HOUSE BILL NO. 218

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE BY REQUEST

Introduced: 3/27/97
Referred: Labor and Commerce

A BILL

FOR AN ACT ENTITLED

"An Act relating to regulation and examination of insurers and insurance agents; relating to kinds of insurance; relating to payment of insurance taxes and to required insurance reserves; relating to insurance policies; relating to regulation of capital, surplus, and investments by insurers; relating to hospital and medical service corporations; and providing for an effective date."

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

*** Section 1.** AS 21.06.030 is amended by adding a new subsection to read:

(h) A volunteer member of an advisory committee who has been appointed by the director under a provision of this title to assist and advise the director on issues or matters concerning a specific area of insurance is not entitled to payment of per diem or travel expenses authorized under AS 39.20.180.

*** Sec. 2.** AS 21.06.110 is amended to read:

Sec. 21.06.110. Director's annual report. As early in each calendar year as

is reasonably possible**,** the director shall prepare and deliver an annual report to the commissioner, who shall notify the legislature that the report is available, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in this state, with a summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose **certificate of authority was surrendered, suspended, or revoked** [BUSINESS WAS CLOSED] during the year **and** [,] the cause of **surrender, suspension, or revocation** [THE CLOSING, AND THE AMOUNT OF ASCERTAINABLE ASSETS AND LIABILITIES OF EACH CLOSED BUSINESS];

(3) the name of each insurer **authorized to do business in this state** against which delinquency or similar proceedings were instituted [,] and**, if against an insurer domiciled in this state,** a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipt and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance [,] or the office of director;

(7) other pertinent information and matters the director considers proper.

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

(a) Each person examined, other than [AS TO] examinations under AS 21.06.130, shall pay **a reasonable rate calculated on** [ALL THE COSTS OF, AND EXPENSES INCURRED BY DIVISION STAFF EXAMINERS, INCLUDING] salary**,** [AND] 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 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.

*** Sec. 4.** AS 21.09.210(b) is amended to read:

(b) Each insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall pay a tax on the total direct premium income received during the year ending on the preceding December 31 and paid for the insurance of property or risks resident or located in the state**,** other than wet marine and transportation insurance, after deducting from the total direct premium income the applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to their policies. No deductions may be made of cash surrender value of policies. Considerations received on annuity contracts are not included in the direct premium income and are not subject to tax. The tax shall be paid to the director **at least** annually **but not more often than once each quarter** on **the dates specified by the director. The method of payment must be by the electronic or other payment method specified by the director. The tax** [OR BEFORE MARCH 1, AND] is computed at the rate of

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

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

*** Sec. 5.** AS 21.09.210(d) is amended to read:

(d) An authorized insurer shall, with respect to all wet marine and transportation contracts written in this state during the preceding calendar year, [ON OR BEFORE MARCH 1 OF EACH YEAR,] pay to the director a tax of three-quarters of one percent on its gross underwriting profit. **The director shall specify the dates that payment is due and the electronic or other method by which payment is to**

be made. The gross underwriting profit is computed by deducting**,** from the net premiums on wet marine and transportation insurance contracts, the net losses paid during the calendar year under the contracts. In the case of an insurer issuing participating contracts, the gross underwriting profit may not include, for computation of the tax prescribed by this section, the amounts refunded or paid as participation dividends by the insurers to the holders of the contracts. In this subsection,

(1) "net losses" means gross losses less salvage and recoveries on reinsurance ceded;

(2) "net premiums" means gross premiums less all return premiums and premiums for reinsurance.

*** Sec. 6.** AS 21.09 is amended by adding a new section to read:

Sec. 21.09.245. Required notice. (a) If an insurer intends to change the insurer's name, domicile, or other information provided on the certificate of authority, the insurer shall file a notice of the change with the director within 30 days before or after the intended change takes effect.

(b) If an insurer changes the insurer's articles of incorporation, bylaws, business address, phone number, or other information maintained by the director, the insurer shall file a notice of the change with the director not later than 90 days after the effective date of the change.

(c) Failure by an insurer to provide notification required by this section may result in a civil penalty of up to $1,000 and, additionally, a civil penalty of up to $50 for each day that the information is withheld from the director.

*** Sec. 7.** AS 21.09 is amended by adding a new section to read:

Sec. 21.09.320. Maintenance of records. (a) An insurer domiciled in a jurisdiction other than this state shall keep at its principal place of business a complete record of its assets, transactions, and affairs in accordance with the methods and systems that are customary or suitable to the kind of insurance transacted.

(b) To meet the requirements of (a) of this section, the insurer shall keep the records specified in AS 21.69.390(d) for 10 years from the date the record was created or as required by the record maintenance requirements of the insurer's domicile jurisdiction, whichever is longer.

