements of this section if

(1) the peer or entity does not have a familial, financial, or professional relationship with a related party;

(2) compensation received by a peer or entity in connection with the external review is reasonable and not contingent on any decision rendered by the peer or entity;

(3) the **health care insurer has** [PLAN AND THE ISSUER HAVE] no recourse against the peer or entity in connection with the external review; and

(4) the peer or entity does not otherwise have a conflict of interest with a related party.

(d) In this section, "related party" means

(1) **a health care insurer or, with respect to group health care insurance, a plan sponsor, including any officer, director, management employee, or fiduciary of the health care insurer or the plan sponsor** [WITH RESPECT TO

(A) A MANAGED CARE PLAN, THE PLAN OR THE INSURER OFFERING THE COVERAGE; OR

(B) INDIVIDUAL HEALTH INSURANCE COVERAGE, THE INSURER OFFERING THE COVERAGE, OR ANY PLAN SPONSOR, FIDUCIARY, OFFICER, DIRECTOR, OR MANAGEMENT EMPLOYEE OF THE PLAN OR ISSUER];

(2) the health care professional that provided the health care involved in the coverage decision;

(3) the institution at which the health care involved in the coverage decision is provided;

(4) the manufacturer of any drug or other item that was included in the health care involved in the coverage decision;

(5) the covered person; or

(6) any other party that, under the regulations that the director may prescribe, is determined by the director to have a substantial interest in the coverage decision.

*** Sec. 17.** AS 21.07.070 is amended to read:

Sec. 21.07.070. Limitation on liability of reviewers. An external appeal agency qualifying under AS 21.07.060 and having a contract with a **health care insurer** [MANAGED CARE ENTITY], and a person who is employed by the agency or who furnishes professional services to the agency, may not be held by reason of the performance of any duty, function, or activity required or authorized under this chapter to have violated any criminal law, or to be civilly liable if due care was exercised in the performance of the duty, function**,** or activity and there was no actual malice or gross misconduct in the performance of the duty, function, or activity.

*** Sec. 18.** AS 21.07.080 is amended to read:

Sec. 21.07.080. Religious nonmedical providers. This chapter may not be construed to

(1) restrict or limit the right of a **health care insurer** [MANAGED CARE ENTITY] to include services provided by a religious nonmedical provider as medical care services covered by the **health care insurance policy** [MANAGED CARE PLAN];

(2) require a **health care insurer** [MANAGED CARE ENTITY], when determining coverage for services provided by a religious nonmedical provider, to

(A) apply medically based eligibility standards;

(B) use health care providers to determine access by a covered person;

(C) use health care providers in making a decision on an internal or external appeal; or

(D) require a covered person to be examined by a health care provider as a condition of coverage; or

(3) require a **health care insurance policy** [MANAGED CARE

PLAN] to exclude coverage for services provided by a religious nonmedical provider because the religious nonmedical provider is not providing medical or other data required from a health care provider if the medical or other data is inconsistent with the religious nonmedical treatment or nursing care being provided.

*** Sec. 19.** AS 21.07.250(12) is amended to read:

(12) "participating health care provider" means a health care provider who has entered into an agreement with a **health care insurer** [MANAGED CARE ENTITY] to provide services or supplies to a patient covered by a **health care insurance policy** [MANAGED CARE PLAN];

*** Sec. 20.** AS 21.07.250(16) is amended to read:

(16) "utilization review" means a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies provided under a **health care insurance policy** [MANAGED CARE PLAN] using specified guidelines, including preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

*** Sec. 21.** AS 21.07.250 is amended by adding a new paragraph to read:

(17) "health care insurer" has the meaning given in AS 21.54.500.

*** Sec. 22.** AS 21.09.020 is amended to read:

Sec. 21.09.020. Exception from [EXCEPTIONS,] certificate of authority requirement. A certificate of authority is not required of an insurer, not otherwise authorized in this state, **with** [IN] regard to

(1) transactions relative to its policies lawfully written in the state, or liquidation of assets and liabilities of the insurer**,** [(] other than collection of new premiums**,** [), ALL AS] resulting from its former authorized operations in the state;

(2) related transactions subsequent to issuance of a policy covering only subjects of insurance not resident, located, or expressly to be performed in the state at time of issuance, and which coverage was lawfully solicited, written, and delivered outside the state;

(3) transactions under surplus lines coverages lawfully written under AS 21.34; [OR]

(4) reinsurance, except as to domestic reinsurers**; or**

(5) transactions relative to policies issued in another state, but only if

(A) the insurer does not market insurance in this state;

(B) the laws of the state of issue apply to this state's residents covered under the policies; and

(C) the insurer complies with other requirements the director adopts by regulation to qualify for an exception under this paragraph.

*** Sec. 23.** 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 **a** [THE ANNUAL] statement **or report** 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 **a statement or report required by this section** [THE ANNUAL STATEMENT] has not been filed by **the due date** [MARCH 1].

*** Sec. 24.** AS 21.09.245(b) is amended to read:

(b) If an insurer changes the insurer's articles of incorporation, bylaws, business address, phone number, **electronic mailing address,** 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.

*** Sec. 25.** AS 21.09 is amended by adding a new section to read:

Sec. 21.09.247. Biographical affidavits. A domestic insurer shall file with the director a complete affidavit of biographical information not later than 30 days after the appointment of an officer or director of the insurer. If requested by the director, a foreign insurer shall file with the director an affidavit of biographical information for the appointment of an officer or director of the insurer. A filing under this section must be on a form approved by the director. A filing is not required if a biographical affidavit of the officer or director has been submitted to the director within one year before the date of appointment. A biographical affidavit filed under this section is confidential and not subject to public inspection.

*** Sec. 26.** AS 21.09.320 is amended to read:

Sec. 21.09.320. Maintenance of records. (a) **A foreign** [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 **business** [INSURANCE] transacted.

(b) To meet the requirements of (a) of this section, the insurer shall keep the records **as required** [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. 27.** AS 21.12.020(a) is amended to read:

(a) Credit for reinsurance transactions shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only with respect to cessions of a kind or class of business that the assuming insurer is licensed or permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance and only if the reinsurance is ceded to an

(1) assuming insurer that is licensed to transact insurance or reinsurance in this state;

(2) assuming insurer that is accredited as a reinsurer in this state; an accredited reinsurer is one that

(A) files evidence of submission to this state's jurisdiction, submits to this state's authority to examine its books and records under AS 21.06.120, is licensed to transact insurance or reinsurance in at least one state that is accredited by the National Association of Insurance Commissioners, or, in the case of a United States branch of an alien admitted insurer, is entered through and licensed to transact insurance or reinsurance in at least one state that is accredited by the National Association of Insurance Commissioners;

(B) maintains at least $20,000,000 in policyholder surplus and

whose accreditation has not been denied by the director within 90 days after application to the director, or maintains less than $20,000,000 in policyholder surplus and whose application for accreditation has been approved by the director; and

(C) files annually with the director a copy of the reinsurer's annual financial statement filed with the insurance department of the reinsurer's state of domicile or state of entry and a copy of the reinsurer's most recent audited financial statement;

(3) assuming insurer that is domiciled in a state, or, in the case of a United States branch of an alien assuming insurer, is entered through a state accredited by the National Association of Insurance Commissioners that employs standards regarding credit for reinsurance ceded substantially similar to those applicable under (1) and (2) of this subsection, the assuming insurer maintains a policyholder surplus of at least $20,000,000, and the assuming insurer submits to the authority of this state to examine its books and records; the surplus requirements in this paragraph do not apply to reinsurance ceded and assumed under a pooling arrangement among insurers in the same holding company system;

(4) assuming alien insurer that

(A) maintains a trust fund in a qualified United States financial institution for the payment of the valid claims of its United States **domiciled** [POLICYHOLDERS AND] ceding insurers, and their assigns and successors in interest, that conforms to the following requirements:

