HOUSE BILL NO. 372

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE

Introduced: 3/21/16
Referred: Labor and Commerce

A BILL

FOR AN ACT ENTITLED

"An Act relating to insurance; relating to expenses for insurance examinations; relating to regulations for insurance utilization review, benefits determination, health care insurance grievance resolution procedures, independent review of adverse determinations or final adverse determinations, independent review organizations, and continuing education providers; relating to required provisions for health care insurance contracts and policies, including health care provider choice; establishing civil penalties for insurers for failure to provide requested records; amending the definition of 'wet marine and transportation' insurance; amending provisions on limited licenses to include crop insurance; relating to third-party administrator notification requirements; relating to certification filing by reinsurance intermediary brokers; relating to rate filings, delivery of insurance policies or endorsements; relating to refunds of variable life insurance policies and variable annuities; establishing limitations on issuance of long-

term care insurance; relating to requirements for group health insurance policies; amending the definition of 'group health insurance'; relating to motor vehicle service contracts; relating to notice requirements for meetings of stockholders or members of a domestic insurer; establishing a definition of 'bona fide association'; relating to requirements and penalties for committing a fraudulent or criminal insurance act; updating criteria for examinations; relating to rate filing deviations; establishing civil penalties for certain wilful violations; and providing for an effective date."

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

*** Section 1.** AS 21.06.120(a) is amended to read:

(a) The director may examine the affairs, transactions, accounts, records, and assets of each authorized and formerly authorized insurer and each licensed and formerly licensed managing general agent, reinsurance intermediary broker, reinsurance intermediary manager, surplus lines broker, and surplus lines association as often as the director considers advisable. In scheduling and determining the nature, scope, and frequency of examinations, the director may consider any factor or material that the director determines is appropriate, including the results of financial statement analysis and ratios, competency of management or change of ownership, actuarial opinions, reports of independent certified public accountants, number and nature of consumer complaints, results of prior examinations, frequency of prior violations of statute and regulation, and criteria set out in the **most recent edition of the Financial Condition Examiners** [EXAMINERS'] Handbook **and the Market Regulation Handbook** [MOST RECENTLY] approved by the National Association of Insurance Commissioners and in effect when the director conducts an examination. Examination of an alien insurer may be limited to its insurance transactions and affairs in the United States. Examination of a reciprocal insurer may also include examination of its attorney-in-fact to the extent that the transactions of the attorney-in-fact relate to the insurer.

*** Sec. 2.** AS 21.06.140(f) is amended to read:

(f) In conducting an examination under this section, the examiner shall observe at a minimum those guidelines and procedures set out in the **most recent edition of the Financial Condition Examiners** [EXAMINERS'] Handbook **and the Market Regulation Handbook** [CURRENTLY] approved by the National Association of Insurance Commissioners that are consistent with this title.

*** Sec. 3.** AS 21.06.160(a) is amended to read:

(a) Each person examined, other than examinations under AS 21.06.130 **and examinations of managing general agents, third-party administrators, reinsurance intermediary managers, motor vehicle service contract providers, or surplus lines brokers**, shall pay a reasonable rate calculated on salary, benefit costs, and estimated division overhead for time spent directly or indirectly related to the examination. Each person examined, other than examinations under AS 21.06.130, shall pay actual out-of-pocket business expenses, including travel expenses, incurred by division staff examiners and shall pay the compensation of a contract examiner, to be set at a reasonable customary rate, for conducting the examination upon presentation of a detailed account of the charges and expenses by the director or under an order of the director. **The director may waive payment of all or part of the actual out-of-pocket business expenses incurred by division staff examiners, or the compensation of a contract examiner, if the director determines that payment of the expenses or compensation creates a financial hardship for a managing general agent, third-party administrator, reinsurance intermediary manager, motor vehicle service contract provider, or surplus line broker.** The accounting may either be presented periodically during the course of the examination or at the termination of the examination. A person may not pay and an examiner may not accept additional compensation for an examination. A person shall pay examination expenses to the division under this subsection using an electronic payment method specified by the director.

*** Sec. 4.** AS 21.07 is amended by adding a new section to read:

Sec. 21.07.005. Regulations. (a) The director shall adopt regulations to provide standards and criteria for

(1) the structure and operation of utilization review and benefit

determination processes;

(2) the establishment and maintenance of procedures by health care insurers to ensure that a covered individual has the opportunity for appropriate resolution of grievances; and

(3) an independent review of an adverse determination or final adverse determination.

(b) The regulations under (a) of this section must be at least as restrictive as the Utilization Review and Benefit Determination Model Act adopted by the National Association of Insurance Commissioners on June 22, 2003, the Health Carrier Grievance Procedure Model Act adopted by the National Association of Insurance Commissioners on June 22, 2003, and the Uniform Health Carrier External Review Model Act adopted by the National Association of Insurance Carriers on June 2, 2008.

(c) The director may adopt regulations for the registration and regulation of independent review organizations, including the establishment of fees in an amount the director determines to be sufficient to reimburse the state for actual expenses incurred in providing a service.

*** Sec. 5.** AS 21.07.010(a) is amended to read:

(a) A contract between a participating health care provider and a health care insurer 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;

(2) **clearly states that the health care provider will adhere to the health care insurer's policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing services under a treatment plan approved by the health care insurer;**

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

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

(5) [(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 **not later than** [WITHIN] 10 working days after the health care insurer 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, **not later than** [WITHIN] 30 days **after** [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;

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

(7) [(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

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

*** Sec. 6.** AS 21.07.020 is amended to read:

Sec. 21.07.020. Required contract provisions for health care insurance policy. A health care insurance policy must contain **a provision**

(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 **that meet the requirements under 42 U.S.C. 300gg-19a(b)** if any coverage is provided for treatment of **an** [A MEDICAL] emergency **medical condition**;

(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, 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 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; EXCEPT AS PROVIDED UNDER (6) OF THIS SECTION, THIS APPEAL

MECHANISM MUST PROVIDE FOR A WRITTEN DECISION

(A) FROM THE HEALTH CARE INSURER 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 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 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 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 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; THE EXTERNAL APPEAL SHALL BE 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;

(5) [(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;

(6) [(11) A PROVISION] describing **the** 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

(7) [(12) A PROVISION] describing available translation or interpreter services, including audiotape or braille information.