*** Sec. 8.** AS 21.12.020(a)(4)(A)(iii) is amended to read:

(iii) in the case of a single assuming insurer, the trust shall consist of trust money representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, include a trust surplus of not less than $20,000,000; the single assuming insurer shall make available to the director an annual certification of the insurer's solvency [BY THE INSURER'S DOMICILIARY REGULATOR AND] by an independent certified public accountant or an accountant holding a substantially equivalent designation as determined by the director;

*** Sec. 9.** AS 21.12.050 is amended to read:

Sec. 21.12.050. Health insurance defined. Health insurance is insurance of human beings (1) against bodily injury, disablement, or death by accident or accidental means; (2) against the resulting expenses of the injury, disablement, or death; (3) against disablement or expense resulting from sickness or childbirth; (4) against expense incurred in prevention of sickness; (5) for dental care; and (6) **including every insurance** that applies to injury, disablement, or death. Transaction of health insurance includes disability insurance **and stop-loss insurance** but does not include workers' compensation insurance.

*** Sec. 10.** AS 21.12.050 is amended by adding a new subsection to read:

(b) In this section, "stop-loss insurance" means insurance purchased by a self-insured employer to cover benefits the employer incurs in excess of a preset limit.

*** Sec. 11.** AS 21.14.010(a) is amended to read:

(a) A life and health domestic insurer, property and casualty domestic insurer, or other insurer required by the director shall, on or before March 1, submit to the director a report of its risk based capital covering the previous calendar year [, IF REQUIRED BY THE DIRECTOR]. The report must be in a form and contain the information required by risk based capital instructions. A domestic insurer required to submit a report under this subsection shall file the report with

(1) the National Association of Insurance Commissioners; and

(2) the insurance regulatory agency in each state in which the insurer

is authorized to transact business [,] if the insurance regulatory agency has requested the report in writing from the insurer; a report requested under this paragraph shall be delivered

(A) not later than 15 days from the receipt of a request if the report has already been filed with the director; or

(B) at the time the report is filed with the director, if the report has not **yet** been filed with the director.

*** Sec. 12.** AS 21.14.200(18) is amended to read:

(18) "risk based capital instructions" means risk based capital instructions **most recently adopted by the National Association of Insurance Commissioners and supplemented with additional information as required** [FOR A LIFE AND HEALTH INSURER OR FOR A PROPERTY AND CASUALTY INSURER ADOPTED BY REGULATION] by the director [UNDER AS 21.14.010];

*** Sec. 13.** AS 21.18.050 is amended to read:

Sec. 21.18.050. Reserves and liabilities, in general. In a determination of the financial condition of an insurer, capital stock and liabilities to be charged against its assets shall include

(1) the amount of its capital stock outstanding, if any;

(2) the amount, estimated consistent with the provisions of this title, necessary to pay all of its unpaid losses and claims incurred on or before the date of statement, whether reported or unreported, together with the expenses of adjustment or settlement;

(3) with reference to life and health insurance and annuity contracts,

(A) the amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and methods adopted under this title that are applicable;

(B) reserves for disability benefits, for both active and disabled lives;

(C) reserves for accidental death benefits;

(D) additional reserves that may be required by the director, consistent with practice formulated or approved by the National Association of

Insurance Commissioners, on account of the insurance;

(4) with reference to health insurance, the amount of reserves required under **AS 21.18.080 - 21.18.086** [AS 21.18.080];

(5) with reference to insurance other than specified in (3) and (4) of this section, and other than title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with this chapter;

(6) taxes, expenses, and other obligations due or accrued at the date of the statement.

*** Sec. 14.** AS 21.18.080 is repealed and reenacted to read:

Sec. 21.18.080. Reserve standards for health insurance. (a) The adequacy of health insurance reserves must be determined based on the sum of policy reserves determined under AS 21.18.082, claim reserves determined under AS 21.18.084, and premium reserves determined under AS 21.18.086.

(b) Reserve adequacy must be determined by a prospective gross premium valuation. For policies in force, in a claims status, or in a continuation of benefits status on the valuation date, the gross premium valuation must take into account the present value of all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, including expected future premium increases.

(c) A gross premium valuation must be performed whenever there is an indication that reserves and future premiums may be insufficient to cover future claims for a particular block of policies or for the entire health insurance block. If a reserve inadequacy is determined to exist, the loss must be immediately recognized and reserves increased to account for the inadequacy. The increased reserves will be considered minimum reserves.

*** Sec. 15.** AS 21.18 is amended by adding new sections to read:

Sec. 21.18.082. Policy reserves for health insurance. (a) Except as provided in (b) of this section, policy reserves are required for all individual and group health insurance policies or groups of policies

(1) with level premiums or with a gross premium pricing structure at time of issue that results in future benefits exceeding the corresponding future

valuation net premiums at any time; or

(2) for which gross premiums are restricted by contract, regulation, or another reason that results in future gross premiums, reduced by expenses for administration, commissions, and taxes, being insufficient to cover future claims.

(b) Policy reserves are not required for health insurance policies that cannot be continued after one year from the date of issue.