(i) the trust and each amendment to the trust shall be established in a form approved by the insurance supervisory official of the state where the trust is domiciled or the insurance supervisory official of another state who, under the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust; the form of the trust and each trust amendment shall be filed with the insurance supervisory official of every state in which the beneficiaries of the trust are domiciled; the trust instrument must provide that contested claims are valid and enforceable upon the final order of any

court of competent jurisdiction in the United States; the trust shall vest legal title to its assets in the trustees of the trust for its United States **domiciled** [POLICYHOLDERS AND] ceding insurers, their assigns, and successors in interest; the trust and the assuming insurer are subject to examination as determined by the director, and the assuming insurer shall submit to examination of its books and records by the director and bear the expense of examination; the trust must remain in effect for so long as the assuming insurer has outstanding liabilities due under the reinsurance agreements subject to the trust;

(ii) on or before March 1 of each year**,** the trustees shall report in writing to the director on the balance of the trust and list the trust's investments at the end of the preceding year, and shall certify the date of termination of the trust, if so planned, or certify that the trust does not expire before the following December 31;

(iii) in the case of a single assuming insurer, the trust shall consist of trust **assets not less than** [MONEY REPRESENTING] the assuming insurer's liabilities attributable to **reinsurance ceded by** [BUSINESS WRITTEN IN] the United States **domiciled ceding insurers** and, in addition, include a trust surplus of not less than $20,000,000 **for the benefit of the United States domiciled ceding insurers as additional security for the liabilities covered by the trust**; the single assuming insurer shall make available to the director an annual certification of the insurer's solvency by an independent certified public accountant or an accountant holding a substantially equivalent designation as determined by the director;

(iv) in the case of a group, including incorporated and individual unincorporated insurers, the trust shall consist of trust **assets** [MONEY] representing the group's liabilities attributable to business ceded by [THE] United States domiciled ceding insurers and, in addition, include a trust surplus not less than $100,000,000 held jointly for the benefit of the United States domiciled ceding insurers **of** [OR]

any member of the group for all years of account **as additional security for the group's liabilities covered by the trust**; the incorporated members of the group may not be engaged in any business other than underwriting as a member of the group and are subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall make available to the director an annual certification of the solvency of each insurer by the group's domiciliary regulator or, if the certification is unavailable, financial statements, prepared by an independent certified public accountant, or an accountant holding a substantially equivalent designation as determined by the director, for each underwriter member of the group;

(v) in the case of a group of incorporated insurers under common administration that complies with the reporting requirements contained in (ii) of this subparagraph, that has continuously transacted an insurance business outside the United States for at least three years immediately before making application for accreditation, that submits to this state's authority to examine its books and records and bears the expense of the examination, and that has aggregate policyholders' surplus of $10,000,000,000, the trust shall **consist of trust assets** [BE] in an amount **not less than** [EQUAL TO] the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to a member of the group under reinsurance contracts issued in the name of the group, and the group shall maintain a joint trustee surplus, of which $100,000,000 shall be held jointly for the benefit of United States domiciled ceding insurers of a member of the group as additional security for the group's liabilities **covered by the trust**, and, within 90 days after its financial statements are due to be filed with the group's domiciliary regulator, each member of the group shall make available to the director an annual certification of the underwriter

member's solvency by the member's domiciliary regulator and financial statement of each underwriter member prepared by its independent certified public accountant, or an accountant holding a substantially equivalent designation as determined by the director; and

(B) reports annually to the director information substantially the same as that required to be reported on the National Association of Insurance Commissioners' annual statement form by licensed insurers to enable the director to determine the sufficiency of the trust fund;

(5) assuming insurer that does not meet the requirements of (1) - (4) of this subsection, but only with respect to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

*** Sec. 28.** AS 21.12.050(b) is amended to read:

(b) Health care insurance means that part of health insurance that provides**, delivers, arranges for, pays for, or reimburses any of the costs of** [BENEFITS FOR] medical care [WHETHER PROVIDED DIRECTLY, THROUGH REIMBURSEMENT, OR OTHER METHOD].

*** Sec. 29.** AS 21.14.200(4) is amended to read:

(4) "company action level event" means a report, an adjusted report that has not been challenged, or an adjusted report for which a challenge has been rejected [,] that is filed under AS 21.14.010 and that indicates that

(A) an insurer's total adjusted capital is greater than or equal to its regulatory action level risk based capital but is less than its company action level risk based capital; [OR]

(B) if a life and health insurer, the insurer has total adjusted capital that is greater than or equal to the insurer's company action level risk based capital but is less than 250 percent of the insurer's authorized control level risk based capital and that has a negative trend; **or**

(C) if a property and casualty insurer or health organization, the insurer or organization has total adjusted capital that is greater than or equal to the company action level risk based capital but is less than 300 percent of its authorized control level risk based capital and

that has a negative trend;

*** Sec. 30.** AS 21.14.200(9) is amended to read:

(9) "life and health insurer"

(A) means an insurer who transacts life insurance as defined in AS 21.12.040 or health insurance as defined in AS 21.12.050 **and who filed with the director the National Association of Insurance Commissioners Life Risk-Based Capital Report**;

(B) does not include a benevolent association under AS 21.72, a fraternal benefit society under AS 21.84, a health maintenance organization under AS 21.86, or a hospital or medical service corporation under AS 21.87;

*** Sec. 31.** AS 21.14.200(12) is amended to read:

(12) "negative trend" for a life and health insurer**, a property and casualty insurer, and a health organization** means a negative trend over a period of time, as determined by the "trend test calculation" in the risk based capital instructions;

*** Sec. 32.** AS 21.14.200(13) is amended to read:

(13) "property and casualty insurer" means an insurer who transacts health insurance as defined in AS 21.12.050, property insurance as defined in AS 21.12.060, casualty insurance as defined in AS 21.12.070, surety insurance as defined in AS 21.12.080, marine or wet marine and transportation insurance as defined in AS 21.12.090, or mortgage guaranty insurance as defined in AS 21.12.110 **and who filed with the director the National Association of Insurance Commissioners Property and Casualty Risk-Based Capital Report**;

*** Sec. 33.** AS 21.14.200 is amended by adding a new paragraph to read:

(21) "health organization" means a health maintenance organization, limited health service organization, dental or vision plan, hospital, medical and dental indemnity or service corporation, or other managed care organization holding a certificate of authority under AS 21.86 or AS 21.87, or a company that writes primarily health insurance as defined in AS 21.12.050 and filed with the director the National Association of Insurance Commissioners Health Risk-Based Capital Report.

*** Sec. 34.** AS 21.22.060(k) is amended to read:

(k) An insurer subject to registration under (a) of this section shall register annually by **May 1** [APRIL 1] of each year for the previous calendar year unless, for good cause shown, the director extends the time for registration. The director may require an insurer that is allowed to register as provided under (c) of this section [,] to furnish a copy of

(1) the registration statement;

(2) the summary specified in (*l*) of this section; or

(3) other information filed by the insurer with the insurance regulatory authority of the insurer's state of domicile.

*** Sec. 35.** AS 21.27.020(b) is amended to read:

(b) To qualify for issuance or renewal of an individual [OR INDIVIDUAL IN THE FIRM] license, an applicant or licensee shall comply with this title and regulations adopted under AS 21.06.090 and

(1) shall be 18 years of age or older;

(2) if for a resident license, shall be a bona fide resident before issuance of the license and actually reside in the state;

(3) shall successfully pass an examination required under AS 21.27.060;

(4) shall be a trustworthy person;

(5) may not use or intend to use the license for the purpose principally of writing controlled business, as defined in AS 21.27.030;

(6) may not have committed an act that is a cause for denial, nonrenewal, suspension, or revocation of a license in this state or another jurisdiction.

*** Sec. 36.** 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) designate one or more compliance officers for the firm;

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

(5) 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. 37.** AS 21.27.025 is repealed and reenacted to read:

Sec. 21.27.025. Required notice of licensee. (a) A licensee shall notify the director in writing within 30 days after a change in residence, place of business, legal name, fictitious name or alias, mailing address, electronic mailing address, or telephone number. A licensee shall report to the director in writing any administrative action taken against the licensee by a governmental agency of another state or by a governmental agency of another jurisdiction within 30 days after the final disposition of the action. A licensee shall submit to the director the final order and other relevant legal documents in the action. A licensee shall report to the director any criminal prosecution of the licensee in this or another state or jurisdiction within 30 days after the date of filing of the criminal complaint, indictment, information, or citation in the prosecution. The licensee shall submit to the director a copy of the criminal complaint, calendaring order, and other relevant legal documents in the prosecution.

