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Wallace
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CS FOR HOUSE BILL NO. 148(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FOURTH 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 insurance; and providing for an effective date."

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

*** Section 1.** AS 12.10.020 is amended by adding a new subsection to read:

(d) Even if the general time limitation has expired, a prosecution for any offense related to life insurance may be commenced within one year after discovery of the offense by an aggrieved party or by a person who has legal capacity to represent an aggrieved party or a legal duty to report the offense and who is not a party to the offense, but in no case shall this provision extend the period of limitation otherwise applicable by more than 20 years.

*** Sec. 2.** AS 21.07.030(a) is amended to read:

(a) If a health care insurer offers a health care insurance policy 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, the health care insurer 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. This subsection does not apply to

(1) a covered person who is offered non-network coverage through another health care insurance policy or through another health care insurer**; or**

(2) a health maintenance organization licensed under AS 21.86.

*** Sec. 3.** AS 21.07.030 is amended by adding a new subsection to read:

(i) A health care insurer that offers a health care insurance policy that provides different levels of coverage for health care services based on network status and performs utilization review shall include details on a prior authorization request form on how a health care provider or covered person may request a benefit-level exception. If the health care insurer approves the prior authorization, the insurer shall detail whether the claim will be processed as a network or non-network claim. If the benefit will be paid based on a non-network reimbursement level and a benefit-level exception requires an application process separate from the prior authorization process, the prior authorization must include instructions for requesting the benefit-level exception. In this subsection, a "benefit-level exception" means an exception to medical care coverage where a health care insurer applies network health care benefit levels to services received from an out-of-network health care provider or facility.

*** Sec. 4.** AS 21.09.200(g) is amended to read:

(g) An insurer shall file with the director or the director's designee an annual audited financial report for the previous year by June 1 of each year [UNLESS, UNDER A REGULATION ADOPTED BY THE DIRECTOR, THE DIRECTOR GRANTS AN EXEMPTION BASED ON A FINDING THAT FILING AN ANNUAL AUDITED FINANCIAL REPORT WOULD CONSTITUTE A FINANCIAL OR ORGANIZATIONAL HARDSHIP ON THE INSURER. THE FILING DATE FOR THE ANNUAL AUDITED FINANCIAL REPORT MAY BE EXTENDED BY THE DIRECTOR UPON SHOWING THAT THE STANDARDS ESTABLISHED BY REGULATION HAVE BEEN MET]. If the director gives the insurer 90 days' advance notice, and for good cause, the director may require an

insurer to file an audited financial report earlier than June 1 of each year. The annual audited financial report must be prepared by a qualified independent certified public accountant. An insurer shall notify the director of the certified public accountant engaged to conduct the audit and issue the annual audited financial report.

*** Sec. 5.** AS 21.09.200 is amended by adding a new subsection to read:

(m) An insurer may apply to the director for an exemption from compliance with a requirement of this section if compliance would cause the insurer to suffer a financial or organizational hardship. The director may, in the director's discretion, approve an exemption. If the director denies an insurer's application for exemption, the insurer may, within 15 days after the date of the denial, submit a request in writing to the director for a hearing as provided under AS 21.06.180 - 21.06.240.

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

(b) Each insurer, and each formerly authorized insurer with respect to premiums written while an authorized insurer in this state, shall pay a tax on the total direct premium written during the year ending on the preceding December 31 and paid for the insurance of property or risks resident or located in the state [, OTHER THAN WET MARINE AND TRANSPORTATION INSURANCE,] after deducting from the total direct premium income the applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to their policies. Deductions may not be made of cash surrender value of policies. Considerations received on annuity contracts are not included in the direct premium income and are not subject to tax. The tax shall be paid to the director at least annually but not more often than once each quarter on the dates specified by the director. The method of payment must be by the electronic or other payment method specified by the director. Except as provided under (m) of this section, the tax is computed at the rate of

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

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

(3) for wet marine and transportation insurance, three-quarters of one percent.

*** Sec. 7.** AS 21.09.242(a) is amended to read:

(a) **Each** [AN] insurer **and** [, INCLUDING A] pharmacy benefits manager **shall**, with respect to **a** medical assistance **program** [PROGRAMS] under AS 47.07, [SHALL] cooperate with the Department of Health to

(1) provide, with respect to an individual who is eligible for or is provided medical assistance under AS 47.07, **at** [ON] the request of the department, information to determine during what period the individual or the individual's spouse or dependents may be or may have been covered by the insurer and the nature of the coverage that is or was provided by the insurer, including the name and address of the insurer and the identifying number of the health care insurance plan;

(2) accept the department's right of recovery and the assignment to the department of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under AS 47.07;

(3) respond **within 60 days** to any inquiry by the department regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the health care item or service; and

(4) agree not to deny a claim submitted by the department solely on the basis of the date of submission of the claim, the type or format of the claim form, **a failure to obtain prior authorization,** or a failure to present proper documentation at the point-of-sale that is the basis of the claim if

(A) the claim is submitted by the department within the three-year period beginning on the date on which the item or service was furnished; and

(B) any action by the department to enforce its rights with respect to the claim is commenced within six years after the department's submission of the claim.