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

(d) If a health care insurer that offers a health care insurance policy requires or provides for a designation by a covered person of a participating primary care provider, the health care insurer shall permit the covered person to designate any participating primary care provider**, including a pediatrician,** 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 **and (h) of this section**, a health care insurer that offers a health care insurance policy 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 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 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 is amended by adding a new subsection to read:

(h) A health care insurer that offers a health care insurance policy that

provides coverage for obstetrical and gynecological care and that requires designation by a covered person of a participating primary care provider may not require authorization or referral for a female patient to receive obstetrical and gynecological care from a participating provider and shall treat authorizations by a health care provider who specializes in obstetrical or gynecological care as the authorization of the primary care provider. This section may not be construed to

(1) waive any exclusions of coverage under the terms and conditions of the health care insurance policy with respect to coverage of obstetrical and gynecological care; or

(2) preclude a health care insurer from requiring that the health care provider who specializes in obstetrical or gynecological care to notify the primary care provider or the health care insurer of treatment decisions.

*** Sec. 10.** AS 21.07.250(3) is repealed and reenacted to read:

(3) "emergency services" means medical care services or items furnished or required to evaluate and treat an emergency medical condition;

*** Sec. 11.** AS 21.07.250(14) is repealed and reenacted to read:

(14) "utilization review" means a set of techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings; techniques may include ambulatory review, prospective review, second opinion certification, concurrent review, case management, discharge planning, or retrospective review.

*** Sec. 12.** AS 21.07.250 is amended by adding a new paragraph to read:

(15) "emergency medical condition" means the sudden and, at the time, unexpected onset of a medical condition or illness that requires immediate medical attention and where failure to provide immediate medical attention would result in

(A) the placing of the person's health in serious jeopardy;

(B) a serious impairment to bodily functions; or

(C) a serious dysfunction of any bodily organ or part.

*** Sec. 13.** AS 21.09.320(b) is amended to read:

(b) To meet the requirements of (a) of this section, the insurer shall keep the

records [AS REQUIRED IN AS 21.69.390(d) OR] as required by the record maintenance requirements of the insurer's domicile jurisdiction[, WHICHEVER IS LONGER].

*** Sec. 14.** AS 21.09.320 is amended by adding new subsections to read:

(c) The director may make a request in writing to review records under (a) of this section. An insurer shall, not later than 10 business days after the date of the request, provide the requested records to the director or make the records available for inspection and copying. All records inspected or examined under this subsection are confidential, but may be used by the director in a proceeding against the insurer.

(d) Failure by an insurer to provide information required in this section may result in a civil penalty of up to $1,000 for each violation and an additional civil penalty of up to $50 for each day the information requested is not provided.

*** Sec. 15.** AS 21.12.090(b) is amended to read:

(b) For the purposes of this title**,** "wet marine and transportation" insurance is that part of marine insurance that includes only

(1) insurance **on** [UPON] vessels, crafts, **and** hulls**,** and **insurance** of interests in or with relation to vessels, crafts, and hulls;

(2) insurance of marine builder's risks, marine war risks**,** and contracts of marine protection and indemnity insurance;

(3) insurance of freights and disbursements pertaining to a subject of insurance coming within this section; **or** [AND]

(4) insurance of personal property and interests in personal property, in the course of exportation from or importation into any country, and in the course of transportation coastwise or on inland waters, including transportation by land, water, or air from point of origin to final destination, in respect to, appertaining to, or in connection with, any and all risks or perils of navigation, transit, or transportation, and while being prepared for and while awaiting shipment, and during delays, storage, transshipment, or reshipment incident thereto.

*** Sec. 16.** 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 class of authority**;

(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** [WITHIN] 30 days **after** [OF] a change in the firm's compliance officer.

*** Sec. 17.** AS 21.27.020(f) is amended to read:

(f) The director may adopt regulations establishing additional education or experience requirements for applicants**,** [OR] 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.

*** Sec. 18.** AS 21.27.025(a) is amended to read:

(a) A licensee shall notify the director in writing **not later than** [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**, 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**,** [OR] by a governmental agency of another jurisdiction**, or by a financial industry regulatory authority sanction or arbitration proceeding not later than** [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 **not later than** [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.

*** Sec. 19.** AS 21.27.150(a) is amended to read:

(a) The director may issue a

(1) travel insurance limited producer license to a person who is appointed under AS 21.27.100 and who sells travel insurance; in this paragraph, "travel insurance" has the meaning given in AS 21.27.152;

(2) title insurance limited producer license to a person whose place of business is located in this state and whose sole purpose is to be appointed by and act on behalf of a title insurer;

(3) bail bond limited producer license to a person who is appointed by and acts on behalf of a surety insurer pertaining to bail bonds;

(4) motor vehicle rental agency limited producer license to a person and, subject to the approval of the director, to employees of the person licensed that the licensee authorizes to transact the business of insurance on the licensee's behalf if, as to an employee, the licensee complies with (D) of this paragraph and if the licensee

(A) rents to others, without operators,

(i) private passenger motor vehicles, including passenger vans, minivans, and sport utility vehicles; or