(b) In addition to any other penalty provided by law, a failure to notify the director as required by this section is cause for denial, nonrenewal, suspension, or revocation of a license.

*** Sec. 38.** AS 21.27.040(e) is amended to read:

(e) As part of the application required by (a) of this section, **a resident** [AN] applicant shall furnish to the director a full set of fingerprints and the fees required by the Department of Public Safety under AS 12.62.160 for criminal justice information and a national criminal history record check so that the director may obtain criminal justice information as provided under AS 12.62 about the applicant. The director shall submit the completed fingerprint card and fees to the Department of Public Safety for a report of criminal justice information under AS 12.62 and a national criminal history record check under AS 12.62.400.

*** Sec. 39.** AS 21.27.100(c) is amended to read:

(c) An individual **who has entered into an employment contract with a licensed** [IN A FIRM WHO ACTS SOLELY ON BEHALF OF A] firm that is appointed as an agent or a managing general agent on behalf of an admitted insurer under this section may not be required to also have an appointment under this section if the individual **has entered into an employment contract** [IN THE FIRM IS LICENSED] with that firm for a specific class of authority.

*** Sec. 40.** AS 21.27.140(b) is amended 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 **by the firm** as an insurance producer, managing general agent, surplus lines broker, trainee independent adjuster, or independent adjuster [BY THE FIRM] is licensed **and has entered into an employment contract with the firm** [AS AN INDIVIDUAL IN THE FIRM].

*** Sec. 41.** AS 21.27 is amended by adding a new section to read:

Sec. 21.27.215. Employment contracts. (a) A firm may enter into an employment contract with a licensed individual to conduct business under the supervision of and in the name of the firm. The employment contract must be in writing and must specify the lines and classes of authorities of the individual and the firm. The individual and the firm shall retain a copy of the contract and shall reply in writing within three working days to an inquiry of the director regarding any business transacted by the individual and the firm.

(b) The firm shall examine the credentials of the individual to determine that the individual is licensed to conduct the kinds of business described in the contract.

(c) A licensed individual may, if authorized by the firm and an insurer for which the firm is an agent, issue on the firm's behalf contracts of insurance in accordance with a written agency employment contract.

(d) A firm shall be responsible for the actions of an individual transacting insurance under the firm's employment contracts. In any disciplinary proceeding under this title, the existence of the employment contract shall be prima facie evidence that

the firm knew of the activities of the individual.

(e) The individual and the firm shall maintain a current list of all of their respective contracts that identifies, for each contract, the parties to the contract, the parties' mailing addresses, electronic mailing addresses, and telephone numbers, and the parties' license numbers, and the effective and termination dates of employment.

(f) A licensee shall retain the records of an employment contract and make the records available for examination and inspection by the director, at any business time during the five years immediately following the date of the termination of the employment contract unless the director orders a longer period of retention. If the licensee assumes the business of another licensee or former licensee by merger, purchase, or otherwise, the requirements of AS 21.27.350(c) apply.

*** Sec. 42.** AS 21.27.350(e) is amended to read:

(e) A licensee shall reply in writing within 10 working days to a records inquiry of the director. The director may inspect or request summary or detailed copies of records for examination by the division. Accounting and financial records inspected or examined under this section are confidential when in the possession of the division, but may be used by the director in a proceeding against the licensee. For purposes of this section, the records of a firm shall include and be considered the records of an individual licensee **who has entered into an employment contract with the firm** [ACTING ON BEHALF OF THE FIRM].

*** Sec. 43.** AS 21.27.360(f) is amended to read:

(f) This section does not apply to an individual **licensee who has entered into an employment contract with a** [IN THE] firm **and** who acts solely on behalf of a firm that maintains compliance with this section.

*** Sec. 44.** AS 21.27.790 is amended to read:

Sec. 21.27.790. Surplus lines broker qualifications. In addition to the general qualifications under AS 21.27.020, to qualify for issuance or for renewal of a **resident** surplus lines broker license, an applicant or licensee shall

(1) be licensed as either an insurance producer or managing general agent for property and casualty lines of authority;

(2) if required by the director by regulation, maintain a bond as

described in AS 21.27.190 in an amount acceptable to the director that requires the surplus lines broker to conduct business under this title, promptly remit the taxes and fees required by law, return premiums promptly when due, and pay proper losses promptly;

(3) if the director requires, maintain an errors and omissions insurance policy acceptable to the director.

*** Sec. 45.** AS 21.27.900(22) is amended to read:

(22) "resident" means

(A) for an individual [OR AN INDIVIDUAL IN THE FIRM], a natural person who is domiciled in this state, whose principal place of business is in this state, who has a present intent to remain in this state while licensed, and who manifests that intent by establishing an ongoing physical presence in this state;

(B) for a firm, a person whose principal place of business is in this state;

*** Sec. 46.** AS 21.33.055(a) is repealed and reenacted 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 procured, continued, or renewed, a premium-receipts tax of 3.7 percent of gross premiums written 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 if the insured's home state is this state. If the insurance covers properties, risks, or exposures located or to be performed both in and out of this state, the tax payable shall be computed based on an amount equal to that portion of the gross premiums allocated under (b) of this section to this state, plus an amount equal to the portion of the premiums allocated under (b) of this section to other properties, risks, or exposures located or to be performed outside of 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 tax paid by the insurer under this section is in lieu of all insurer taxes and fire department dues. In this subsection, "premium" includes all premiums, membership fees, assessments, dues, and any other consideration for insurance.

*** Sec. 47.** AS 21.33.055 is amended by adding a new subsection to read:

(d) On default of a nonadmitted insurer in the payment of the tax, the insured shall pay the tax within 30 days after 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. 48.** AS 21.33.061(c) is repealed and reenacted to read:

(c) If the insured's home state is this state, the insured shall pay to the director, on or before March 1 following the calendar year in which the insurance was procured, continued, or renewed, a tax of 3.7 percent of the gross premiums paid for the insurance other than wet marine and transportation insurance, less any return premiums. For wet marine and transportation insurance, if the insured's home state is this state, the insured shall pay to the director a tax of three-fourths of one percent of the gross premiums paid for the wet marine and transportation insurance. If the insurance covers properties, risks, or exposures located or to be performed both in and out of this state, the tax payable shall be computed based on an amount equal to 3.7 percent on that portion of the gross premiums allocated under (d) of this section to this state, plus an amount equal to the portion of the premiums allocated under (d) of this section to other properties, risks, or exposures located or to be performed outside of

this state. In the event of cancellation and rewriting of the insurance contract, the additional premium for tax purposes is the premium in excess of the unearned premium of the cancelled insurance contract. In this subsection, "premium" includes all premiums, membership fees, assessments, dues, and any other consideration for insurance.

*** Sec. 49.** AS 21.33.061 is amended by adding a new subsection to read:

(j) If the tax payable under (c) of 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. 50.** AS 21.33 is amended by adding a new section to read:

Sec. 21.33.063. Agreements with other states. The director is authorized to participate in an agreement with another state for the purposes of collecting and disbursing to the other state any premium tax collected under this chapter and payable to the other state and for receiving from the other state premium tax it has collected and is owed to this state. To the extent that another state where a portion of the properties, risks, or exposures reside has failed to enter into an agreement with this state, the director shall retain all of the net premium tax collected by this state.

*** Sec. 51.** AS 21.34.020(b) is repealed and reenacted to read:

(b) If a policyholder meets the standards of an exempt commercial purchaser under this title and regulations adopted by the director, insurance may be procured from a surplus lines broker without complying with (a)(2), (3), and (4) of this section if

(1) the broker procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that the insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

(2) the exempt commercial purchaser has subsequently requested in writing that the broker procure or place the insurance from a nonadmitted insurer.