*** Sec. 8.** AS 21.12.020(h) is amended to read:

(h) The director shall consider the list of reciprocal jurisdictions published through the National Association of Insurance Commissioners committee process in

determining a reciprocal jurisdiction and has the discretion to defer to the list. The director may approve a jurisdiction not on the list in accordance with criteria developed under regulations adopted by the director. The director may remove a jurisdiction from the list of reciprocal jurisdictions upon determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction in accordance with a process set out in regulation by the director. Upon removal of a reciprocal jurisdiction from the list, credit for reinsurance ceded to an assuming insurer that has a home office or is domiciled in that jurisdiction shall be allowed if otherwise allowed under this section. The director shall timely create and publish a list of assuming insurers that have satisfied the conditions set out in this subsection and to which cessions shall be granted credit in accordance with (a) of this section. The director may add an assuming insurer to a list if a National Association of Insurance Commissioners accredited jurisdiction has added the assuming insurer to a list of assuming insurers or, if upon initial eligibility, the assuming insurer submits the information to the director as required under (a)(6)(D) of this section and complies with any additional requirements the director may impose by regulation. If the director determines that an assuming insurer no longer meets one or more of the requirements of (a)(6) of this section, the director may revoke or suspend the eligibility of the assuming insurer under (a)(6) of this section in accordance with procedures set out in regulation. While an assuming insurer's eligibility is suspended, a reinsurance agreement issued, amended, or renewed after the effective date of the suspension does not qualify for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with (c) of this section. If an assuming insurer's eligibility is revoked, a credit for reinsurance may not be granted after the effective date of the revocation with respect to any reinsurance agreement entered into by the assuming insurer, including a reinsurance agreement entered into before the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the director and consistent with (c) of this section. Upon entry of an order of rehabilitation, liquidation, or conservation against the ceding insurer, the supervising court **may** [SHALL] require an assuming insurer under (a)(6) of this section to post 100 percent security for the benefit of the ceding

insurer or its estate. Nothing in this subsection shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement consistent with this section. Credit under (a)(6) of this section may be taken only for reinsurance agreements entered into, renewed, or amended on or after the date the director has determined that the assuming insurer is eligible for credit, and may not be taken for reinsurance of losses incurred or reserves reported before that date. Credit under (a)(6) of this section may not apply to reinsurance agreements entered into, to losses incurred, or to reserves posted before application under (a)(6) of this section.

*** Sec. 9.** AS 21.12.020(i)(2) is amended to read:

(2) "reciprocal jurisdiction" means a jurisdiction that

(A) is not a United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or in the case of a covered agreement between the United States and the European Union, is a member state of the European Union; in this subparagraph, "covered agreement" is an agreement entered into under 31 U.S.C. 313 - 314 (Dodd-Frank Wall Street Reform and Consumer Protection Act) that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize **credit for reinsurance**;

(B) is a United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners financial standards and accreditation program; or

(C) is a qualified jurisdiction, as determined by the director under (a)(5)(C) of this section, that is not otherwise described in (A) and (B) of this paragraph and that meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the director in regulation;

*** Sec. 10.** AS 21.18.112(e) is amended to read:

(e) An insurer shall establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(1) quantify the benefits, guarantees, and funding associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts and, for policies or contracts with significant tail risk, that reflect conditions appropriately adverse to quantify the tail risk;

(2) incorporate assumptions, risk analysis methods, and financial models and management techniques that are consistent with, but not necessarily identical to, those used in the insurer's overall risk assessment process while recognizing potential differences in financial reporting structures and prescribed assumptions or methods;

(3) incorporate assumptions that are derived in one of the following manners:

(A) the assumptions are prescribed in the valuation manual;

(B) for assumptions that are not prescribed, the assumptions shall be established using the insurer's available experience, to the extent it is relevant and statistically credible; to the extent that data is not available, relevant, or statistically credible, the assumptions shall be established using other relevant or statistically credible experience;

(4) provide margins for uncertainty, including adverse deviation and estimation error, so that the greater the uncertainty the larger the margin and resulting reserve;

(5) for an insurer using a principle-based valuation for one or more policies or contracts subject to this subsection as specified in the valuation manual,

(A) establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual **and a process for appropriate waiver or modification of the established procedures**;

(B) provide to the director an annual certification of the

effectiveness of the internal controls with respect to the principle-based valuation; the controls shall be designed to ensure that all material risks inherent in the liabilities and associated assets subject to the valuation are included in the valuation and that valuations are made in accordance with the valuation manual; the certification shall be based on the controls in place as of the end of the preceding calendar year;

(C) develop and file with the director upon request a principle-based valuation report that complies with standards prescribed in the valuation manual;

(6) a principle-based valuation may include a prescribed formulaic reserve component.

*** Sec. 11.** AS 21.18.900(12) is amended to read:

(12) "policyholder behavior" means **a lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or election of a policy benefit by the terms of a policy or contract, or another** [AN] action of a policyholder, contract holder, or another person with the right to elect options**; "policyholder behavior" does not include events of mortality or morbidity that result in a benefit prescribed by the terms of a policy or contract**;

*** Sec. 12.** 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, except that not more than one compliance officer may be designated for each **line** [CLASS] of authority **under AS 21.27.115**;

(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, not later than 30 days after a change in the firm's compliance officer.

*** Sec. 13.** AS 21.27.020(f) is amended to read:

(f) The director may adopt regulations establishing additional education or experience requirements for applicants, licensees, and continuing education providers under this chapter upon due consideration of the availability and accessibility of education and training opportunities in rural areas of the state. Regulations adopted under this subsection are subject to the following provisions:

(1) additional educational or experience requirements may not apply to a licensee who has been licensed by the division of insurance before January 1, 1980;

(2) a licensee shall complete at least 24 credit hours of approved continuing education courses during each two-year license period;

(3) if a licensee has accumulated more credit hours than required under (2) of this subsection by the end of the license period, a maximum of eight hours may be carried over to meet the requirements of (2) of this subsection in the next license period;

(4) a program or seminar may not be approved as an acceptable continuing education program unless it is a formal program of learning that contributes to the professional competence of the licensee; individual study programs or correspondence courses may be used to fulfill continuing education requirements if approved by the director;

(5) a nonresident licensee is exempt from the requirements of this subsection**, except for a nonresident independent adjuster who designates this state as the adjuster's home state**.

