



LAWS OF ALASKA

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Chapter No.

177

AN ACT

Relating to medical malpractice and health insurance coverage; and providing for an effective date.

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

* Section 1. PURPOSE. The purpose of this Act is to insure that no person suffers denial or revocation of licensure for failure to procure insurance from the Medical Indemnity Corporation of Alaska as required by ch. 102 SLA 1976. This Act is for the further purpose of insuring that the coverage of occurrence policies issued by the Medical Indemnity Corporation of Alaska before the effective date of this Act continues to extend to claims arising out of occurrences covered by policies issued before the effective date of this Act, but that (1) the Medical Indemnity Corporation of Alaska need not be liable on an occurrence basis for any claims arising under policies newly issued or renewed after the effective date of this Act; (2) persons who procured coverage from the Medical Indemnity Corporation of Alaska before the effective date of this Act neither be allowed to cancel the coverage procured nor evade the requirement of payment of premiums for that coverage; and (3) persons who did not procure retroactive coverage from the Medical Indemnity Corporation of Alaska by January 1, 1977 are not entitled to, nor may the Medical Indemnity Corporation of Alaska issue, that coverage. This Act is for the further purpose of assuring that the Medical Indemnity Corporation of Alaska remains a viable and competitive market for malpractice insurance. The purpose of the amendment made in sec. 22 of this Act and of the amendments of the provisions of AS 8 in this Act is to assure that medical care is not denied to any person by virtue of his failure or refusal to enter into an agreement with a health care provider in the medical, dental and related professions to submit to arbitration claims arising under health care or treatment provided.

* Sec. 2. AS 21.78.050 is amended by adding a new paragraph to read:

(3) is the Medical Indemnity Corporation of Alaska, and the director has ordered termination of the business of the corporation in accordance with AS 21.88.055.

* Sec. 3. AS 21.78.100(b) is amended to read:

(b) The director may apply for and secure an order dissolving the corporate existence of a domestic insurer, except the Medical Indemnity Corporation of Alaska, upon his application for an order of liquidation of the insurer or at any time after the order has been granted.

* Sec. 4. AS 21.88.030(a)(1) is repealed and re-enacted to read:

(1) four physicians licensed in the state and engaged in private practice in the state; no more than two of the physicians shall practice or live in a municipality having a population of more than 100,000, and two of the physicians must be indemnified against loss by reason of liability for an act or omission in the delivery of professional health care by the Medical Indemnity Corporation of Alaska;

* Sec. 5. AS 21.88.030 is amended by adding a new subsection to read:

(f) No governor, officer, or employee or former governor, officer, or employee of the corporation is liable for damages or other relief in any action by reason of his actions or inactions as a governor, officer, or employee of the corporation, or by reason of the actions or inactions of the corporation, its board of governors, officers or employees unless the person acts with actual knowledge that he was acting outside the scope of his authority, or unless at the time he was acting for a purpose which he knew was not in the best interests of the corporation, or with respect to any criminal action he had actual knowledge or should have known his action was unlawful. If a claim or action is brought against a person entitled to the protection of this subsection, the claim or action shall be defended by the state. If it is established that the person was acting with actual knowledge that he was acting outside the scope of his authority, or at the time was acting for a purpose which he knew was not in the best interests of the corporation, or with respect to any criminal action he had actual knowledge or should have known his action was unlawful, then he shall reimburse the state for the cost to the state of his defense.

* Sec. 6. AS 21.88.050(a)(1) is amended to read:

(1) in the form approved by the director, issue to all physicians and hospitals who are found to be acceptable risks under standards developed under (8) of this subsection, and who pay the premiums for it a contract or contracts indemnifying physicians and hospitals and their employees who are health care providers against loss by reason of liability for covered claims for an act or omission in the delivery of professional health care in this state, and agreeing to tender on behalf of the physicians and hospitals and their employees who are health care

providers a defense to a covered claim in a proceeding brought under AS 09.55.530 - 09.55.560; the minimum limit of liability issued to physicians shall be \$200,000 per occurrence and \$600,000 aggregate liability per year, and the minimum limit of liability provided in contracts issued to hospitals shall be \$200,000 per occurrence and an annual aggregate liability of \$1,000,000 minimum plus an additional \$20,000 per bed for each occupied bed over 50; the contract shall cover the defense against but need not indemnify liability for punitive damages arising from a covered claim; at the option of the physician or hospital and for an additional premium the contract may cover claims against the physician or hospital that arise out of professional services performed by the physician or hospital for any period after December 31, 1974 if the coverage is issued before January 1, 1977 except that coverage will not be provided for a claim already filed or of which the physician or hospital had or reasonably should have had notice at the time the retroactive insurance was purchased;

* Sec. 7. AS 21.88.050(a) is amended by adding a new paragraph to read:

(8) establish standards for the acceptability of risks; in establishing these standards the corporation may exclude a physician based on individual risk selection factors, but may not exclude a physician based only on the classification of the physician.