(ii) cargo motor vehicles, including cargo vans, pickup trucks, and trucks with a gross vehicle weight of less than 26,000 pounds that do not require the operator to possess a commercial driver's license;

(B) rents motor vehicles only to persons under rental agreements that do not exceed a term of 90 days;

(C) transacts only the following kinds of insurance:

(i) motor vehicle liability insurance with respect to liability arising out of the use of a vehicle rented from the licensee during the term of the rental agreement;

(ii) uninsured or underinsured motorist coverage, with minimum limits described in AS 21.96.020(c) and (d) arising from the use of a vehicle rented from the licensee during the term of the rental agreement;

(iii) insurance against medical, hospital, surgical, and disability benefits to an injured person and funeral and death benefits to dependents, beneficiaries, or personal representatives of a deceased person if the insurance is issued as incidental coverage with or supplemental to liability insurance and arises out of the use of a vehicle rented from the licensee during the term of the rental agreement;

(iv) personal effects insurance, including loss of use, with respect to damage to or loss of personal property of a person renting the vehicle and other vehicle occupants while that property is being loaded into, transported by, or unloaded from a vehicle rented from the licensee during the term of the rental agreement;

(v) towing and roadside assistance with respect to vehicles rented from the licensee during the term of the rental agreement; and

(vi) other insurance as may be authorized by regulation by the director;

(D) notifies the director in writing, **not later than** [WITHIN] 30 days **after** [OF] employment, of the name, date of birth, social security number, location of employment, and home address of an employee authorized by the licensee to transact insurance on the licensee's behalf; and

(E) provides other information as required by the director;

(5) nonresident limited producer license to a person; a license that the director issues under this paragraph grants the same scope of authority as a limited lines producer license issued to the person by the person's home state;

(6) credit insurance limited producer license to a person who sells limited lines credit insurance;

(7) miscellaneous limited producer license to a person who transacts insurance in this state that restricts the person's authority to less than the total authority for a line of authority described in AS 21.27.115(1) - (6) [, (8), AND (9)];

(8) portable electronics limited producer license to a vendor that sells or offers portable electronics insurance as defined in AS 21.36.515; the following provisions apply to a license issued under this paragraph:

(A) a vendor shall file with the director a sworn application for a license under this paragraph on a form prescribed and furnished by the director; the vendor shall provide the name, residence address, location of the vendor's home office, and other information required by the director for an employee or officer that is designated by the vendor as the person responsible for the vendor's compliance with the requirements of this chapter; however, if the vendor derives more than 50 percent of its revenue from the sale of portable electronics insurance, the vendor shall provide the information required under this subparagraph for all officers, directors, and shareholders of record having beneficial ownership of 10 percent or more of any class of securities registered under the federal securities law;

(B) a portable electronics limited producer license issued under this paragraph must authorize the employees or authorized representatives of a

vendor to transact portable electronics insurance at each location at which a vendor offers portable electronics to customers in this state; and

(C) the employees or authorized representatives of the vendor may transact portable electronics insurance and are not required to obtain a limited producer license if

(i) the employees or authorized representatives are not compensated based primarily on the number of customers enrolled for coverage; however, an employee or authorized representative may receive compensation for activities under the license that is incidental to the employee's or authorized representative's overall compensation;

(ii) the insurer issuing the portable electronics insurance provides a training program for employees and authorized representatives of the portable electronics limited producer licensee that includes instruction about the portable electronics insurance offered to customers and the disclosures required under AS 21.36.515; and

(iii) the vendor maintains a register of each location in the state where the vendor offers portable electronics insurance and submits the register to the director **not later than** [WITHIN] 30 days after the director requests the register**;**

(9) crop insurance limited producer license to a person who sells or offers crop insurance coverage for damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease, or other yield-reducing conditions or perils provided by the private insurance market or that is subsidized by the Federal Crop Insurance Corporation, including multi-peril crop insurance.

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

(a) Except as provided in this title, the director may renew a license biennially on a date set by the director if the licensee continues to be qualified under this chapter and, on or before [THE CLOSE OF BUSINESS OF] the **license expiration** [RENEWAL] date, meets all renewal requirements established by regulation**, submits a renewal application,** and pays the renewal license fees set under AS 21.06.250 for

each license **authority** to the director. A licensee is responsible for knowing the date that a license **expires** [LAPSES] and for renewing a license before expiration. The director shall notify the licensee of the license renewal 30 days before the renewal date.

*** Sec. 21.** AS 21.27.380(b) is amended to read:

(b) If a license is not renewed on or before the renewal date set by the director, the license **expires** [LAPSES]. A licensee may not act as or represent to be an insurance producer, managing general agent, reinsurance intermediary broker, reinsurance intermediary manager, surplus lines broker, or independent adjuster during the time a license has **expired** [LAPSED]. The director may reinstate **an expired** [A LAPSED] license if the person continues to qualify for the license **and** [,] pays renewal license fees [,] and a delayed renewal penalty. Reinstatement does not exempt a person from a penalty provided by law for transacting business while unlicensed. A license may not be renewed if it has **expired** [LAPSED] for two years or longer.

*** Sec. 22.** AS 21.27.380(d) is amended to read:

(d) **The director shall mail a notice** [NOTICE] of **expiration** [LAPSE FROM THE DIRECTOR] stating the reason for the **expiration** [LAPSE SHALL BE MAILED] to a licensee at the licensee's last address on record with the director. The director shall obtain a certificate of mailing from the United States Postal Service.