*** Sec. 14.** AS 21.27.025(a) is amended to read:

(a) A licensee shall notify the director in writing not later than 30 days after a change in residence, place of business, legal name, fictitious name or alias, mailing address, electronic mailing address, telephone number, or compliance officer. A licensee shall report to the director in writing any administrative action taken against the licensee by a governmental agency [OF ANOTHER STATE, BY A GOVERNMENTAL AGENCY OF ANOTHER JURISDICTION,] or by a financial

industry regulatory authority sanction or arbitration proceeding not later than 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 **in writing** any criminal prosecution of the licensee in this or another state or jurisdiction not later than 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.

*** Sec. 15.** AS 21.27.115 is amended to read:

Sec. 21.27.115. Lines of authority. If a person has met the applicable requirements of AS 21.27.020 and 21.27.270, the director shall issue a license for one or more of the following lines of authority:

(1) life insurance coverage on natural persons; in this paragraph, "life insurance coverage"

(A) includes benefits of endowment and annuities; and

(B) may include benefits in the event of death or dismemberment by accident and benefits for disability income;

(2) **accidental and** health **or sickness** insurance coverage for sickness, bodily injury, or accidental death; in this paragraph, "**accidental and** health **or sickness** insurance coverage" **includes health insurance, as defined in AS 21.12.050(a), and** may include benefits for disability income;

(3) property insurance coverage for the direct or consequential loss for damage to property of every kind;

(4) casualty insurance coverage against legal liability, including that for death, injury, or disability or damage to real or personal property; in this paragraph, "casualty insurance" includes surety insurance as defined in AS 21.12.080;

(5) variable life and variable annuity products insurance coverage;

(6) personal lines property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;

(7) limited lines credit insurance;

(8) [REPEALED

(9) REPEALED

(10)] any insurance for which a limited lines license may be issued under AS 21.27.150.

*** Sec. 16.** AS 21.27.270(b) is amended to read:

(b) Unless the director denies or refuses to renew a license under AS 21.27.410, the director shall issue a nonresident producer, limited lines, surplus lines broker, managing general agent, reinsurance intermediary broker, **independent adjuster,** or reinsurance intermediary manager license to a person who is not a resident of this state if

(1) the person is currently licensed and is in good standing in the person's home state; the director may verify the person's licensing status through the producer licensing database records maintained by the National Association of Insurance Commissioners or its affiliates or subsidiaries;

(2) the person has paid the fees required under AS 21.06.250 and has submitted to the director

(A) the license application the person submitted to the person's home state; or

(B) if the person is not a firm, a completed uniform application or, if a firm, the uniform business entity application; and

(3) the person's home state awards nonresident producer, limited lines, surplus lines **broker**, managing general agent, reinsurance intermediary broker, **independent adjuster,** and reinsurance intermediary manager licenses to residents of this state on the same basis as does this state.

*** Sec. 17.** AS 21.27.270(h) is amended to read:

(h) A nonresident applicant for an independent adjuster license who [ONLY ADJUSTS CLAIMS RELATED TO PORTABLE ELECTRONICS INSURANCE UNDER AS 21.36.515 AND WHO] is licensed as an independent adjuster and in good standing in the applicant's home state does not have to meet the requirements of AS 21.27.060 or 21.27.830 to be licensed under this section. [A RESIDENT OF CANADA MAY NOT BE LICENSED AS AN INDEPENDENT ADJUSTER UNDER THIS SECTION UNLESS THE APPLICANT HAS OBTAINED A

RESIDENT INDEPENDENT ADJUSTER LICENSE IN ANOTHER STATE OR DECLARED ANOTHER STATE THE APPLICANT'S HOME STATE AND OBTAINED AN INDEPENDENT ADJUSTER LICENSE IN THAT STATE.]

*** Sec. 18.** AS 21.27.270(i) is amended to read:

(i) If a nonresident independent [PORTABLE ELECTRONICS] adjuster applicant's home state does not license independent adjusters, the independent [PORTABLE ELECTRONICS] adjuster applicant may designate the applicant's home state as any state in which the applicant is licensed in good standing.

*** Sec. 19.** AS 21.27.270 is amended by adding a new subsection to read:

(j) A nonresident applicant for issuance or renewal of an independent adjuster license or firm independent adjuster license who designates this state as the applicant's home state must qualify for licensure under AS 21.27.020 and apply for the issuance or renewal of the license in accordance with AS 21.27.040.

*** Sec. 20.** AS 21.27.380(d) is amended to read:

(d) The director shall **send** [MAIL] a notice of **license** expiration stating the reason for the expiration to a licensee at the licensee's **most current electronic mail address or mailing** [LAST] address on record with the director. [THE DIRECTOR SHALL OBTAIN A CERTIFICATE OF MAILING FROM THE UNITED STATES POSTAL SERVICE.]

*** Sec. 21.** AS 21.27.630(d) is amended to read:

(d) A third-party administrator may not use a fictitious name or alias unless the **third-party administrator's** [LICENSEE'S] legal name and fictitious name or alias are on the registration.

*** Sec. 22.** AS 21.27.640(b) is amended to read:

(b) To qualify for issuance or renewal of a registration, an applicant or registrant shall comply with this title, regulations adopted under AS 21.06.090, and

(1) be a trustworthy person;

(2) have active working experience in administrative functions that, in the director's opinion, exhibits the ability to competently perform the administrative functions of a third-party administrator;

(3) not have committed an act that is a cause for denial, nonrenewal,

suspension, or revocation of a registration or license in this state or another jurisdiction;

(4) maintain a lawfully established place of business [AS DESCRIBED IN AS 21.27.330] in this state, unless licensed as a nonresident under AS 21.27.270;

(5) disclose to the director all owners, officers, directors, or partners, if any;

(6) designate a compliance officer for the firm;

(7) provide in or with its application

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

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

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

(D) certified financial statements for the preceding two years, or for each year and partial year that the applicant has been in business if less than two years, prepared by an independent certified public accountant establishing that the applicant is solvent, that the applicant's system of accounting, internal control, and procedure is operating effectively to provide

reasonable assurance that money is promptly accounted for and paid to the person entitled to the money, and any other information that the director may require to review the current financial condition of the applicant; and

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

(8) provide to the director documents necessary to verify the statements contained in or in connection with the application; and

(9) notify the director, in writing, not later than 30 days after

(A) a change in compliance officer, residence, place of business, mailing address, or phone number;

(B) the final disposition of an administrative action taken against the registrant by a governmental agency [OF ANOTHER STATE, BY A GOVERNMENTAL AGENCY OF ANOTHER JURISDICTION,] or by a financial industry regulatory authority sanction or arbitration proceeding; in addition, a registrant shall submit to the director documents relating to the final disposition on, including the final order and other relevant legal documents in, the action; or

(C) a conviction of a misdemeanor or felony of the third-party administrator, its officers, directors, partners, owners, or employees.