*** Sec. 52.** AS 21.34.040(c) is amended to read:

(c) A nonadmitted insurer may be eligible to provide coverage in this state if it qualifies under one of the following:

(1) a foreign but nonalien stock insurer may qualify under this subsection if it has the minimum unimpaired basic capital and additional surplus equal to that required in its domiciliary jurisdiction, or maintains [$10,000,000 AS OF DECEMBER 31, 1991, $12,500,000 AS OF DECEMBER 31, 1992, AND] $15,000,000 [AS OF DECEMBER 31, 1993], whichever is greater;

(2) a foreign but nonalien mutual insurer, a reciprocal insurer, or a mutual protection and indemnity association may qualify under this subsection if it has the minimum unimpaired basic surplus and additional surplus equal to that required in its domiciliary jurisdiction or maintains [$10,000,000 AS OF DECEMBER 31, 1991, $12,500,000 AS OF DECEMBER 31, 1992, AND] $15,000,000 [AS OF DECEMBER 31, 1993], whichever is greater;

(3) an alien insurer other than an alien mutual protection and indemnity association may qualify under this subsection if it meets the minimum requirements in (1) or (2) of this subsection and maintains in the United States an irrevocable trust fund in an amount not less than $2,500,000 in a solvent federally insured bank acceptable to the director, as security to the full amount, for the protection of all its policyholders and creditors of each member of the mutual insurer, reciprocal insurer, or mutual protection and indemnity association in the United States; 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;

(4) a Lloyd's syndicate or an insurer belonging to a similar group, including incorporated and individual unincorporated insurers, 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 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;

(5) each syndicate or insurer belonging to an insurance exchange created by the laws of individual states may qualify if the insurance exchange 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;

(6) an alien mutual protection and indemnity association may qualify under this subsection if it has the minimum unimpaired basic capital and additional surplus equal to that required in its domiciliary jurisdiction or $10,000,000, whichever is greater, and maintains in the United States an irrevocable trust fund in an amount not less than $1,000,000 in a federally insured bank acceptable to the director, as security to the full amount, for the protection of all its policyholders and creditors or each member of the mutual protection and indemnity association in the United States; 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 wet marine and transportation 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**;**

(7) an insurer not domiciled in the United States or its territories qualifies under this subsection if it is listed on the Quarterly Listing of Alien Insurers maintained by the National Association of Insurance Commissioners International Insurers Department.

*** Sec. 53.** AS 21.34.040 is amended by adding new subsections to read:

(f) If an insurer has less than the minimum capital and surplus required in (c) of this section, the insurer may satisfy the requirements of this section upon an affirmative finding of acceptability by the director. The director's finding must be based on factors including quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability, and company record and reputation within the industry. The director may not make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than $4,500,000.

(g) The director may participate in interstate agreements formed for the purpose of developing additional and alternative nationwide uniform eligibility requirements that are applicable to nonadmitted insurers domiciled in another state or territory of the United States.

*** Sec. 54.** AS 21.34.080(a) is amended to read:

(a) A surplus lines broker shall execute and file with the [MONTHLY] report required by AS 21.34.170 a written report, which shall be kept confidential, regarding each surplus lines insurance transaction occurring in the preceding **period** [CALENDAR MONTH]. The report must include

(1) the name and address of the insured;

(2) the identity of each insurer including the National Association of Insurance Commissioners company number and the percentage of coverage provided by each;

(3) a complete description of the subject and location of the risk;

(4) the amount of gross premium written for the insurance; and

(5) other information required by the director.

*** Sec. 55.** AS 21.34.170(a) is amended to read:

(a) A surplus lines broker shall file with the director [ON OR BEFORE THE

END OF EACH MONTH], on forms prescribed by the director, a report of all surplus lines insurance, by type of insurance as required to be reported in the annual statement that must be filed with the director by admitted insurers. The report must include all surplus lines insurance transactions during the preceding **period** [CALENDAR MONTH] showing the aggregate gross premiums written, the aggregate return premiums, the amount of aggregate tax remitted to this state, and the amount of aggregate tax remitted to each other state for which an allocation is made under AS 21.34.180. **The forms shall be filed quarterly on March 1, June 1, September 1, and December 1 of each year.**

*** Sec. 56.** AS 21.34.180 is repealed and reenacted to read:

Sec. 21.34.180. Surplus lines tax. (a) In addition to collecting the full amount of gross premiums written by an insurer for surplus lines insurance, the surplus lines broker shall collect and pay to the director a tax of 2.7 percent on the net premium, which is the total gross premiums written, less any return premiums, for the insurance. Where the insurance covers properties, risks, or exposures located or to be performed both in and out of this state, the tax payable shall be computed based on an amount equal to 2.7 percent on that portion of the net premiums allocated under (f) of this section to this state, plus an amount equal to the portion of the premiums allocated under (f) of this section to other states or territories based on the tax rates and fees applicable to other properties, risks, or exposures located or to be performed outside of this state.

(b) The surplus lines broker may not absorb the tax or any part of it and may not rebate, for any reason, any part of the tax.

(c) 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.

(d) The director may participate in an agreement with another state formed for the purpose of collecting and disbursing to a remitting state any funds collected under (a) of this section applicable to other properties, risks, or exposures located or to be performed outside of this state. To the extent that another state where a portion of the

properties, risks, or exposures resides has failed to enter into an agreement with this state, the director shall retain all of the net premium tax collected by this state.

(e) At the time of filing the quarterly report as set out in AS 21.34.170, each surplus lines broker shall pay the premium tax due for transactions occurring during the period covered by the report. The tax must be paid by electronic or other means as specified by the director.

(f) In determining the amount of premiums taxable in this state, all premiums written, procured, or received in this state shall be considered written on properties, risks, or exposures located or to be performed in this state except premiums that are properly allocated or apportioned and reported as taxable premiums of a remitting state. Allocation of the amount of premiums taxable for surplus lines insurance covering properties, risks, or exposures only partially located or to be performed in this state shall be determined by reference to an allocation schedule established by regulation adopted by the director subject to the following:

(1) if a policy covers more than one classification, the following apply:

(A) for any portion of the coverage identified by a classification on the allocation schedule, the tax shall be computed by using the allocation schedule for the corresponding portion of the premium;

(B) for any portion of the coverage not identified by a classification on the allocation schedule, the tax shall be computed by using an alternative equitable method of allocation for the property or risk;

(C) for any portion of the coverage where the premium is indivisible, the tax shall be computed by using the method of allocation that pertains to the classification describing the predominant coverage;

(2) if the information provided by the surplus lines broker is insufficient to substantiate the method of allocation used by the surplus lines broker, or if the director determines that the broker's method is incorrect, the director shall determine the equitable and appropriate amount of tax due to this state as follows:

(A) by use of the allocation schedule if the risk is appropriately identified in the schedule;

(B) if the allocation schedule does not identify a classification

appropriate to the coverage, the director may give significant weight to documented evidence of the underwriting bases and other rating criteria used by the insurer; the director may also consider other available information to the extent sufficient and relevant, including the percentage of the insured's physical assets in this state, the percentage of the insured's sales in this state, the percentage of income or resources derived from this state, and the amount of premium tax paid to another jurisdiction for the policy.

(g) If the amount of tax due under (a) of this section is less than $50 in any jurisdiction, the tax must be paid in the jurisdiction in which the reports and summary of exported business are filed.

(h) The director shall, at least annually, furnish to the commissioner of a remitting state a copy of all filings reporting an allocation of taxes required by this section.

(i) This section does not apply to insurance of risks of state government or its political subdivisions, to an agency of state government or its political subdivisions, or to insurance of aircraft primarily engaged in interstate or foreign commerce.

(j) A surplus lines broker shall pay to the division a late payment fee of $50 a month plus five percent of the tax due each calendar month or part of a month during which the broker fails to pay the full amount of the tax or a portion of the tax and interest at the rate of one percent of the tax due each calendar month or part of a month for the period the broker fails to pay the tax. The late payment fee, not including interest, may not exceed $250 plus 25 percent of the tax due. The tax payment shall be made in the form required by the director, or a penalty shall be added to the tax equal to 25 percent of the tax due, not to exceed $2,000, with a minimum penalty of $100. In addition to any other penalty provided by law, if the provisions of this section are wilfully violated, a civil penalty may be assessed of not more than $10,000. The director may suspend or revoke the license of a broker that fails to pay its taxes, a penalty, or a late payment fee required under this section.