*** Sec. 23.** 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** [WITHIN] 30 days **after** [OF]

(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** [THE SUSPENSION OR REVOCATION OF AN INSURANCE LICENSE OR REGISTRATION BY ANOTHER STATE OR JURISDICTION]; or

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

*** Sec. 24.** AS 21.27.650 is amended by adding a new subsection to read:

(r) An insurer shall review its books and records quarterly to determine whether a person or insurance producer has acted as the insurer's third-party administrator. If an insurer determines that a person or insurance producer has acted as the insurer's third-party administrator, the insurer shall promptly notify the person or insurance producer and the director of this determination. The insurer and the person or insurance producer must fully comply with the provisions of this chapter not later than 30 days after notification.

*** Sec. 25.** AS 21.27.690(b) is amended to read:

(b) An insurer may use a nonresident reinsurance intermediary broker who is not licensed under this chapter if **the reinsurance intermediary broker has filed a**

certification with the director that the reinsurance intermediary broker is operating only for a foreign insurer and the person is licensed in good standing as a resident reinsurance intermediary broker by an insurance regulator of another state that is accredited by the National Association of Insurance Commissioners. Upon written request, the director may grant written permission for a domestic insurer to use an alien reinsurance intermediary broker not licensed by and without a place of business in a jurisdiction subject to accreditation by the National Association of Insurance Commissioners if the alien reinsurance intermediary broker **has filed a certification with the director that the reinsurance intermediary broker is operating only for a domestic insurer and** is licensed in good standing by its domiciliary insurance regulator. The domestic insurer and unlicensed reinsurance intermediary broker are subject to all other requirements of this section.

*** Sec. 26.** AS 21.34.035(b) is amended to read:

(b) The rates and rating methods for health care insurance placed and written under this section are subject to **AS 21.51.405 and AS 21.54.015** [AS 21.87.190]. The surplus lines broker shall make the filings required under **AS 21.51.405 and AS 21.54.015** [AS 21.87.190] and maintain the records and accounts as required under AS 21.87.230.

*** Sec. 27.** AS 21.34.050(a) is amended to read:

(a) In addition to meeting the requirements of AS 21.34.040, a nonadmitted insurer shall be considered an eligible surplus lines insurer if it [PAYS FEES REQUIRED BY REGULATION AND] appears on the most recent list of eligible surplus lines insurers published by the director. The list is to be published at least semiannually by

(1) posting the list on the division's Internet website; and

(2) providing a copy of the list to a person on request to the division.

*** Sec. 28.** AS 21.34.050(c) is amended to read:

(c) A nonadmitted insurer shall be removed from the list of eligible surplus lines insurers if the nonadmitted insurer [FAILS TO PAY, BEFORE JULY 1 OF EACH YEAR, THE FEE AUTHORIZED UNDER THIS SECTION OR] fails to meet the requirement under AS 21.34.040(d). However, the director may reinstate a

nonadmitted insurer on the list of eligible surplus lines insurers if

[(1) THE NONADMITTED INSURER INADVERTENTLY FAILED TO PAY THE FEE OR MEET THE REQUIREMENT UNDER AS 21.34.040(d);

(2)] the nonadmitted insurer has remedied the reason for removal from the list [; AND

(3) THE NONADMITTED INSURER PAYS A LATE FEE AS ESTABLISHED BY REGULATION].

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

(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 **home state of the insured is this state and 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.

*** Sec. 30.** AS 21.36.025 is amended by adding new subsections to read:

(b) A person may not sell a membership in an association or labor union for the purpose of qualifying an individual for group insurance.

(c) A person that sells a membership in an association may not offer group insurance for purposes of selling membership in an association or labor union.

*** Sec. 31.** AS 21.36.185 is amended to read:

Sec. 21.36.185. Maintenance of complaint handling records. Except for records subject to health carrier grievance reporting and recordkeeping requirements established under AS 21.07.005, an [AN] insurer shall maintain a complete record of all the complaints received by the insurer since the date of the insurer's last market conduct examination under AS 21.06.120 or for four years, whichever occurs first. This record must indicate the total number of complaints, the

classification of each complaint by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this section, "complaint" means any written communication primarily expressing a grievance.

*** Sec. 32.** AS 21.36.225 is amended 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 **policyholder** [COVERED INDIVIDUAL] at least 45 days before the effective date of the cancellation.

(b) An insurer shall provide written notice to a **policyholder** [COVERED INDIVIDUAL] of changes in coverage or premium at least 45 days before the effective date of the change in coverage or premium.

*** Sec. 33.** AS 21.36.360(b) is amended to read:

(b) A fraudulent insurance act is committed by a person who, with intent to injure, defraud, or deceive

(1) collects a sum as premium or charge for insurance if the insurance has not been provided or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy authorized under this title;

(2) presents to an insurer a written or oral statement in support of a claim for payment or other benefit under an insurance policy, knowing that the statement contains false, incomplete, or misleading information **or omits information** concerning a matter material to the claim;

(3) assists or conspires with another to prepare or make a written or oral statement that is presented to an insurer in support of a claim for a benefit under an insurance policy, knowing that the statement contains false, incomplete, or misleading information **or omits information** concerning a matter material to the claim;

(4) wilfully collects as premium or charge for insurance a sum in excess of the premium or charge applicable to the insurance as specified in the policy by the insurer in accordance with the applicable classifications and rates approved by

the director, or in cases where classifications and rates are not subject to approval, the premiums and charges applicable to the insurance as specified in the policy and fixed by the insurer;

(5) fails to make disposition of funds received or held or misappropriates funds received or held representing premiums or return premiums; [OR]

(6) fails to pay its tax liability under this title when due**; or**

(7) makes a written or oral statement in response to an insurer's inquiries related to another person's claim for payment or other benefit under an insurance policy, knowing that the statement contains false, incomplete, or misleading information or omits information concerning a matter material to the claim.