*** Sec. 23.** AS 21.27.990(8) is amended to read:

(8) "compliance officer" means a licensee designated for a specific line [AND CLASS] of authority under **AS 21.27.115** [THIS CHAPTER] who is responsible for a firm's compliance with the insurance statutes and regulations of this state;

*** Sec. 24.** AS 21.27.990(12) is amended to read:

(12) "home state," with respect to

(A) an insurance producer, means the District of Columbia or a state or territory of the United States in which an insurance producer maintains

the producer's principal place of residence or principal place of business and is licensed to act as an insurance producer;

(B) an independent [PORTABLE ELECTRONICS] adjuster, means the District of Columbia or a state or territory of the United States in which an independent [PORTABLE ELECTRONICS] adjuster maintains the independent [PORTABLE ELECTRONICS] adjuster's principal place of residence or principal place of business and is licensed to act as an independent adjuster or, if the state or territory of the United States of the independent [PORTABLE ELECTRONICS] adjuster's principal place of residence or principal place of business does not license independent adjusters, the state or territory of the United States designated by the independent [PORTABLE ELECTRONICS] adjuster where the independent [PORTABLE ELECTRONICS] adjuster is licensed;

*** Sec. 25.** AS 21.27.990(13) is amended to read:

(13) "independent [PORTABLE ELECTRONICS] adjuster" means **a person** [AN INDEPENDENT ADJUSTER] who **investigates, negotiates, or settles property, casualty, or workers' compensation claims for insurers or self-insurers** [COLLECTS, FURNISHES, OR ENTERS CLAIM INFORMATION FOR PORTABLE ELECTRONICS INSURANCE ISSUED UNDER AS 21.36.515];

*** Sec. 26.** AS 21.27.990(20) is amended to read:

(20) "limited lines" means those lines of insurance defined in AS 21.27.150 [OR ANY OTHER LINE OF INSURANCE THAT THE DIRECTOR DESIGNATES BY ORDER AS A LIMITED LINE];

*** Sec. 27.** AS 21.33.055(d) is amended 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. **For wet marine and transportation insurance, a surplus lines broker may pay the tax on behalf of the nonadmitted insurer or the insured.** 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 **from the director** [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. 28.** AS 21.34.035 is amended to read:

Sec. 21.34.035. Health care <u>insurance and disability</u> insurance. (a) Except for a multiple employer welfare arrangement, health care insurance **<u>and disability insurance</u>** may be placed in and written by a nonadmitted insurer if

(1) the director finds it is in the best interest of the public and issues an order to that effect; and

(2) the insurance is in compliance with this chapter.

(b) The rates and rating methods for health care insurance **<u>and disability insurance</u>** placed and written under this section are subject to AS 21.51.405 and AS 21.54.015. The surplus lines broker shall make the filings required under AS 21.51.405 and AS 21.54.015 and maintain the records and accounts as required under AS 21.87.230.

(c) Health care insurance **<u>and disability insurance</u>** may not be procured under this chapter

(1) for the purpose of obtaining a lower premium rate than acceptable by an authorized insurer; or

(2) for obtaining a competitive advantage.

(d) **<u>Health care insurance and disability insurance</u>** [INSURANCE] placed in or written by a nonadmitted insurer and the activities of the surplus lines broker relating to that transaction are subject to this title.

(e) In this section,

<u>(1) "disability insurance" means disability insurance as defined in AS 21.12.052 that is excess insurance or for individuals unable to obtain disability insurance with any admitted insurer;</u>

(2) "health care insurance" has the meaning given in AS 21.12.050(b).

*** Sec. 29.** AS 21.34.040(d) is amended to read:

(d) **An insurer, including a nonadmitted insurer, not domiciled in a state or territory of the United States and not listed on the Quarterly Listing of Alien Insurers maintained by the National Association of Insurance Commissioners International Insurers Department** [A NONADMITTED INSURER] may be eligible to provide coverage in this state if it files with the director or the director's designee a copy of its current annual financial statement that has been certified by the insurer. The financial statement must be filed with and approved by the regulatory authority in the domicile of the [NONADMITTED] insurer [,] or certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's domicile. **The** [A FOREIGN] insurer shall **file** [PROVIDE] the approved or certified financial statement **with the director or director's designee** not more than **nine** [SIX] months after the close of the reporting period. [AN ALIEN INSURER SHALL PROVIDE THE APPROVED OR CERTIFIED FINANCIAL STATEMENT NOT MORE THAN NINE MONTHS AFTER THE CLOSE OF THE REPORTING PERIOD. IN THE CASE OF AN INSURANCE EXCHANGE, THE STATEMENT MAY BE AN AGGREGATE COMBINED STATEMENT OF ALL UNDERWRITING SYNDICATES OPERATING DURING THE PERIOD REPORTED UPON.]

*** Sec. 30.** AS 21.34.170(a) is amended to read:

(a) A surplus lines broker shall file with the director, 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 showing the aggregate gross premiums written, the aggregate return premiums, **and** 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 **surplus lines broker** [FORMS] shall **file the report** [BE FILED] quarterly on March 1, June 1, September 1, and December 1 of each year.