*** Sec. 57.** AS 21.34.190(a) is amended to read:

(a) The fee for filing the statement under **AS 21.34.180(e)** [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. The surplus lines broker shall pay the fee at the time of filing of the statement.

*** Sec. 58.** AS 21.34.900 is amended by adding new paragraphs to read:

(10) "affiliate" or "affiliated" means, with respect to an insured, any entity that controls, is controlled by, or is under common control with the insured;

(11) "affiliated group" means any group of entities that are all affiliated;

(12) "control" means for purposes of an entity having "control" over another entity

(A) the entity directly or indirectly or acting through 1 or more other persons owns, controls, or has the power to vote 25 percent or more of any class of voting securities of the other entity; or

(B) the entity controls in any manner the election of a majority of the directors or trustees of the other entity;

(13) "exempt commercial purchaser" has the meaning given under 15 U.S.C. 8206 (Nonadmitted and Reinsurance Reform Act of 2010);

(14) "home state" means, for purposes of determining the home state of an insured in a multistate placement of nonadmitted insurance,

(A) except as provided in (B) of this paragraph, "home state" means, with respect to an insured:

(i) the state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

(ii) if 100 percent of the insured risk is located out of the state referred to in (i) of this subparagraph, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated;

(B) if two or more insureds from an affiliated group are named insureds on a single policy, "home state" under (A) of this paragraph is based on the member of the affiliated group that has the largest percentage of premium attributed to it under the insurance contract;

(C) for purposes of (A) of this paragraph, the principal place of business of an insured is the state where the insured maintains its headquarters and where the insured's high-level officers direct control and coordinate the business activities of the insured;

(15) "remitting state" means a state that has entered into an agreement with this state for remitting to this state any premium tax collected by the other state on premiums allocated to properties, risks, or exposures located in this state.

*** Sec. 59.** AS 21.36 is amended by adding a new section to read:

Sec. 21.36.225. Notice of health insurance coverage cancellation, coverage change, or premium change. (a) Except for a health care insurance policy subject to AS 21.51.400 or AS 21.54.130, an insurer may not cancel a health insurance policy unless the insurer provides written notice to a covered individual at least 45 days before the effective date of the cancellation.

(b) An insurer shall provide written notice to a covered individual of changes in coverage or premium at least 45 days before the effective date of the change in coverage or premium.

*** Sec. 60.** AS 21.36.360(q) is amended to read:

(q) A fraudulent or criminal insurance act described in

(1) (b) of this section that is committed to obtain $10,000 or more is a class B felony;

(2) **(c), (d), or (p)(4)** [(c) OR (d)] of this section is a class B felony;

(3) (b) of this section that is committed to obtain $500 or more but less than $10,000 is a class C felony;

(4) (e), (f), (g), or (h), of this section is a class C felony;

(5) (b) of this section that is committed to obtain less than $500 is a class A misdemeanor;

(6) (i), (j), (k), (*l*), (m), or (n) of this section is a class A misdemeanor;

(7) (o) of this section is a class B misdemeanor;

(8) (p)(1) of this section is a class B misdemeanor unless another specific penalty is provided for the violation of the provision; and

(9) **(p)(2) and (3)** [(p)(2) - (4)] of this section may be prosecuted under

AS 11.46.

*** Sec. 61.** AS 21.45.020 is amended by adding new subsections to read:

(c) A life insurance policy or annuity contract delivered or issued for delivery in this state and each life insurance policy or annuity contract application must contain a notice prominently printed on or attached to the first page stating

(1) on written request, an insurer is required to provide, within a reasonable time, reasonable factual information regarding the benefits and provisions of the policy or contract to the policy or contract holder; and

(2) if, for any reason, the policy or contract holder is not satisfied with the policy or contract, the policy or contract holder may return the policy or contract within 10 days after the policy or contract is delivered and, except as provided in (d) of this section, receive a refund of all money paid.

(d) For a variable life insurance policy or variable annuity contract, the refund under (c) of this section must equal the difference between the premiums paid, including any policy or contract fees or other charges, and the amounts allocated to any separate accounts under the policy or contract on the date the returned policy is received by the insurer or its insurance producer.

*** Sec. 62.** AS 21.51.405 is amended by adding new subsections to read:

(b) An insurer shall file with the director the premium rates charged for an individual health care insurance plan before using them. A premium rate or premium rate change must be on file with the director for a waiting period of at least 45 days before the effective date of the premium rate. That period may be extended by the director or the insurer for an additional 15 days if, during the initial 30-day waiting period, notice is given stating that additional time for consideration of the filing is needed. A filing becomes effective at the end of the waiting period unless disapproved by the director during the waiting period. If an insurer fails to provide information requested by the director during the waiting period, the filing is considered withdrawn by the insurer, and the premium rate does not become effective.

(c) The director shall adopt regulations

(1) establishing procedures for filing and use of rates; and

(2) specifying information that must be submitted in a filing required

under (b) of this section.

*** Sec. 63.** AS 21.53.020 is amended to read:

Sec. 21.53.020. Disclosure and performance standards. An insurer, hospital or medical service corporation, or [A] fraternal benefit society that delivers or issues for delivery a long-term care insurance policy may not

(1) cancel, fail to renew, or otherwise terminate the policy on the grounds of age or deterioration of the mental or physical health of the insured [OR CERTIFICATE HOLDER];

(2) include a provision requiring a new waiting period in the event existing coverage is converted to or replaced by a new or another form of health insurance within the same company, unless there is an increase in benefits voluntarily selected by the insured **or group policyholder**; or

(3) provide coverage only for skilled nursing care [,] or provide significantly more coverage for skilled care in a facility than is provided for coverage for lower levels of care [; EVALUATION OF THE COVERAGE PROVIDED UNDER THIS PARAGRAPH MUST BE BASED ON THE NUMBER OF DAYS OF COVERAGE PROVIDED FOR LOWER LEVELS OF CARE, WHEN COMPARED TO THE NUMBER OF DAYS OF COVERAGE PROVIDED FOR SKILLED CARE].

*** Sec. 64.** AS 21.53.030(a) is amended to read:

(a) An insurer, hospital or medical service corporation, or [A] fraternal benefit society may not include, in a long-term care insurance policy or certificate, a definition of "preexisting condition" that is more restrictive than the following: preexisting condition means [THE EXISTENCE OF SYMPTOMS THAT WOULD CAUSE AN ORDINARILY PRUDENT PERSON TO SEEK DIAGNOSIS, CARE, OR TREATMENT, OR] a condition for which medical advice or treatment was recommended by, or received from**,** a provider of health care services [,] within six months preceding the effective date of coverage of an insured person.

*** Sec. 65.** AS 21.53.030(b) is amended to read:

(b) In a long-term care insurance policy**,** [OR CERTIFICATE] an insurer, hospital or medical service corporation, or [A] fraternal benefit society may not

exclude coverage for a loss or confinement that is the result of a preexisting condition, unless the loss or confinement begins within six months following the effective date of coverage of an insured person.

*** Sec. 66.** AS 21.53.030(d) is amended to read:

(d) This section does not prohibit an insurer, hospital or medical service corporation, or [A] fraternal benefit society from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on the application, from applying that insurer's, hospital or medical service corporation's, or fraternal benefit society's established underwriting standards. Unless otherwise provided in the policy [OR CERTIFICATE], a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in (b) of this section expires. A long-term care insurance policy [OR CERTIFICATE] may not exclude, limit, or reduce, or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions after the waiting period described in (b) of this section, unless the waiver or rider has been specifically approved by the director.

*** Sec. 67.** AS 21.53.040 is amended to read:

Sec. 21.53.040. Prior hospital or institutional care conditions prohibited. (a) A long-term care insurance policy may not be delivered or issued for delivery in this state if the policy conditions eligibility

(1) on a prior hospitalization requirement;

(2) on the receipt of a higher level of institutional care, when care is provided in an institutional setting;

(3) for noninstitutional benefits on a prior institutional stay of more than 30 days for which benefits are paid; [OR]

(4) on admission to an institutional care facility for the same or a related condition within a period of less than 30 days after discharge from the institution, if the policy provides benefits only following institutionalization**; or**

(5) for a benefit, other than a waiver of premium, postconfinement, postacute care, or recuperative benefit, on a prior

institutionalization.