*** Sec. 34.** 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) 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), [OR] (g)**, or (p)(2) or (3)** 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; **and**

(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) OF THIS SECTION MAY BE PROSECUTED UNDER AS 11.46].

*** Sec. 35.** AS 21.36.390(b) is amended to read:

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

violation of the provisions of **AS 21.36.030, 21.36.050, or 21.36.360** [AS 21.36.360] shall immediately send the director a report disclosing the basis for that belief and any other information that the director may require.

*** Sec. 36.** AS 21.39.040(a) is amended to read:

(a) Each insurer shall file with the director, except as to inland marine risks, which, by general custom of the business, are not written according to manual rates or rating plans, and except for rates for commercial insurance for which the director, by regulation authorizes an informational filing as set out in (k) of this section, every manual, minimum, class rate, rating schedule, loss cost adjustment, or rating plan and every other rating rule, and each modification of any of them that it proposes to use. Each filing

(1) shall be made under the applicable filing procedures in AS 21.39.041, 21.39.210, or 21.39.220;

(2) must state the proposed effective date**; the effective date may be**

(A) a specific date;

(B) the date the filing is approved by the director; or

(C) a date conditioned on some other event when approved by the director; and

(3) must indicate the character and extent of the coverage contemplated.

*** Sec. 37.** AS 21.39.070(a) is repealed and reenacted to read:

(a) Each member of or subscriber to a rating organization shall adhere to the filings made on its behalf by the organization except that an insurer may file with the director, in accordance with AS 21.39.040(a), a deviation from the class rates, schedules, rating plans, or rules respecting a kind of insurance, or class of risk within a kind of insurance, or a combination of them.

*** Sec. 38.** AS 21.42.160(d) is amended to read:

(d) Each policy and annuity contract issued by an insurer, and the forms thereof filed with the director, must have printed on them an appropriate designating letter or figure, or combination of letters or figures, or terms identifying the respective forms of policies or contracts [, TOGETHER WITH THE YEAR OF ADOPTION OF

THE FORM]. When a change is made in the form, the designating letters, figures, or terms [AND YEAR OF ADOPTION] must be correspondingly changed.

*** Sec. 39.** AS 21.42.250(c) is amended to read:

(c) An insurer may provide **an** [A PROPERTY AND CASUALTY] insurance policy or **endorsement** [ENDORSEMENTS] by posting the policy or endorsement on the insurer's Internet website and clearly identifying the posted policy or **endorsement** [ENDORSEMENTS] purchased by the insured in the declaration page provided to the insured. **An** [A PROPERTY AND CASUALTY] insurance policy or endorsement posted under this subsection

(1) must contain the standard or uniform provisions [FOR PROPERTY AND CASUALTY INSURANCE] required by AS 21.42.140;

(2) must be in a form approved by the director under AS 21.42.120;

(3) must be posted in a manner that reasonably allows the insured to retrieve and print or save the policy or endorsement from the website without paying a fee;

(4) must remain posted on the insurer's Internet website during the time that the policy or endorsement is in effect, be retained by the insurer for not less than three years after the policy or endorsement is no longer in effect, and be made available to the insured on request; and

(5) may not include personally identifiable information.

*** Sec. 40.** AS 21.45.020(d) is amended to read:

(d) For a variable life insurance policy or variable annuity contract, the refund under (c) of this section must equal the sum of

(1) 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**; and

(2) the **value of** 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. 41.** AS 21.48.010(a) is amended to read:

(a) A group life insurance policy may not be **issued for delivery**

[DELIVERED] in this state [INSURING THE LIVES OF MORE THAN ONE INDIVIDUAL] unless **the group is a bona fide association as defined in AS 21.97.900 or**

[(1)] the **group** [POLICYHOLDER] was formed for purposes other than obtaining insurance or is a trust established**, adopted, or participated in** by one or more employers or labor unions or by one or more employers and labor unions**, and**

(1) [; (2)] the policy covers at least two individuals at the date of issue;

(2) [(3)] an individual eligible for coverage is subject to uniformly applied standards of insurability as may be imposed by the insurer;

(3) [(4)] amounts of group life insurance are determined based on some plan that will preclude individual selection;

(4) [AND (5)] the group life insurance **policy** [CONTRACT] is in compliance with the other applicable provisions of this chapter**; and**

(5) the group meets other requirements established by the director in regulation.

*** Sec. 42.** AS 21.48.010(b) is amended to read:

(b) **This** [THE PROVISIONS OF (a) OF THIS] section **does** [DO] not apply to life insurance policies

(1) insuring only individuals related by blood, marriage, or legal adoption;

(2) insuring only individuals having a common interest through ownership of a business enterprise, or a substantial legal interest or equity in a business enterprise, and who are actively engaged in its management; or

(3) insuring only individuals otherwise having an insurable interest in each other's lives.

*** Sec. 43.** AS 21.48.010 is amended by adding new subsections to read:

(e) A group life insurance policy may be issued to a group that does not meet one or more of the requirements under (a) of this section only if the director finds that issuance

(1) is in the best interests of the public;

(2) results in economies of acquisition or administration; and

(3) meets other requirements established by the director in regulation.

(f) An insurer shall submit to the director information satisfactory to the director that the group meets the requirements of (a) or (e) of this section, and the director must affirmatively approve of the group before an insurer may issue a group life policy to a group under (a) or (e) of this section.