*** Sec. 31.** AS 21.34.190 is amended to read:

Sec. 21.34.190. Filing fee. (a) The fee for filing the statement under AS 21.34.180(e) 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 **and in a form and manner required by the director**.

(b) If the **surplus lines broker does not pay the** filing fee [IS NOT PAID] when due, **the surplus lines broker shall pay** an additional late payment fee of **$50 a month** [$250] plus two percent of the fee due per month, or part of a month, **during which the surplus lines broker fails to pay the full amount of the filing fee. The late payment fee may not exceed $250 plus 10 percent of the filing fee due. If the surplus lines broker does not pay the filing fee in the form or manner required by the director, a penalty fee will be assessed equal to 25 percent of the filing fee due, not to exceed $1,000, with a minimum penalty of $50. In addition to any other penalty provided by law, the director may assess a penalty of not more than $10,000 for a violation of this section. The director may suspend or revoke the license of a surplus lines broker that fails to pay a fee under this section** [SHALL BECOME DUE AND PAYABLE BY THE SURPLUS LINES BROKER].

*** Sec. 32.** AS 21.34.900(8) is amended to read:

(8) "home state," for purposes of determining the home state of an insured in a multistate **or multinational** placement of nonadmitted insurance, is defined as follows:

(A) except as provided in (B) **or (C)** 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) **if two or more insureds are named insureds on a nonaffiliated group policy, "home state" under (A) of this paragraph**

(i) is based on the group policyholder if the group policyholder pays 100 percent of the premium; or

(ii) is based on the named insured of the group policy if the group policyholder does not pay 100 percent of the premium from the policyholder's own funds;

(D) for purposes of (A) of this paragraph, the principal place of business of an insured is

(i) 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**; or**

(ii) if an insured's high-level officers direct, control, and coordinate the business activities of the insured in more than one state or if the insured maintains its headquarters in a jurisdiction outside the United States, the state where the greatest percentage of the insured's taxable premium for the insurance contract is allocated;

(E) for purposes of (A) of this paragraph, the principal residence of an insured is

(i) the state where the insured resides for the greatest number of days in a calendar year; or

(ii) if the insured resides for the greatest number of days in a calendar year in a jurisdiction outside the United States, the state where the greatest percentage of the insured's taxable premium for the insurance contract is allocated;

*** Sec. 33.** AS 21.34.900(15) is amended to read:

(15) "wet marine and transportation insurance" **has the meaning given**

in AS 21.12.090(b) [MEANS ONE OR MORE OF THE FOLLOWING:

(A) INSURANCE UPON, OF INTEREST IN, OR RELATING TO VESSELS, CRAFTS, HULLS, EXCEPT VESSELS OF 50 DISPLACEMENT TONS OR LESS;

(B) INSURANCE OF MARINE BUILDERS RISKS, MARINE WAR RISKS, AND CONTRACTS OF MARINE PROTECTION AND INDEMNITY INSURANCE;

(C) INSURANCE OF FREIGHT AND DISBURSEMENTS PERTAINING TO A SUBJECT OF INSURANCE COMING WITHIN THIS PARAGRAPH; OR

(D) INSURANCE OF PERSONAL PROPERTY AND INTERESTS IN PERSONAL PROPERTY, IN COURSE OF EXPORTATION FROM OR IMPORTATION INTO A COUNTRY OR IN THE COURSE OF COASTAL OR INLAND WATER TRANSPORTATION, INCLUDING TRANSPORTATION BY LAND, WATER, OR AIR FROM POINT OF ORIGIN TO FINAL DESTINATION IN CONNECTION WITH ANY AND ALL RISKS OR PERILS OF NAVIGATION, TRANSIT, OR TRANSPORTATION, AND WHILE BEING REPAIRED FOR AND WHILE AWAITING SHIPMENT, AND DURING ANY DELAYS, TRANSSHIPMENT, OR RESHIPMENT INCIDENT TO THEM].

*** Sec. 34.** AS 21.36.125(a) is amended to read:

(a) A person may not commit any of the following acts or practices:

(1) misrepresent facts or policy provisions relating to coverage of an insurance policy;

(2) fail to acknowledge and act promptly upon communications regarding a claim arising under an insurance policy;

(3) fail to adopt and implement reasonable standards for prompt investigation of claims;

(4) refuse to pay a claim without a reasonable investigation of all of the available information and an explanation of the basis for denial of the claim or for an offer of compromise settlement;

(5) fail to affirm or deny coverage of claims within a reasonable time of the completion of proof-of-loss statements;

(6) fail to attempt in good faith to make prompt and equitable settlement of claims in which liability is reasonably clear;

(7) engage in a pattern or practice of compelling insureds to litigate for recovery of amounts due under insurance policies by offering substantially less than the amounts ultimately recovered in actions brought by those insureds;

(8) compel an insured or third-party claimant in a case in which liability is clear to litigate for recovery of an amount due under an insurance policy by offering an amount that does not have an objectively reasonable basis in law and fact and that has not been documented in the insurer's file;

(9) attempt to make an unreasonably low settlement by reference to printed advertising matter accompanying or included in an application;

(10) attempt to settle a claim on the basis of an application that has been altered without the consent of the insured;

(11) make a claims payment without including a statement of the coverage under which the payment is made;

(12) make known to an insured or third-party claimant a policy of appealing from an arbitration award in favor of an insured or third-party claimant for the purpose of compelling the insured or third-party claimant to accept a settlement or compromise less than the amount awarded in arbitration;

(13) delay investigation or payment of claims by requiring submission of unnecessary or substantially repetitive claims reports and proof-of-loss forms;

(14) fail to promptly settle claims under one portion of a policy for the purpose of influencing settlements under other portions of the policy;

(15) fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; [OR]

(16) offer a form of settlement or pay a judgment in any manner prohibited by AS 21.96.030;

(17) violate a provision contained in AS 21.07**; or**

(18) offer a valuation that depreciates the expense of labor in violation of AS 21.60.030.