* Sec. 8. AS 21.88.050(b)(2) is repealed and re-enacted to read:

(2) negotiate for and procure reinsurance from private casualty insurers or reinsurers for any and all liability incurred by contracts issued by it;

* Sec. 9. AS 21.88.050(b) is amended by adding new paragraphs to read:

(10) for an additional premium provide coverage to physicians and hospitals for liability in excess of the minimum limits of liability coverage required to be maintained under (a)(1) of this section, but limited to \$1,000,000 for physicians and \$5,000,000 for hospitals;

(11) in a form approved by the director and for an additional premium determined under sec. 80 of this chapter, issue endorsements which provide indemnity for claims not yet reported which arise out of professional services rendered during a period of continuous coverage under the originally issued contract, to physicians and hospitals who pay the premium for it and who are terminating their original covered claims contract with the corporation for a period of not less than one year;

* Sec. 10. AS 21.88.050(b) is amended by adding a new paragraph to read:

(12) subject to specific approval by the director, extend coverage to corporate entities which

(A) own an establishment licensed as a hospital and insured by the corporation;

(B) provide health care through physicians who are the corporation's sole stockholders, and all of whom are insured by the corporation; or

(C) are nonprofit organizations formed principally for the purpose of providing health care under the direct supervision of employed physicians, provided all the physicians are insured by the corporation.

* Sec. 11. AS 21.88 is amended by adding a new section to read:

Sec. 21.88.055. TERMINATION. (a) If at any time the corporation posts written premiums for two consecutive years of less than 35 per cent of all premiums written in Alaska for physicians' medical malpractice insurance or posts written premiums for one calendar year of less than 20 per cent of all premiums written in Alaska for physicians' medical malpractice, the director may hold a public hearing in accordance with AS 21.06.180 - 21.06.230 to determine whether the business of the corporation should be terminated.

(b) Upon the effective date of an order of termination issued by the director under (a) and (d) of this section, the terms of the governors appointed under sec. 30 of this chapter expire, and the corporation, its governors, officers and employees are relieved of all further liabilities for all their obligations to the creditors and policyholders of the corporation, and the business of the corporation shall be liquidated according to ch. 78 of this title.

(c) At any time after termination of the corporation by the director, the director may, after public hearing held in accordance with AS 21.06.180 - 21.06.230 and (d) of this section, order reactivation of the corporation if the director finds that malpractice insurance is unavailable for physicians and hospitals on the voluntary market. The business of the corporation shall commence operation upon appointment by the governor of new governors to the board.

(d) In determining whether to terminate or reactivate the business of the corporation the director shall consider the following:

(1) the level of expected premiums and losses for continued operation;

(2) the requirement for state funds to support continued operation;

(3) the availability of alternative markets for coverage to a substantial majority of physicians and hospitals in the state;

(4) the costs of continued operation of the corporation;

(5) the impact that the continued operation of the corporation will have on rates charged for coverage by the corporation or by alternative markets; or

(6) the expected number of physicians or hospitals who would participate if the operations were continued.

(e) If after public hearing held in accordance with (a) and (c) of this section the director determines that continuing the business of the corporation would result in substantial underwriting loss unless excessive premiums are charged to participating physicians and hospitals, the director may order termination of the corporation.

* Sec. 12. AS 21.88.060 is amended by adding a new subsection to read:

(b) The corporation is exempt from taxation under this section for a period of five years starting from July 1, 1978.

* Sec. 13. AS 21.88.080(4) and (5) are amended to read:

(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which is actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for covered claims reported and unpaid, reserves for covered claims incurred during the policy period and not reported, and reasonable expenses for the operation of the corporation;

(5) rates shall not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including covered claims paid, reserves for covered claims reported and unpaid, reserves for covered claims incurred during the policy period and not reported, and reasonable expenses for the operation of the corporation;

* Sec. 14. AS 21.88.070 is amended to read:

Sec. 21.88.070. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers which it insures. The information shall be on forms prescribed by the director, and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. At least annually the corporation shall report to the director the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to and the expenses incurred by the corporation during the year. This report shall be available to the public. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become available to the public may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All statistics including the supplemental reports shall be made available to the State Medical Board.