*** Sec. 44.** AS 21.51.020 is amended to read:

Sec. 21.51.020. Scope, format of policy. A policy of health insurance may not be delivered or issued for delivery to a person in this state unless it otherwise complies with this title, and complies with the following:

(1) the entire money and other considerations must be expressed in the policy;

(2) the time the insurance takes effect and terminates must be expressed in the policy;

(3) it must insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be considered the policyholder, any two or more eligible members of that family, including husband, wife, dependent children, or any children under a specified age, which **may** [SHALL] not exceed **25** [23] years, and any other person dependent **on** [UPON] the policyholder;

(4) the style, arrangement, and over-all appearance of the policy must give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of endorsements or attached papers must be plainly printed in light-faced type of a style in general use, the size of which must be uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point; in this paragraph, text includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions;

(5) the exceptions and reductions of indemnity must be set out in the policy and, other than those contained in AS 21.51.040 - 21.51.260, must be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and Reductions,"

except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies;

(6) each form, including riders and endorsements, must be identified by a form number in the lower left-hand corner of the first page;

(7) the policy may not contain a provision making a portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set out in full in the policy; this paragraph does not apply to the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the director.

*** Sec. 45.** AS 21.51.070(a) is amended to read:

(a) **Except for a policy offered or renewed in this state on a health care exchange and subject to federal regulations on reinstatement, there** [THERE] shall be a provision as follows:

"Reinstatement: If (1) a renewal premium is not paid within the time granted the insured for payment, (2) a subsequent acceptance of premium by the insurer or by an agent authorized by the insurer to accept the premium occurs, without requiring in connection therewith an application for reinstatement, and (3) the insurer issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of the application by the insurer or, lacking approval, upon the 45th day following the date of the conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from the accidental injury that may be sustained after the date of reinstatement and loss due to the sickness that may begin more than 10 days after that date. In all other respects, the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. A premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to a period more than 60 days

before the date of reinstatement."

*** Sec. 46.** AS 21.51.405(b) is amended 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 **90** [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 **90-day** [45-DAY] waiting period, notice is given stating that additional time for consideration of the filing is needed. A filing may become 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.

*** Sec. 47.** AS 21.51.500 is amended by adding a new paragraph to read:

(4) "health care exchange" means an American Health Benefit Exchange established under 42 U.S.C. 18031.

*** Sec. 48.** AS 21.53.068 is amended to read:

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 **does not compensate** [COMPENSATES] the issuer based on the number of policies issued.

*** Sec. 49.** AS 21.54.015(b) is amended to read:

(b) A health care insurer may decline to cover or may restrict the coverage offered to a self-employed individual under an association plan authorized under **AS 21.54.060(6)** [AS 21.54.060(7)].

*** Sec. 50.** AS 21.54.015(c) is amended 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 **90** [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 **90-day** [45-DAY] waiting period, notice is given stating that additional time for consideration of the filing is needed. A filing may become 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.

*** Sec. 51.** AS 21.54.060 is amended to read:

Sec. 21.54.060. Group health insurance defined. Group health insurance is that form of health insurance covering groups of persons as defined below, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of the groups of persons and issued **on** [UPON] the following basis:

(1) under a policy issued to an employer or trustees of a fund established by an employer, who shall be considered the policyholder, insuring employees of the employer for the benefit of persons other than the employer; in this paragraph the term "employees" includes the officers, managers, and employees of the employer, the individual proprietor or partner if the employer is an individual proprietor or partnership, the officers, managers, and employees of subsidiary or affiliated corporations, the individual proprietors, partners, and employees of individuals and firms if the business of the employer and the individual or firm is under common control through stock ownership, contract, or otherwise; in this paragraph, "employees" may include retired employees; a policy issued to insure employees of a public body may provide that the term "employees" includes elected or appointed officials; the policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship; a policy issued to insure employees of a corporation may provide that the term "employees" includes directors of the corporation, whether or not the directors receive compensation;

(2) under a policy issued to an association, including a labor union, that **is a bona fide association that** has a constitution and bylaws and that **insures** [HAS BEEN ORGANIZED AND IS MAINTAINED IN GOOD FAITH FOR PURPOSES OTHER THAN THAT OF OBTAINING INSURANCE, INSURING] members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees; in this paragraph, the term "employees" may include retired employees;

(3) under a policy issued to the trustees of a fund established**, adopted, or participated in** by two or more employers [IN THE SAME OR RELATED INDUSTRY] or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in (2) of this section, which trustees shall be considered the policyholder, to insure employees of the employers or members of the unions or of the association, or employees of members of the association, for the benefit of persons other than the employers or the unions or the association; in this paragraph, the term "employees" may include the officers, managers, and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership; in this paragraph, the term "employees" may include retired employees; the policy may provide that the term "employees" includes the trustees or their employees, or both, if their duties are principally connected with the trusteeship;

(4) under a policy issued to a person or organization to which a policy of group life insurance may be issued or delivered in this state to insure a class or classes of individuals that could be insured under the group life policy;

(5) [UNDER A POLICY ISSUED TO COVER ANY OTHER SUBSTANTIALLY SIMILAR GROUP THAT, IN THE DISCRETION OF THE DIRECTOR, MAY BE SUBJECT TO THE ISSUANCE OF A GROUP HEALTH INSURANCE POLICY OR CONTRACT;

(6)] a group health insurance policy that contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group may provide for the continuation of the benefit provisions,

or a part or parts of them, after the death of the person in the insured group;

(6) [(7)] under a policy issued to an association of employers covering the employees and dependents of the employees, or issued to an association of self-employed individuals covering self-employed individuals and dependents of the self-employed individuals, or issued to an association that includes a combination of employers and self-employed individuals; for purposes of this paragraph,

(A) an association described under this paragraph shall comply with the following requirements:

(i) the association shall have a constitution and bylaws;

(ii) the association shall be maintained in good faith for the benefit of persons other than the association or its officers or trustees;

(iii) membership in the association shall be restricted to large or small employers, or self-employed individuals, who are residents of the state; however, an employer domiciled in another state may become a member of the association for purposes of obtaining coverage through the association only for the employees and dependents of the employees of that employer who are residents of this state;

(iv) except as provided under AS 21.54.015, the association may not condition membership in the association or coverage under a health insurance policy issued to the association on any of the factors listed under AS 21.54.100(a);

(B) "self-employed individual" means an individual who derives a substantial portion of the individual's income from a trade or business through which the individual has attempted to earn taxable income and for which the individual has filed the appropriate Internal Revenue Service form and schedule for the previous taxable year.