*** Sec. 35.** AS 21.36.225(a) is amended to read:

(a) **An** [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 policyholder at least 45 days before the effective date of the cancellation.

*** Sec. 36.** AS 21.36.235(a) is amended to read:

(a) Except as provided in AS 21.36.305, if the renewal premium is increased more than 10 percent for a reason other than an increase in coverage or exposure base, or if after renewal there will be a material restriction or reduction in coverage not specifically requested by the insured, written notice shall be mailed to the insured and to the agent or broker of record as required by AS 21.36.260

[(1) AT LEAST 20 DAYS BEFORE EXPIRATION OF A PERSONAL INSURANCE POLICY; OR

(2)] at least 45 days before expiration of **the** [A BUSINESS OR COMMERCIAL] policy.

*** Sec. 37.** AS 21.36.240(a) is amended to read:

(a) An insurer may only fail to renew a personal insurance policy on the policy's annual anniversary. An insurer may not fail to renew a policy unless a written notice of nonrenewal is mailed to the named insured under AS 21.36.260 at least [20 DAYS FOR A PERSONAL INSURANCE POLICY, AND AT LEAST] 45 days [FOR A BUSINESS OR COMMERCIAL INSURANCE POLICY,] before the date the policy expires or the anniversary date of a policy written for a term longer than one year or with no fixed expiration date.

*** Sec. 38.** AS 21.36.240 is amended by adding a new subsection to read:

(e) For purposes of this section, an offer of placement with an affiliate insurer does not constitute a failure by an insurer to renew coverage.

*** Sec. 39.** AS 21.36 is amended by adding a new section to Article 4 to read:

Sec. 21.36.245. Cancellation of and failure to renew property and casualty insurance. An insurer may not cancel or fail to renew a property insurance policy, or a

casualty insurance policy insuring a business or commercial property, as a result of a claim to an insurer made solely to meet a local, state, or federal aid requirement where the insurer does not apply coverage and does not pay a benefit.

*** Sec. 40.** AS 21.36.475(a) is amended to read:

(a) An owner controlled insurance program or a contractor controlled insurance program is subject to both AS 21.39 and AS 21.42, must be approved by the director, and shall be allowed only for a major construction project **or a major multi-owner residential construction project**. Owner controlled and contractor controlled insurance programs are limited to property insurance as defined in AS 21.12.060 and casualty insurance as defined in AS 21.12.070.

*** Sec. 41.** AS 21.36.475(b) is amended to read:

(b) In this section, an owner controlled or contractor controlled **insurance** [INSURED] program does not include

(1) builder's risk or course of construction insurance;

(2) insurance relating to the transportation of cargo or other property;

(3) insurance covering one or more affiliates, subsidiaries, partners, or joint venture partners of a person; or

(4) insurance policies endorsed to name one or more persons as additional insureds **if naming a person as an additional insured is a term required by a contract; this paragraph does not apply to an owner controlled or contractor controlled insurance program for a major construction project**.

*** Sec. 42.** AS 21.36.475(c) is amended by adding a new paragraph to read:

(7) "major multi-owner residential construction project" means a construction project for condominiums, townhouses, cooperative housing developments, or other residential housing involving at least 50 units and three or more property owners with a total cost of $25,000,000 or more.

*** Sec. 43.** AS 21.36.505(a) is amended to read:

(a) A person may not sell, market, promote, advertise, or otherwise distribute a health discount plan unless

(1) each advertisement, policy, document, information, statement, or other communication regarding the health discount plan and the plan itself contain a

statement, in bold and prominent type, that the health discount plan is not insurance;

(2) [THE DISCOUNTS OFFERED UNDER THE HEALTH DISCOUNT PLAN ARE SPECIFICALLY AUTHORIZED BY A CONTRACT WITH EACH PROVIDER OF THE SERVICES OR SUPPLIES LISTED IN CONJUNCTION WITH THE PLAN;

(3)] the health discount plan states the name, address, and telephone number of the administrator of the plan;

(3) [(4)] the person makes readily available to the consumer a complete, accurate, and up-to-date list of providers participating in the plan that offer discounted health care services or supplies in the consumer's local area and the discounts offered by the providers;

(4) [(5)] the person provides the consumer the right to cancel the health discount plan within 30 days after purchase of the plan;

(5) [AND (6)] the person provides the consumer with a full refund of all payments made, except for a nominal processing fee, within 30 days after notification of cancellation of the plan under (5) of this subsection**;**

(6) the person registers the health discount plan in accordance with regulations adopted by the director; and

(7) the person renews the health discount plan when required under regulations adopted by the director.

*** Sec. 44.** AS 21.36.910(d) is amended to read:

(d) In addition to an order issued under (c) of this section, the director may, after a hearing, order restitution, assess a penalty of not more than $2,500 for each violation or $25,000 for engaging in a general business practice in violation of this chapter. **The director may include interest calculated under AS 09.30.070 in an order for restitution entered under this subsection.**

*** Sec. 45.** AS 21.39.155(c) is amended to read:

(c) An insurer may impose a surcharge not to exceed 25 percent of the premium for assigned risk pool insurance, except that a surcharge may not be applied to the first **$6,000** [$3,000] in premium in any policy year.

*** Sec. 46.** AS 21.42.250(a) is amended to read:

(a) An insurer shall provide a policy or endorsement to the insured or to the person entitled to it by mail or **electronic mail** [DELIVERY] or by posting on the insurer's Internet website under (c) of this section within a reasonable period of time after its issuance. The insurer is not required to mail, deliver, or post the policy or endorsement until all conditions required by the insurer have been met by the insured.

*** Sec. 47.** AS 21.42.375(e) is amended to read:

(e) Except as necessary to qualify a plan as a high deductible health plan eligible for a health savings account tax deduction under 26 U.S.C. 223 (Internal Revenue Code), a health care insurer that offers, issues, delivers, or renews a health care insurance plan in the individual or group market in the state that provides coverage for mammography screening, diagnostic breast examinations, and supplemental breast examinations may not impose cost sharing, a deductible, coinsurance, a copayment obligation, or another similar out-of-pocket expense on an insured for coverage of a low-dose mammography screening, diagnostic breast examination, [OR] supplemental breast examination**, biopsy, or consultation**.