* Sec. 15. AS 21.88.080 is amended by adding new paragraphs to read:

(15) if the earned premiums of the corporation for any given year are less than the incurred claims, claim expense, underwriting expense, reserves for that year and provision for repayment of any loans, the corporation may, subject to the prior approval of the director, levy an assessment upon the insureds who held policies during that year; the assessment, which may be made in periodic installments, shall be made within three years and may not exceed 150 per cent of the physician's premium for that year; the termination of any policy does not relieve the insured of contingent liability for his proportionate share of the obligations to the corporation which accrued while the policy was in force;

(16) if the earned premiums of the corporation for any given year exceed its incurred claim expense, underwriting expense, reserves for that year and provision for repayment of any loan, the corporation may, subject to the prior approval of the director, apportion and pay or credit its insureds who held policies during that year; a payment or credit shall be proportionate to the insured's earned premium for that year;

(17) if the corporation develops a surplus of assets over all liabilities, including the repayment of any loan provision, which is at least equal to the minimum capital stock required of a new domestic stock insurer authorized to transact like kinds of insurance, upon application, the director shall issue his certificate authorizing the corporation to extinguish the assessment provision under (15) of this section to all insured with policies then in force, and to omit provisions imposing the assessment under (15) of this section in all policies delivered or issued for delivery for as long as all the surplus remains unimpaired; upon impairment of the surplus, the director shall immediately revoke the certificate; however, a policy then in force, and for the remainder of the period for which the premium has been paid, is not subject to the revocation of the assessment provision under (15) of this section, but after revocation no policy may be issued or renewed without providing for an assessment of the insured under (15) of this section.

* Sec. 16. AS 21.88 is amended by adding a new section to read:

Sec. 21.88.095. TRANSFER OF CORPORATE ASSETS AND LIABILITIES. (a) The corporation may, subject to the prior approval of the director, transfer its assets and liabilities to a company which meets all of the following conditions:

(1) the company possesses a valid certificate of authority to transact casualty insurance business in the state; in evaluating the capital and surplus of the company for qualification for a certificate of authority, the value of the assets and liabilities transferred by the corporation may not be considered;

(2) the company pays to the corporation the full value of any surplus in the corporation not represented by any unrepaid proceeds of loans by the loan fund to the corporation;

(3) the company executes a complete reinsurance and hold harmless agreement in a form approved by the director covering all of the obligations of the corporation to its creditors and policyholders; and

(4) the company executes modifications of loan agreements with the loan fund by which the company agrees

(A) to assume the obligations;

(B) that, if at any time the company writes less than the premium levels provided in sec. 55(a) of this chapter, the director may determine that the loan provisions shall be modified to provide a scheduled amortization repayment of the principal over a period not to exceed 10 years and at an interest rate of four points above the federal discount rate, as that rate is adjusted from time to time; and

(C) that the provision for repayment provided in sec. 210(b)(1) of this chapter shall be modified to provide for annual installments of at least 25 per cent of the excess of premium and investment income collected over the total of claims, reserves and expenses on the Alaska medical malpractice book of business or 25 per cent of the excess of premiums and investment income collected over the total of claims, reserves and expenses on the corporation's total book of business, whichever is greater;

(5) the company meets such other requirements as the director may reasonably require to protect the interests of the state, the health care provider insureds, the involved company, and the public;

(6) the company provides the board of governors with a written statement from the director that the company qualifies under (1) - (5) of this subsection.

(b) If and while the company to which the assets and liabilities of the corporation are transferred in the manner provided in (a) of this section continues to write premiums in excess of the levels provided in sec. 55 of this chapter, it shall enjoy the benefit of the following provisions:

(1) the company is entitled to carry forward and offset against its premium tax obligation to the state the amount by which the aggregate claims paid on reinsurance assumed under (a)(3) of this section exceeds aggregate reserves on the same business established at the date of the reinsurance agreement; and

(2) the obligation to repay to the loan fund loans assumed by the company at the time of transfer of the assets and liabilities of the corporation need not be shown as a liability on the books of the corporation.

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* Sec. 17. AS 21.88.210(b)(1) is amended to read:

(1) to provide surplus in respect to policyholders which may not exceed a total of \$3,000,000 outstanding at any time; these obligations shall be subordinated to all other obligations of the corporation; loans made under this paragraph shall be repaid to the fund in annual installments of at least 25 per cent of the excess of premiums collected over the total of claims, reserves, expenses, and assessments made by the association, if any; interest shall be paid on the outstanding balance at a rate equal to seven per cent a year;

* Sec. 18. AS 21.88.210(b)(2) is amended to read:

(2) if the director determines that the corporation is unable to procure reinsurance from a private casualty insurer or reinsurer for any liability incurred by contracts issued by it, additional loans up to an aggregate of \$6,000,000 when taken together with loans made under (1) of this subsection to compensate for fluctuations in loss experience; loans made under this paragraph shall be in parity with all other obligations of the corporation except that they shall be subordinated to obligations of policyholders and claimants for indemnity of loss; these loans shall be repaid within five years at an annual interest rate of six per cent.