*** Sec. 52.** AS 21.54.060 is amended by adding new subsections to read:

(b) An insurer may issue a group health insurance policy to a group that does not meet one or more of the requirements under (a)(1) - (4) and (6) of this section on a

finding by the director that issuance of a group policy to the group

(1) is in the best interests of the public;

(2) results in economies of acquisition or administration; and

(3) meets other requirements adopted by the director by regulation.

(c) An insurer must submit to the director information satisfactory to the director that the group meets the requirements of (b) of this section and the director must affirmatively approve of the group before an insurer may issue a group health insurance policy under (b) of this section.

*** Sec. 53.** AS 21.54.500(4) is repealed and reenacted to read:

(4) "bona fide association" has the meaning given in AS 21.97.900;

*** Sec. 54.** AS 21.56.110(a) is amended to read:

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

*** Sec. 55.** AS 21.56.120(e) is amended to read:

(e) In determining the premium rates for a small employer covered under an association health insurance policy authorized under **AS 21.54.060(6)** [AS 21.54.060(7)], a small employer insurer may not use the claims experience of the small employer while the employer was covered under another health insurance policy and may use only that underwriting information obtained through the insurer's normal application process for new small employer groups that are not written under the association plan.

*** Sec. 56.** AS 21.56.250(6) is amended to read:

(6) "bona fide association" has the meaning given in **AS 21.97.900** [AS 21.54.500];

*** Sec. 57.** AS 21.59.150 is amended to read:

Sec. 21.59.150. Provider license renewal, expiration [LAPSE], reinstatement. (a) A provider may renew a license issued under AS 21.59.110 - 21.59.290 biennially on a date set by the director if the licensee continues to be qualified under AS 21.59.110 - 21.59.290 and, on or before the close of business of the renewal date, meets all renewal requirements established by regulation, and pays

the renewal license fees set by the director. A licensee is responsible for knowing the date that a license will **expire** [LAPSE] and for renewing a license on or before that date. The director shall notify the licensee of the impending **expiration** [LAPSE] 30 days before the **expiration** [LAPSE] date. The director may not renew a license except in compliance with AS 21.59.110 - 21.59.290 and may not renew the license of a person, or to be exercised by a person, found by the director to be untrustworthy, incompetent, or financially irresponsible, or who has not established to the satisfaction of the director that the person is qualified under AS 21.59.110 - 21.59.290.

(b) If a provider's license is not renewed on or before the **expiration** [LAPSE] date set by the director, the license **expires** [LAPSES]. A licensee may not act as or represent to be a provider during the time a license has **expired** [LAPSED]. The director may reinstate **an expired** [A LAPSED] license if the person continues to qualify for the license and pays license renewal fees and a delayed renewal penalty. Reinstatement does not exempt a person from a penalty provided by law for transacting business while unlicensed. A license that has **expired** [LAPSED] for two years or longer may not be renewed.

*** Sec. 58.** AS 21.59.170(a) is amended to read:

(a) A motor vehicle service contract must allow the service contract holder to cancel the motor vehicle service contract **not later than** [WITHIN] 30 days after the date that the motor vehicle service contract was delivered to the service contract holder, **not later than** [WITHIN] 10 days after the date of delivery if the motor vehicle service contract is delivered to the service contract holder at the time of sale, or within a longer period, as set out in the motor vehicle service contract. If the service contract holder returns the motor vehicle service contract to the provider within the applicable time period and a claim has not been made under the motor vehicle service contract before the contract is returned to the provider, the motor vehicle service contract is void, and the provider shall refund the full amount of the provider fee to the service contract holder or credit the account of the service contract holder **not later than** [WITHIN] 45 days after the return of the contract to the provider. If the provider does not pay or credit a refund owed under this subsection **not later than** [WITHIN] 45 days after a service contract holder returns a motor vehicle service contract, a

penalty in the amount of 10 percent of the [UNEARNED] provider fee paid by the service contract holder for each month the refund remains unpaid shall be added to the refund. The right to void the motor vehicle service contract provided in this subsection is not transferable and applies only to the original service contract holder for a contract under which a claim is not made before the contract is returned to the provider.

*** Sec. 59.** AS 21.59.170(b) is amended to read:

(b) After the time specified in (a) of this section, or if a claim has been made under the motor vehicle service contract within that time, a service contract holder may cancel the motor vehicle service contract, and the provider shall refund to or credit the account of the contract holder the prorated amount of the unearned provider fee, less any claims paid, **not later than** [WITHIN] 45 days after the return of the service contract to the provider. If the provider does not pay or credit a refund owed under this subsection **not later than** [WITHIN] 45 days after a service contract holder returns a motor vehicle service contract, a penalty in the amount of 10 percent of the unearned provider fee paid by the service contract holder for each month the refund remains unpaid shall be added to the refund. A provider may charge a reasonable cancellation fee not to exceed 7.5 percent of the **unearned** provider fee paid by the service contract holder.