*** Sec. 48.** AS 21.42.375(f) is amended by adding new paragraphs to read:

(4) "biopsy" means a medical procedure involving the removal of tissue to determine the presence of cancer cells;

(5) "consultation" means a medical consultation with a health care provider to discuss the results of a diagnostic breast examination and whether further biopsies or other diagnostic procedures are needed.

*** Sec. 49.** AS 21.42.377(a) is amended to read:

(a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan shall provide coverage for the costs of colorectal cancer screening examinations and laboratory tests under the schedule described in (b) of this section. [THE COVERAGE REQUIRED BY THIS SECTION IS SUBJECT TO STANDARD POLICY PROVISIONS APPLICABLE TO OTHER BENEFITS, INCLUDING DEDUCTIBLE OR COPAYMENT PROVISIONS.]

*** Sec. 50.** AS 21.42.377(b) is amended to read:

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

cancer screening includes coverage for colorectal cancer examinations and laboratory tests **as recommended by the most recent** [SPECIFIED IN] American Cancer Society guidelines for colorectal cancer screening of [ASYMPTOMATIC] individuals **considered at average risk for colorectal cancer**. Coverage shall be provided for all colorectal screening examinations and tests**, including a colonoscopy performed as a result of a positive result on a non-colonoscopy preventive screening test,** that are administered at a frequency identified in the **most recent** American Cancer Society guidelines for colorectal cancer.

*** Sec. 51.** AS 21.42.377(e) is amended to read:

(e) For individuals considered at

(1) average risk for colorectal cancer, coverage or benefits shall be provided for the choice of screening, so long as it is conducted in accordance with the specified frequency**; coverage required by this paragraph is not subject to cost sharing, including deductible, coinsurance, or copayment provisions;**

(2) [. FOR INDIVIDUALS CONSIDERED AT] high risk for colorectal cancer, screening shall be provided at a frequency determined necessary by a health care provider.

*** Sec. 52.** AS 21.45.305(c)(2) is amended to read:

(2) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent a year or the following, which shall be specified in the contract if the interest rate will be reset: (A) the five-year constant maturity treasury rate reported by the federal reserve as of a date, or average over a period, rounded to the nearest 1/ 20 of one percent, specified in the contract not more than 15 months before the contract issue date or redetermination date under (D) of this paragraph; (B) reduced by 125 basis points; (C) where the resulting interest rate is not less than **0.15** [ONE] percent; and (D) the interest rate must apply for an initial period and may be redetermined for additional periods; the redetermination date, basis, and period, if any, must be stated in the contract; the basis is the date or average over a specified period that produces the value of the five-year constant maturity treasury rate to be used at each redetermination date.

*** Sec. 53.** AS 21.48.010(f) is amended to read:

(f) An insurer shall submit to the director information **demonstrating** [SATISFACTORY TO THE DIRECTOR] that the group meets the requirements of (a) or (e) of this section**. If the director finds the information to be satisfactory, the director shall** [, AND THE DIRECTOR MUST AFFIRMATIVELY] approve [OF] the [GROUP BEFORE AN] insurer **to** [MAY] issue a group life policy to a group under (a) or (e) of this section. **The director's approval is not required for a single employer group, labor union group, or multiple employer welfare arrangement authorized under AS 21.85.**

*** Sec. 54.** AS 21.51.060(b) is amended to read:

(b) A policy in which the insurer reserves the right to refuse renewal shall have, at the beginning of the provision in (a) of this section,

"Unless not less than **45** [30] days before the premium due date the insurer has delivered to the insured or has mailed to the last address of the insured as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

*** Sec. 55.** AS 21.57.160(1) is amended to read:

(1) "**agricultural** [AGRICULTURE] credit transaction commitment" means a binding agreement to loan money up to a fixed amount as needed for agricultural purposes;

*** Sec. 56.** AS 21.59 is amended by adding a new section to read:

Sec. 21.59.125. Motor vehicle service contract approval. (a) A provider may not deliver or issue for delivery a motor vehicle service contract unless the provider files the contract with the division and receives approval from the director for the contract.

(b) If a change is made to a motor vehicle service contract after it has been approved, the provider shall file and receive approval for the changed contract in accordance with (a) of this section.

*** Sec. 57.** AS 21.59.140(c) is amended to read:

(c) 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 within 30 days after the date of filing of the criminal complaint, indictment, 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.

*** Sec. 58.** AS 21.60 is amended by adding a new section to read:

Sec. 21.60.030. Depreciation of labor. In a residential property policy, the valuation of the expense of labor may not be depreciated, except where offered as a stand-alone endorsement that specifically identifies the nontangible items subject to depreciation. An endorsement offered under this section must be an optional coverage and provide a proportionate reduction in premium.

*** Sec. 59.** AS 21.76.070 is amended to read:

Sec. 21.76.070. Excess insurance. A cooperative agreement may authorize the board of directors to purchase excess or catastrophic insurance on behalf of the joint insurance arrangement. The cost of the insurance shall be apportioned in the manner specified in the joint insurance agreement. The board may purchase insurance under this section only from an insurer authorized to do business in the state, except that an arrangement formed by municipalities or school districts may purchase insurance under this section from a risk-sharing pool established by a national association of similar entities if the risk-sharing pool meets the qualifications for **a nonadmitted** [AN UNAUTHORIZED] insurer under **AS 21.34.040(d)** [AS 21.34.040(b) AND (d) AND 21.34.220] and has capital and policyholders surplus in an amount at least as great as would be required if the association were a domestic multiple line insurer. An arrangement may purchase insurance under this section for property and liability risks from unauthorized insurers allowed for use by licensed Alaska surplus lines brokers.