(b) A long-term care insurance policy **containing a postconfinement, postacute care, or recuperative benefit must clearly label the limitations or conditions, including any required number of days of confinement, "Limitations or Conditions on Eligibility for Benefits"** [MAY CONTAIN A LIMITATION OR CONDITION ON ELIGIBILITY FOR BENEFITS, NOT PROHIBITED IN (a) OF THIS SECTION, IF THE LIMITATION OR CONDITION IS CLEARLY SET OUT] in a separate paragraph of the policy [OR CERTIFICATE].

*** Sec. 68.** AS 21.53.050(a) is amended to read:

(a) A long-term care insurance applicant may return a policy within 30 days after delivery and have the premium refunded if, after examination of the policy, the applicant is not satisfied with the policy. A long-term care insurance policy must have a notice prominently printed on the first page of the policy or separately attached stating that the applicant has the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the applicant is not satisfied with the policy **for any reason. This subsection also applies to application denials, and any refund must be made within 30 days after return or denial**.

*** Sec. 69.** AS 21.53.050(b) is amended to read:

(b) An insurer, hospital or medical service corporation, or [A] fraternal benefit society shall deliver an outline of coverage to a prospective applicant for long-term care insurance at the time of initial solicitation by a means that prominently directs the attention of the recipient to the document and its purpose. In the case of agent solicitations, an agent shall deliver the outline of coverage before the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with an application or enrollment form. The outline of coverage must include

(1) a description of the principal benefits and coverage provided in the policy;

(2) a statement of the principal exclusions, reductions, and limitations contained in the policy;

(3) a statement of the terms under which the policy [OR CERTIFICATE, OR BOTH,] may be continued in force or discontinued, including a reservation in the policy of a right to change the premium; continuation or conversion provisions of group coverage must be specifically described;

(4) a statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(5) a description of the terms under which the policy [OR CERTIFICATE] may be returned and premium refunded; [AND]

(6) a brief description of the relationship between the cost of care and benefits**; and**

(7) a statement that discloses to the policyholder whether the policy is intended to be a federal qualified long-term care insurance contract under 26 U.S.C. 7702B(b) (Internal Revenue Code).

*** Sec. 70.** AS 21.53.050 is amended by adding new subsections to read:

(d) For a policy issued to a group defined in AS 21.53.200(3)(A), an insurer, hospital or medical service corporation, or fraternal benefit society is not required to provide an outline of coverage if the information required on the outline of coverage under (b) of this section is contained in other enrollment materials. An insurer, hospital or medical service corporation, and fraternal benefit society shall provide the enrollment materials to the director on request.

(e) If an application for a long-term care insurance policy is approved, the insurer shall deliver the policy to the applicant not later than 30 days after the date of approval.

*** Sec. 71.** AS 21.53.060(a) is amended to read:

(a) In addition to the requirements of AS 21.45, at the time of policy delivery, a policy summary shall be included with an individual life insurance policy if the policy or policy rider provides long-term care benefits. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request [,] but**,** regardless of request**,** shall deliver a policy summary not later than the time of policy delivery. The summary must include

(1) an explanation of how the long-term care benefits interact with other components of the policy, including deductions from death benefits;

(2) an illustration of the amount and length of benefits, and guaranteed lifetime benefits, if any, for each covered person;

(3) an explanation of each exclusion, reduction, and limitation on long-term care benefits; [AND]

(4) if applicable to the policy type,

(A) disclosure of the effects of exercising other rights under the policy;

(B) disclosure of guarantees related to the long-term care costs of insurance charges; and

(C) current and projected maximum lifetime benefits**; and**

(5) if the director adopts a regulation that permits but does not require inflation protection, and the policy does not provide for inflation protection, a statement that inflation protection is not available under the policy.

*** Sec. 72.** AS 21.53.060 is amended by adding a new subsection to read:

(c) If a claim under a long-term care insurance policy is denied by an insurer, the insurer shall, within 60 days after the date of a written request by a policyholder or a representative of a policyholder,

(1) provide a written explanation of the reasons for the denial; and

(2) make available all information directly related to the denial.

*** Sec. 73.** AS 21.53 is amended by adding new sections to read:

Sec. 21.53.062. Incontestability period. (a) If a long-term care insurance policy has been in force for less than six months, an insurer may rescind the policy or deny an otherwise valid long-term care claim under the policy on a showing of misrepresentation that is material to the acceptance for coverage.

(b) If a long-term care insurance policy has been in force for at least six months but less than two years, an insurer may rescind the policy or deny an otherwise valid long-term care claim under the policy on a showing of misrepresentation that is both material to the acceptance for coverage and pertains to the condition for which benefits are sought.

(c) If a long-term care insurance policy has been in force for two years or more, the policy is not contestable on the grounds of misrepresentation alone and may only be contested on a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(d) If an insurer has paid benefits under a long-term care insurance policy, the insurer may not recover the benefit payments if the policy is rescinded.

(e) This section applies to a life insurance policy that accelerates benefits for long-term care. However, if an insured dies, this section does not apply to the remaining death benefit of a life insurance policy that accelerates benefits for long-term care, and the remaining death benefit under the policy is subject to AS 21.45.040.

Sec. 21.53.064. Nonforfeiture benefits. (a) Except as provided in (b) of this section, a long-term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder has been offered the option of purchasing a policy including a nonforfeiture benefit. The insurer may offer a nonforfeiture benefit in the form of a rider to the policy. If a policyholder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that is available for a specified period of time following a substantial increase in premium rates.

(b) With respect to group long-term care insurance, an insurer shall make the offer required in (a) of this section to the group policyholder. For a policy issued as group long-term care insurance, other than a continuing care retirement community or other similar entity, the insurer shall make the offer required in (a) of this section to each proposed certificate holder.

Sec. 21.53.066. Producer training requirements. (a) A person may not sell, solicit, or negotiate long-term care insurance unless the person is licensed as an insurance producer for health or life insurance lines of authority and has completed a one-time training course that meets the requirements in (d) of this section.

(b) A person currently licensed and selling, soliciting, or negotiating long-term care insurance may not continue to sell, solicit, or negotiate long-term care insurance unless the person has completed a one-time training course that meets the requirements in (d) of this section.

(c) A person who sells, solicits, or negotiates long-term care insurance shall

complete ongoing training that meets the requirements in (e) of this section.

(d) The one-time training course required under this section

(1) must be at least eight credit hours;

(2) may not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by state or federal law;

(3) must consist of topics related to long-term care insurance, long-term care services, and, if applicable, qualified long-term care insurance partnership programs, including

(A) state and federal requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services;

(B) available long-term care services and providers;

(C) changes or improvements in long-term care services or providers;

(D) alternatives to the purchase of private long-term care insurance;

(E) the effect of inflation on benefits and the importance of inflation protections; and

(F) consumer suitability standards and guidelines.

(e) The ongoing training course required under (c) of this section must be at least four credit hours every 24 months and must comply with the requirements in (d)(2) and (3) of this section.

(f) The director may approve the training requirements in (d) and (e) of this section as continuing education courses under AS 21.27.020.

(g) An insurer shall

(1) obtain verification that a producer received the training required under this section before a producer is permitted to sell, solicit, or negotiate the insurer's long-term care insurance products;

(2) maintain records of required training subject to the state's record retention requirements;

(3) make the verification required under (1) of this subsection available to the director on request.

(h) An insurer shall maintain

(1) records with respect to the training of its producers concerning the distribution of its partnership policies that allows the director to provide assurance to the medical assistance program under AS 47.07 that producers have received the training described in (d)(3) of this section and that producers have demonstrated an understanding of the partnership policies and their relationship to public and private coverage of long-term care in this state; and

(2) the records described under (1) of this subsection in accordance with the record requirements under AS 21.09.320 and shall make the records available to the director on request.

Sec. 21.53.068. Limitations related to producers and third-party administrators. An insurer that authorizes issuance of a long-term care insurance policy by a producer or a third-party administrator under the underwriting authority of the insurer granted to the producer or a third-party administrator using the insurer's underwriting guidelines may issue a long-term care insurance policy through the producer or a third-party administrator only if the insurer compensates the issuer based on the number of policies issued.