* Sec. 19. AS 21.88.900(4) is repealed and re-enacted to read:

(4) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital; a corporate entity covered under AS 21.88.050(b)(12); and an employee of a health care provider acting within the course and scope of his employment;

* Sec. 20. AS 21.88.900 is amended by adding new paragraphs to read:

(16) "continuous coverage" means one or more successive policy periods which is uninterrupted by cancellation or failure to renew for any reason;

(17) "covered claim" means

(A) a claim by an injured patient reported to the corporation during the period of continuous coverage by the corporation of the insured health care provider for an act or omission in the delivery of health care services during the same period of continuous coverage; and

(B) additional claims as defined in the policy, with the prior approval of the director, and

which are reported within specified periods after the expiration of the policy.

* Sec. 21. (a) The coverage obligations and duties of the insured under policies issued by the Medical Indemnity Corporation of Alaska before the effective date of this Act may not be breached without the consent of the Medical Indemnity Corporation of Alaska and the director of the division of insurance.

(b) All policies issued by the Medical Indemnity Corporation of Alaska and in force on the effective date of this Act are terminated as of the first annual renewal of the in-force policy after the effective date of this Act. A person purchasing a policy for any term beginning after the effective date of this Act shall be issued a policy to cover only "covered claims" as defined in AS 21.88.900(17), added in sec. 20 of this Act, which occur after the effective date of this Act.

* Sec. 22. AS 09.55.535(a) is amended to read:

(a) A patient and any health care provider may execute an agreement to submit to arbitration any dispute, controversy, or issue arising out of care or treatment by the health care provider during the period that the agreement is in force or that has already arisen between the parties. Execution of an agreement under this subsection by a patient may not be made a prerequisite to receipt of care or treatment by the health care provider.

* Sec. 23. AS 09.55.536(a) is amended to read:

(a) In an action for damages due to personal injury or death based upon the provision of professional services by a health care provider when the parties have not agreed to arbitration of the claim under sec. 535 of this chapter, the court shall appoint within 20 days after filing of answer to a summons and complaint a three-person expert advisory panel unless the court decides that an expert advisory opinion is not necessary for a decision in the case. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel, giving the parties the opportunity to object or make suggestions.

* Sec. 24. AS 09.55.560(1) is amended to read:

(1) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital; a corporate entity covered under AS 21.88.050(b)-(12); and an employee of a health care provider acting within the course and scope of his employment;

* Sec. 25. AS 08.20.170(a)(3) is amended to read:

(3) unprofessional conduct, including but not limited to the denial of care or treatment to a patient or person seeking assistance from the chiropractor if the sole reason for the denial is the failure or refusal of the patient or person seeking assistance to execute an agreement to arbitrate a dispute, controversy, or issue arising out of the care or treatment, as provided in AS 09.55.-535(a);

* Sec. 26. AS 08.36.310 is amended by adding a new paragraph to read:

(28) denies care or treatment to a patient or person seeking assistance from the dentist if the sole reason for the denial is the failure or refusal of the patient or person seeking assistance to execute an agreement to arbitrate a dispute, controversy, or issue arising out of the care or treatment, as provided in AS 09.55.-535(a).

* Sec. 27. AS 08.64.380(3)(A) is amended to read:

(A) a violation of the provisions of AS 11.15.060;

* Sec. 28. AS 08.64.380(3)(G) is amended to read:

(G) violating any code of ethics adopted by regulation by the State Medical Board;

* Sec. 29. AS 08.64.380(3) is amended by adding a new subparagraph to read:

(H) denial of care or treatment to a patient or person seeking assistance from the physician if the sole reason for the denial is the failure or refusal of the patient to execute an agreement to arbitrate a dispute, controversy, or issue arising out of the care or treatment, as provided in AS 09.55.-535(a).

* Sec. 30. AS 08.68.270 is amended by adding a new paragraph to read:

(11) denies care or treatment to a patient or person seeking assistance if the sole reason for the denial is the failure or refusal of the patient or person seeking assistance to execute an agreement to arbitrate a dispute, controversy, or issue arising out of the care or treatment, as provided in AS 09.55.535(a).