*** Sec. 60.** AS 21.59.180(a) is amended to read:

(a) To ensure the faithful performance of a provider's obligations to its service contract holders, a provider shall either

(1) obtain from an insurer or risk retention group authorized to transact the business of insurance in the state insurance that either reimburses the provider for obligations arising from a provider's motor vehicle service contract issued in the state or, if the provider fails to perform its obligations under a motor vehicle service contract issued in the state, pays to the service contract holder the provider's covered contractual obligations under the terms of the service contract on behalf of the provider; **an** [A PROVIDER] insurer issuing a policy under this paragraph must satisfy one of the following:

(A) maintain surplus as to policyholders and paid-in capital of at least $15,000,000 and annually file with the director copies of the provider's

financial statements, its annual statement to the National Association of Insurance Commissioners, and the statement of actuarial opinion and opinion summary required by and filed in the provider's state of domicile; or

(B) maintain surplus as to policyholders and paid-in capital at least equal to $10,000,000, but not more than $15,000,000, and demonstrate to the satisfaction of the director that the company maintains a ratio of net written premiums, wherever written, to surplus as to policyholders and paid-in capital of not greater than 3 to 1 and annually files with the director copies of the provider's audited financial statements, its annual statement to the National Association of Insurance Commissioners, and the statement of actuarial opinion and opinion summary required by and filed in the provider's state of domicile; or

(2) maintain, solely or together with the parent company, a net worth or stockholders' equity of $100,000,000 and, upon request by the director, provide the director with a copy of the provider's or the parent company's most recent annual report filed with the United States Securities and Exchange Commission within the last calendar year or, if the company does not file with the United States Securities and Exchange Commission, a copy of the company's audited financial statements, which show a net worth of the provider or its parent company of at least $100,000,000; if the parent company's annual report or financial statements are filed to meet the provider's financial stability requirement, then the parent company shall agree to guarantee the obligations of the provider relating to motor vehicle service contracts sold by the provider in this state.

*** Sec. 61.** AS 21.69.310(a) is amended to read:

(a) Meetings of stockholders or members of a domestic insurer shall be held in the city or town of its principal office or place of business [IN THIS STATE]. The meetings may be held, for good cause, in another location [WITHIN THE STATE] upon approval of the director.

*** Sec. 62.** AS 21.69.310(c) is amended to read:

(c) Each insurer shall, during the first six months of each calendar year, hold the annual meeting of its stockholders or members to fill vacancies existing or

occurring in the board of directors, receive and consider reports of the insurer's officers as to its affairs, and transact other business which may properly be brought before it. **The director may approve a later date for the annual meeting upon written request by the insurer and with good cause shown. The request for a later annual meeting date shall be made in writing to the director at least 30 days before the end of the six-month requirement. Not** [NO] less than 20 days' notice shall be given of the meeting in the manner provided in the bylaws, except where notice of the annual meeting of a mutual insurer is contained in its policies.

*** Sec. 63.** AS 21.69.390(b) is amended to read:

(b) A person determined by the director, following an appropriate hearing as provided in AS 21.06.170 - 21.06.230, to have removed or attempted to remove any records from the place where they are required to be kept under (a) [OR (d)] of this section with the intent to wrongfully remove them, or to have concealed or attempted to conceal them from the director, is subject to a civil penalty of not more than $25,000. If a domestic insurer violates a provision of this section the director may institute delinquency proceedings against the insurer under the provisions of AS 21.78.

*** Sec. 64.** AS 21.85.500(5) is amended to read:

(5) "multiple employer welfare arrangement" has the meaning given in 29 U.S.C. 1002; ["MULTIPLE EMPLOYER WELFARE ARRANGEMENT" DOES NOT INCLUDE A GROUP THAT THE DIRECTOR DESIGNATES UNDER AS 21.54.060(5) AS SUBJECT TO ISSUANCE OF A GROUP HEALTH INSURANCE POLICY;]

*** Sec. 65.** AS 21.97.020 is amended to read:

Sec. 21.97.020. General penalty. A person determined by the director, following an appropriate hearing as provided in AS 21.06.170 - 21.06.230, to have **wilfully** violated a provision of this title or a regulation adopted under it [, FOR WHICH VIOLATION A GREATER PENALTY IS NOT PROVIDED IN THIS TITLE,] is subject to a civil penalty of not more than **$25,000** [$2,500].

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

(47) "bona fide association" means an association

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

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

(C) for which insurance is not required to become a member of the association;

(D) in which members of the association share a common enterprise or economic social affinity or relationship;

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

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

(G) in which an individual eligible for coverage is subject to uniformly applied standards of insurability as may be imposed by the insurer;

(H) in which premiums for the group insurance policy are actuarially sound;

(I) that does not offer an insurance policy to an individual other than in connection with a member of the association; and

(J) that meets other requirements established by the director in regulations.

*** Sec. 67.** AS 21.06.087; AS 21.07.250(9); AS 21.54.500(4); and AS 21.69.390(d) are repealed.

*** Sec. 68.** AS 21.07.050, 21.07.060, 21.07.070, 21.07.250(1), 21.07.250(2), and 21.07.250(7) are repealed.

*** Sec. 69.** AS 21.27.115(8) and 21.27.115(9) are repealed.

*** Sec. 70.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Commerce, Community, and Economic Development may adopt regulations necessary to implement this Act, except that the effective date of the regulations may not be earlier than the effective date of the statutes being implemented.

*** Sec. 71.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

REVISOR'S INSTRUCTION. The revisor of statutes is requested to change the catch line of AS 21.27.380 from "License renewal, lapse, and reinstatement" to "License renewal, expiration, and reinstatement."

*** Sec. 72.** Section 70 of this Act takes effect immediately under AS 01.10.070(c).

*** Sec. 73.** Section 68 of this Act takes effect January 1, 2017.

*** Sec. 74.** AS 21.27.150(a)(9), enacted by sec. 19 of this Act, and sec. 69 of this Act take effect March 1, 2017.