*** Sec. 74.** 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) terms of renewability;

(B) initial and subsequent conditions of eligibility;

(C) nonduplication of coverage provisions;

(D) coverage of dependents;

(E) benefit triggers;

(F) preexisting conditions and recurrent conditions;

(G) termination of insurance**, including incontestability**

periods;

(H) continuation or conversion;

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

(J) requirements for replacement;

(K) producer training, education, compensation, and testing;

(L) marketing practices;

(M) independent review of benefit determinations;

(N) penalties and reporting practices; and

(O) premium rates, including rate filing requirements;

(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**; and**

(5) the standard format and content of the outline of coverage required under AS 21.53.050.

*** Sec. 75.** AS 21.53.200(3) is amended to read:

(3) "group long-term care insurance" means a long-term care insurance policy, subscriber's contract, or fraternal benefit society certificate that is delivered or issued for delivery in this state and issued to

(A) one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination of them, for employees or former employees or a combination of them, or for members or former members or a combination of them, of the labor organization;

(B) a professional, trade, or occupational association for its members or former or retired members, or combination of them, if the association is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation, and has been maintained in good faith for purposes other than obtaining insurance;

(C) an association or a trust or the trustee of a fund established, created, or maintained for the benefit of members of one or more associations **that meets the requirements in AS 21.53.080**;

(D) a group other than described in this paragraph if the director determines that the issuance of the group policy is not contrary to the best interest of the public, would result in economies of acquisition or administration, and the benefits are reasonable in relation to the premiums charged;

*** Sec. 76.** AS 21.53.200(4) is amended to read:

(4) "long-term care insurance"

(A) means an individual or group insurance policy, including group and individual life insurance or annuities, a subscriber's contract, fraternal benefit society certificate, or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services that are provided in a setting other than an acute care unit of a hospital, and includes a policy or rider that provides for payment of benefits based on cognitive impairment or loss of functional capacity;

(B) ["LONG-TERM CARE INSURANCE"] does not include

(i) an insurance policy, subscriber's contract, or fraternal benefit society certificate that is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability insurance and related asset protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage**; or**

(ii) a life insurance policy that accelerates the death benefit specifically for one or more of the qualifying events of

terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement and that provides the option of a lump-sum payment for that benefit if the benefit and the eligibility for the benefit under the life insurance policy are not conditioned on the receipt of long-term care;

*** Sec. 77.** AS 21.54.015 is amended by adding new subsections to read:

(c) Except for large employer health care insurance plan premium rates exempted by the director by regulation under (d) of this section, an insurer shall file with the director the premium rates charged for each health care insurance plan before using them. A premium rate or premium rate change must be on file with the director for a waiting period of at least 45 days before the effective date of the premium rate. That period may be extended by the director or the insurer for an additional 15 days if, during the initial 30-day waiting period, notice is given stating that additional time for consideration of the filing is needed. A filing becomes effective at the end of the waiting period unless disapproved by the director during the waiting period. If an insurer fails to provide information requested by the director during the waiting period, the filing is considered withdrawn by the insurer, and the premium rate does not become effective.

(d) The director shall adopt regulations

(1) establishing procedures for the filing and use of rates; and

(2) specifying information that must be submitted in a filing required under (c) of this section.

*** Sec. 78.** AS 21.54.020(a) is amended to read:

(a) On the written request of a covered person, a health care insurer shall pay amounts due under a health insurance policy directly to the provider of medical care services. A health insurance policy may not contain a provision that requires services be provided by a particular hospital or person, except as applicable to a [MANAGED CARE PLAN UNDER AS 21.07 OR A] health maintenance organization under AS 21.86. If a health care insurer makes a claim payment to the covered person after the covered person has given written notice electing direct payment to the provider of

the service, the health care insurer shall also pay that amount to the provider of the service.

*** Sec. 79.** AS 21.54 is amended by adding a new section to article 2 to read:

Sec. 21.54.180. Individual health care insurance policies offered in the group market. (a) Except as provided in (b) of this section, a person may not sell, solicit, or negotiate an individual health care insurance policy to an employer or employee of an employer, and an insurer may not issue an individual health care insurance policy to an employee of an employer.

(b) Notwithstanding the definition of "group market" in AS 21.54.500, a person may sell, solicit, or negotiate an individual health care insurance policy to an employer or employee of an employer, and an insurer may issue an individual health care insurance policy to an employee of an employer, only if

(1) the employee is not an eligible employee as defined in AS 21.56.250; or

(2) the employer does not offer a health benefit plan and has not offered a health benefit plan in the last six months.

(c) An individual health care insurance policy offered under (b) of this section is health care insurance offered in the individual market and subject to the requirements of AS 21.51. In this subsection, "individual market" means the market for health care insurance that does not include coverage under a health care insurance plan as defined in AS 21.54.500.

*** Sec. 80.** AS 21.54.500(16) is amended to read:

(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;

*** Sec. 81.** AS 21.59.070 is amended to read:

Sec. 21.59.070. Other provisions applicable. In addition to the provisions of this chapter, the following provisions of this title shall apply to automobile 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 stock insurers:

(1) AS 21.03;

(2) AS 21.06;

(3) AS 21.09.050;

(4) AS 21.09.100;

(5) AS 21.09.120 - 21.09.210;

(6) **AS 21.09.245;**

(7) AS 21.09.247;

(8) AS 21.12;

(9) [(7)] AS 21.36;

(10) [(8)] AS 21.69;

(11) [(9)] AS 21.78;

(12) [(10)] AS 21.97.

*** Sec. 82.** AS 21.66.020 is amended by adding new subsections to read:

(b) When a title insurance company holding a certificate of authority under this chapter is found to be insolvent by a proceeding in a court of competent jurisdiction, the director shall take control of deposits made by the title insurance company and held in this state. If the finding of insolvency is from a court in another state, the director shall file for an ancillary receivership under AS 21.78 to administer the deposits and other assets in this state and pay claims in this state. Any funds remaining after payment of all claims under policies in this state shall be forwarded to the receiver.

(c) On request of a title insurance company, the director shall return the assets held on deposit when the company is no longer authorized to write insurance in this state, the director is satisfied that there are no risks in the state covered by contracts of the company, and the assets are no longer required to be held by any provision of law.

(d) In addition to the provisions of this section, the following provisions of this title also apply with respect to deposits under this section to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions:

(1) AS 21.24.040(a), (d), and (e);

(2) AS 21.24.060.

*** Sec. 83.** 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**; and**

(7) basic information, including the joint title plan name, the physical address, the mailing address, the electronic mailing address, and telephone numbers.

*** Sec. 84.** AS 21.69.390(d) is amended to read:

(d) To meet the requirements of (a) of this section, a domestic insurer shall keep at its principal place of business in the state the following records of assets, transactions, and affairs:

(1) a general ledger;

(2) copies of reports prepared to comply with AS 21.09.200 -

21.09.210;

(3) if prepared in the normal course of business, financial statements prepared under generally accepted accounting principles on which a licensed certified public accountant has expressed an opinion;

(4) filings made by a domestic insurer or affiliates of the domestic insurer with a government agency with which a domestic insurer or affiliates of the domestic insurer's securities may be registered;

(5) a state certificate of authority;

(6) filings made under AS 21.21;

(7) original **contract** [POLICY] and claim files for insurance **and other products sold to consumers** [OF PROPERTY OR A RISK RESIDENT OR LOCATED IN THE STATE];

(8) a corporate minutes book;

(9) articles of incorporation;

(10) corporate bylaws;

(11) **administrative management** contracts; and

(12) other records required by the director by regulation.

*** Sec. 85.** AS 21.72.170 is amended to read:

Sec. 21.72.170. Other provisions applicable. In addition to the provisions contained in the chapter, other chapters and provisions of this title shall apply to benevolent associations, to the extent applicable, as follows:

(1) AS 21.03;

(2) AS 21.06;

(3) AS 21.09.010, 21.09.050, 21.09.100**,** and 21.09.130 - 21.09.190;

(4) **AS 21.09.247;**

(5) AS 21.18.010 and 21.18.030;

(6) [(5)] AS 21.36;

(7) [(6)] AS 21.42;

(8) [(7)] AS 21.69.370, 21.69.390, 21.69.400, 21.69.630, and 21.69.640;

(9) [(8)] AS 21.78.