* Sec. 31. AS 08.71.170 is amended by adding a new paragraph to read:

(15) denies care or treatment to a patient or person seeking assistance from the optician if the sole reason for the denial is the failure or refusal of the patient to execute an agreement to arbitrate a dispute, controversy, or issue arising out of the care or treatment, as provided in AS 09.55.535(a).

* Sec. 32. AS 08.72.240 is amended by adding a new paragraph to read:

(4) denies care or treatment to a patient or person seeking assistance from the optometrist if the sole reason for the denial is the failure or refusal of the patient or person seeking assistance to execute an agreement to arbitrate a dispute, controversy, or issue arising out of the care or treatment, as provided in AS 09.55.535(a).

* Sec. 33. AS 08.80.260 is amended by adding a new paragraph to read:

(10) denial of care or treatment to a patient or person seeking assistance from the pharmacist if the sole reason for the denial is the failure or refusal of the patient or person seeking assistance to execute an agreement to arbitrate a dispute, controversy or issue arising out of the care or treatment, as provided in AS 09.55.535(a).

* Sec. 34. AS 08.86.070 is amended by adding a new subsection to read:

(b) The board may, after hearing, suspend or revoke the license of a licensed psychologist or psychological associate if he denies care or treatment to a patient or person seeking assistance from the psychologist or psychological associate and the sole reason for the denial is the failure or refusal of the patient or person seeking assistance to execute an agreement to arbitrate a dispute, controversy, or issue arising out of the care or treatment, as provided in AS 09.55.535(a).

* Sec. 35. AS 18.23 is amended by adding a new section to read:

Sec. 18.23.065. PATIENT ACCESS TO RECORDS. Notwithstanding the provisions of this chapter or any other law, a patient is entitled to inspect and copy any records developed or maintained by a health care provider or other person pertaining to the health care rendered to the patient.

* Sec. 36. AS 18.23.070(3) is amended to read:

(3) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist registered under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital; a corporate entity covered under AS 21.88.050(b)(12); and an employee of a health care provider acting within the course and scope of his employment;

* Sec. 37. AS 18.23.070(5) is repealed and re-enacted to read:

(5) "review organization" means

(A) a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320c-1 et seq., to gather and review information relating to the care and treatment of patients for the purposes of

(i) evaluating and improving the quality of health care rendered in the area or medical institution;

(ii) reducing morbidity or mortality;

(iii) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(iv) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(v) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

(vi) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(vii) acting as a professional standards review organization under 42 U.S.C., sec. 1320c-1 et seq.;

(viii) reviewing, ruling on, or advising on controversies, disputes or questions between a health insurance carrier or health maintenance organization and one or more of its insured or enrollees; between a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board; between a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee; between a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or enrollee; or between a health care provider or his patients and the federal or a state or local government, or an agency of the federal or a state or local government;

(ix) acting on the recommendation of a credential review committee or a grievance committee;

(B) the State Medical Board established by AS 08.64.010.

* Sec. 38. AS 21.39 is amended by adding a new section to read:

Sec. 21.39.175. STATISTICS. Any insurer providing malpractice coverage for health care providers shall collect, maintain and report information concerning claims against health care providers which it insures. The information shall be on forms prescribed by the director, and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. At least annually the insurer shall report to the director the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to and the expenses incurred by the corporation during the year. This report shall be available to the public. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become available to the public may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All statistics, including the supplemental reports, shall be made available to the State Medical Board.

* Sec. 39. AS 39.30.090(14) is amended to read:

(14) For each permanent part-time employee electing coverage under this section, the state shall contribute one-half the state contribution rate for permanent full-time state employees, and the permanent part-time employee shall contribute the other one-half.

* Sec. 40. The following laws are repealed: AS 08.20.115; AS 08.32.015; AS 08.36.115; AS 08.64.215; AS 08.68.165; AS 08.-71.085; AS 08.72.115; AS 08.80.115; AS 08.84.035; AS 08.86.125; AS 18.20.045; AS 21.18.090(5) and (6); AS 21.88.050(a)(2), (3) and (7), 21.88.080(1), (2) and (14), 21.88.110 - 21.88.180, and 21.88.900(1).

* Sec. 41. AS 08.64.380(3)(D) is repealed.

* Sec. 42. Sections 5, 10, 19, 24, 36, and 40 of this Act are retroactive to June 28, 1976.

* Sec. 43. Sections 2, 3, 4, 6, 7, 8, 9, 11, 13, 14, 15, 16, 18, 20, 21, 22, 25, 26, 29 - 34, and 39 of this Act take effect July 1, 1978.

* Sec. 44. Sections 1, 12, 17, 23, 27, 28, 35, 37, 38, 41 and 42 of this Act take effect immediately in accordance with AS 01.10.070(c).