*** Sec. 60.** AS 21.79.020(c) is amended to read:

(c) This chapter does not apply to

(1) that part of a policy or contract that is not guaranteed by the member insurer;

(2) that part of the risk borne by the policy or contract owner;

(3) a policy or contract of reinsurance, unless an assumption certificate has been issued;

(4) that part of a policy or contract, except for part of a policy or contract, including a rider, that provides long-term care or other health insurance benefits, to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value,

(A) averaged over the period of four years before the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever occurs first, exceeds the rate of interest determined by subtracting two percentage points from the published monthly average for that same four-year period or for a lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever occurs first; and

(B) on and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever occurs first, exceeds the rate of interest determined by subtracting three percentage points from the most recent published monthly average;

(5) a portion of a policy or contract issued to a plan or program of an employer, association, or similar entity to provide life, health, or an annuity benefit to an employee, member, or other person, to the extent that the plan or program is self-funded or uninsured, including a benefit payable by the employer, association, or similar entity under

(A) a multiple employer welfare arrangement as defined in 29 U.S.C. 1002 (Employee Retirement Income Security Act of 1974);

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan; or

(D) an administrative services only contract;

(6) that part of a policy or contract that provides a dividend or

experience rating credit or voting rights, or provides that a fee or allowance be paid to a person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(7) a policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(8) a person who is a payee or beneficiary of a contract owner who is a resident of this state if the payee or beneficiary is provided coverage by the association of another state;

(9) a person covered under (d) of this section if any coverage is provided by the association of another state to that person;

(10) an unallocated annuity contract issued to or in connection with a benefit plan protected under the United States Pension Benefit Guaranty Corporation, regardless of whether the United States Pension Benefit Guaranty Corporation has become liable to make any payments with respect to the benefit plan;

(11) that part of an unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery;

(12) that part of a policy or contract to the extent that assessments required by AS 21.79.070 with respect to the policy or contract are preempted by law;

(13) an obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy owner, including, without limitation,

(A) a claim based on marketing materials;

(B) a claim based on a side letter or other document that was issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(C) a misrepresentation of or regarding policy or contract benefits;

(D) an extra contractual claim; or

(E) a claim for penalties or consequential or incidental

damages;

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

(15) that part of a policy or contract to the extent the part of the policy or contract provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but that have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; if a policy's or contract's interest or changes in value are credited less frequently than annually, then, for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(16) a policy or contract providing a hospital, medical, prescription drug, or other health care benefit in accordance with **42 U.S.C. 1395w-21 - 42 U.S.C. 1395w-28, 42 U.S.C. 1395w-101 - 42 U.S.C. 1395w-154, 42 U.S.C. 1396 - 42 U.S.C. 1396w-8,** [42 U.S.C. 1395w-21 - 1395w-154] or federal regulations adopted under those sections;

(17) a person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before, on, or after 26 U.S.C. 5891(c)(3)(A) became effective; or

(18) structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before, on, or after 26 U.S.C. 5891(c)(3)(A) became effective.

*** Sec. 61.** AS 21.86.040(a) is amended to read:

(a) The governing body of a health maintenance organization may include providers, or other individuals, or both. At least **one member** [ONE-THIRD] of the governing body must **be a consumer to represent** [CONSIST OF CONSUMERS WHO ARE SUBSTANTIALLY REPRESENTATIVE OF] enrollees.

*** Sec. 62.** AS 21.86.060(b) is amended to read:

(b) In addition to basic health care services, a health maintenance organization may provide, or arrange for, other health care services on a prepayment**, fixed fee,** or other financial basis.

*** Sec. 63.** AS 21.86.060 is amended by adding new subsections to read:

(d) A health maintenance organization shall provide coverage for emergency services, as that term is defined in AS 21.07.250, that are necessary to screen and stabilize a covered person at the health maintenance organization provider employee or contracted provider level of cost sharing when the services are not provided by a health maintenance organization provider. The health maintenance organization may require the transfer of a hospitalized covered person upon stabilization.

(e) A health maintenance organization shall provide coverage at the health maintenance organization provider employee or contracted provider level of cost sharing upon referral from a health maintenance organization provider that states the covered person requires medically necessary services from a provider that is not a health maintenance organization provider. The health maintenance organization may deny the referral when an in-network provider is available to provide the medically necessary services.

*** Sec. 64.** AS 21.96.090 is amended by adding a new subsection to read:

(g) A risk retention group shall file a report in accordance with AS 21.09.210(a) and pay the tax required for a domestic and foreign insurer under AS 21.09.210(b).

*** Sec. 65.** AS 21.96.120 is amended to read:

Sec. 21.96.120. Waiver for state innovation. The director may apply to **a federal agency for a waiver of federal law that relates to a health insurance requirement, including applying to** the United States Secretary of Health and

Human Services **and the United States Department of the Treasury** under 42 U.S.C. 18052**, as amended,** for a waiver of applicable provisions of P.L. 111-148 (Patient Protection and Affordable Care Act)**, as amended,** with respect to health insurance [COVERAGE] in the state for a plan year beginning on or after January 1, 2017. The director may implement a state plan meeting the waiver requirements in a manner consistent with state and federal law and as approved by the United States Secretary of Health and Human Services.

*** Sec. 66.** AS 21.97.900 is amended by adding a new paragraph to read:

(48) "motor vehicle" means a motor vehicle subject to registration under AS 28.10.011.

*** Sec. 67.** AS 21.09.210(d); AS 21.27.020(g), 21.27.330(a); AS 21.34.030(d); AS 21.39.020(b)(4); AS 21.42.377(c); AS 21.59.290(2); and AS 21.86.078 are repealed.

*** Sec. 68.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 21.36.475(b), as amended by sec. 41 of this Act, applies to contracts entered into on or after the effective date of this Act.

*** Sec. 69.** This Act takes effect immediately under AS 01.10.070(c).