*** Sec. 86.** AS 21.75.060(b) is amended to read:

(b) The proposed attorney-in-fact shall fulfill the requirements of and shall execute and file with the director when applying for a certificate of authority, a declaration setting out

(1) the name of the insurer;

(2) the location of the insurer's principal office, which shall be the same as that of the attorney-in-fact and shall be maintained in this state**, and the mailing address, electronic mailing address, and telephone numbers**;

(3) the kinds of insurance proposed to be transacted;

(4) the names and addresses of the original subscribers;

(5) the designation and appointment of the proposed attorney-in-fact and a copy of the power of attorney;

(6) the names and addresses of the officers and directors of the attorney-in-fact, if a corporation, or its members, if a firm;

(7) the powers of the subscribers' advisory committee, and the names and terms of office of the members;

(8) that all money paid to the reciprocal insurer shall, after deducting any sum payable to the attorney-in-fact, be held in the name of the insurer and for the purposes specified in the subscribers' agreement;

(9) a copy of the subscribers' agreement;

(10) a statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted and that the insurer has received from each subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than six months at an adequate rate filed with and approved by the director;

(11) a statement of the financial condition of the insurer, a schedule of its assets, and a statement that the surplus as required by AS 21.75.050 is on hand;

(12) a copy of each policy, endorsement, and application form it then proposes to issue or use.

*** Sec. 87.** AS 21.79.025(a) is amended to read:

(a) The benefits for which the association may become liable may not exceed

the lesser of

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

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

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

(B) in health insurance benefits,

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

(ii) $300,000 for disability insurance **as defined in AS 21.12.052 and long-term care insurance as defined in AS 21.53.200**;

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

(C) **$250,000** [$100,000] in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(3) with respect to any one contract holder or plan sponsor whose plan owns directly or in trust one or more unallocated annuity contracts not included in (4) of this subsection, $5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts held by that contract holder or plan sponsor except that, in the case of one or more unallocated annuity contracts that are covered under this chapter and that are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be provided by the association if the largest interest in the trust or entity owning the contract is held by a plan sponsor whose principal place of business is in this state; however, the association is not liable to cover more than $5,000,000 in benefits with respect to an unallocated annuity contract not included in (4) of this subsection;

(4) with respect to an individual participating in a governmental retirement benefit plan established under 26 U.S.C. 401, 26 U.S.C. 403(b), or 26 U.S.C. 457 and covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased, in the aggregate, $100,000 in present-value annuity benefits, including net cash surrender and net cash withdrawal values; or

(5) with respect to each payee of a structured settlement annuity, or beneficiary of the payee if the payee is deceased, $100,000 in present-value annuity benefits in the aggregate, including net cash surrender and net cash withdrawal values, if any.

*** Sec. 88.** AS 21.84.335(b) is amended to read:

(b) In addition to the provisions of 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;

(4) AS 21.09.100;

(5) AS 21.09.200;

(6) AS 21.09.205;

(7) **AS 21.09.245;**

(8) AS 21.09.247;

(9) AS 21.18;

(10) [(8)] AS 21.21;

(11) [(9)] AS 21.27;

(12) [(10)] AS 21.33;

(13) [(11)] AS 21.36;

(14) [(12)] AS 21.42.290;

(15) [(13)] AS 21.42.355;

(16) [(14)] AS 21.53;

(17) [(15)] AS 21.54;

(18) [(16)] AS 21.56;

(19) [(17)] AS 21.69.370;

(20) [(18)] AS 21.69.640;

(21) [(19)] AS 21.78; and

(22) [(20)] AS 21.96.060.

*** Sec. 89.** AS 21.85.030(a) is amended to read:

(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 **also** provide

(A) life **or disability** insurance coverage to its participants if the life **or disability** insurance coverage is provided under contracts **with other insurers** that comply with this title; **or**

(B) limited short-term disability insurance coverage, if

approved by the director;

(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.

*** Sec. 90.** AS 21.85.040 is amended to read:

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**; and**

(10) for a foreign multiple employer welfare arrangement,

(A) a certificate of the public official having supervision of insurance in its state or country of domicile or state of entry into the United States, showing that it is authorized to transact the kinds of insurance proposed to be transacted in this state or an affidavit attesting to the reasons why a certificate is not available;

(B) a copy of the arrangement's most recent financial statement filed with its state of domicile, if any, with an actuarial opinion on reported unpaid claims;

(C) a copy of a management discussion and analysis filed with its state of domicile, if any; and

(D) a copy of the report of last examination, if any, made of the insurer, issued by the insurance supervisory official of its state of domicile or state of entry into the United States.

*** Sec. 91.** AS 21.86 is amended by adding a new section to read:

Sec. 21.86.045. Biographical affidavits. A domestic health maintenance organization shall file with the director a complete affidavit of biographical

information not later than 30 days after the appointment of an officer or member of the governing body of the organization. If requested by the director, a foreign health maintenance organization shall file with the director an affidavit of biographical information for the appointment of an officer or member of the governing body of that organization. A filing under this section must be on a form approved by the director. A filing is not required if a biographical affidavit of the officer or director has been submitted to the director within one year before the date of appointment. A biographical affidavit filed under this section is confidential and not subject to public inspection.

*** Sec. 92.** 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 21.07;

(4) AS 21.09, except AS 21.09.090;

(5) AS 21.18.010;

(6) AS 21.18.030;

(7) AS 21.18.040;

(8) AS 21.18.080 - 21.18.086;

(9) AS 21.36;

(10) AS 21.42.110, **21.42.345 - 21.42.395** [AS 21.42.345 - 21.42.395];

(11) AS 21.51.120 and 21.51.400;

(12) **AS 21.51.405;**

(13) AS 21.53;

(14) [(13)] AS 21.54;

(15) [(14)] AS 21.56;

(16) [(15)] AS 21.69.400;

(17) [(16)] AS 21.69.520;

(18) [(17)] AS 21.69.600, 21.69.620, and 21.69.630;

(19) [(18)] AS 21.78;

(20) [(19)] AS 21.96.060;

(21) [(20)] AS 21.97.

*** Sec. 93.** AS 21.96.030 is amended to read:

Sec. 21.96.030. Payment. Unless another form of payment is agreed to by the policy holder or beneficiary, an [AN] insurance company doing business in this state may not pay a judgment or settlement of a claim in this state for a loss incurred in this state with an instrument other than a negotiable bank check payable on demand and bearing even date with the date of writing or by electronic funds transfer.

*** Sec. 94.** AS 21.07.040, 21.07.250(7), 21.07.250(8), 21.07.250(9); AS 21.27.020(e), 21.27.025(b), 21.27.340, 21.27.900(14); AS 21.53.200(5); and AS 21.87.190(b) are repealed.

*** Sec. 95.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: LONG-TERM CARE INSURANCE LICENSEES COURSE REQUIREMENT. A person licensed and selling, soliciting, or negotiating long-term care insurance on the effective date of this section may not continue to sell, solicit, or negotiate long-term care insurance beginning one year after the effective date of this section unless the person has successfully completed a one-time course, as required by AS 21.53.066, enacted by sec. 73 of this Act.

*** Sec. 96.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATION ADOPTION. The director of insurance may adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the law implemented by the regulation.

*** Sec. 97.** The uncodified law of the State of Alaska is amended by adding a new section to read:

REVISOR'S INSTRUCTIONS. The revisor of statutes is instructed to change the

following:

(1) the chapter heading of AS 21.07 from "Regulation of Managed Care Insurance Plans" to "Patient Protections under Health Care Insurance Policies";

(2) the catch line of AS 21.34.170 from "Monthly reports, summary of exported business" to "Quarterly reports, summary of exported business."

*** Sec. 98.** Section 96 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 99.** Sections 46 - 58 of this Act take effect July 21, 2011.

*** Sec. 100.** Sections 62 and 77 of this Act take effect January 1, 2012.

*** Sec. 101.** Except as provided in secs. 98 - 100 of this Act, this Act takes effect July 1, 2011.