(c) The structure of valuation net premiums used under a health insurance policy must be consistent with the structure of gross premiums on the date the policy is issued.

(d) For return of premium benefits, deferred cash benefits, policies with premium rates that are not guaranteed, and where the effects of insurer underwriting by policy duration are specifically used in the valuation morbidity standard, termination rates that exceed the mortality rates in the tables required in (g)(2) of this section may be used but may not exceed the lesser of

(1) 80 percent of the total termination rate used in the calculation of gross premiums; or

(2) eight percent.

(e) The methods and procedures used to determine health insurance policy reserves must be consistent with the methods and procedures used to determine claim reserves for a health insurance policy.

(f) Negative reserves on a benefit may be offset against positive reserves for other benefits in the same policy, but the total policy reserve with respect to all benefits combined may not be less than zero.

(g) Except as provided in (h) - (k) of this section, policy reserves must be determined based on

(1) a maximum interest rate equal to the maximum interest rate allowed under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the individual disability income policy;

(2) a termination assumption equal to the mortality table allowed under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the individual disability income policy or equal to a mortality table approved by the

director for use in determining the policy reserves;

(3) for long-term care policies issued after July 1, 1997,

(A) a mortality assumption equal to the 1983 Group Annuity Mortality Table without projection and a lapse assumption for policy durations one through four equal to the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums or eight percent; and

(B) a lapse assumption for policy durations five and later of 100 percent of the voluntary lapse rate used in the calculation of the gross premiums or four percent;

(4) a two-year full preliminary term method under which the terminal reserve is zero on the first and second policy anniversary dates;

(5) a morbidity assumption for

(A) individual disability income insurance issued (i) after December 31, 1997, equal to Tables A or B of the 1985 Commissioners' Individual Disability Tables for policies; and (ii) before January 1, 1998, equal to the 1964 or 1985 Commissioners' Individual Disability Tables; the insurer shall indicate which morbidity table the insurer will use for all individual disability income policies issued in a calendar year;

(B) group disability income insurance issued

(i) after December 31, 1997, equal to the 1987 Commissioners' Group Disability Table; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(C) scheduled or fixed time period hospital, surgical, or maternity benefit policies issued

(i) after December 31, 1997, equal to the 1974 Medical Expense Table A from the Transactions of the Society of Actuaries, Volume XXX; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(D) cancer expense benefits for policies issued

(i) after December 31, 1997, equal to the 1985 National Association of Insurance Commissioners Cancer Claim Cost Tables; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(E) accidental death benefits for policies issued

(i) after December 31, 1997, equal to the 1959 accidental death benefit table; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998; or

(F) all other individual or group policy benefits equal to a morbidity table established for reserve determination by an actuary qualified to determine the morbidity table and approved by the director; the morbidity table must contain a pattern of incurred claims cost that reflects the underlying morbidity and may not be constructed for the primary purpose of minimizing reserves.

(h) The reserve method for return of premium or other deferred cash benefits must be a preliminary term method that is applied only in relation to the issue date of the policy and is a

(1) one-year preliminary term method if benefits are provided before the 20th policy anniversary; or

(2) two-year preliminary term method if the benefits are provided only on or after the 20th policy anniversary.

(i) The reserve method for long-term care insurance must be calculated on a

(1) two-year full preliminary term method for a policy or certificate issued on or before July 1, 1997; and

(2) one-year full preliminary term method for a policy or certificate issued after July 1, 1997.

(j) Reserve adjustments due to rate changes, revised assumptions, or other reasons for return of premium or other deferred cash benefits must be applied on the effective date of the adoption of the reserve adjustment.

(k) An alternative method or basis of determining policy reserves may be used

if the aggregate policy reserve is not less than the aggregate policy reserves determined under (c) - (j) of this section.

(l) An insurer shall annually review prospective policy liabilities on policies valued by tabular reserves to determine the continuing adequacy and reasonableness of the tabular reserves given future gross premiums. The insurer shall make adjustments to the tabular reserves if the tests indicate that the basis of the reserves is no longer adequate.

(m) Policy reserves that are valued based on the 1964 or 1985 Commissioners Individual Disability Tables must include a provision for a waiver of premium benefit with the minimum reserve for the benefit equal to the valuation net premium to be waived.

(n) Policy reserves for long-term care insurance may not be less than the net single premium for any nonforfeiture benefits provided by the policy or certificate.

Sec. 21.18.084. Claim reserves for health insurance. (a) Claim reserves are required for all incurred and unpaid claims on all health insurance policies.

(b) Claim expense reserves are required for the estimated expense of settlement of all incurred and unpaid claims.

(c) Claim reserves for prior valuation years must be tested for adequacy and reasonableness using claim runoff schedules in accordance with the statutory annual statement, including consideration of any residual unpaid liability. Claim reserve adequacy must be determined in the aggregate.

(d) Claim reserves must be determined as follows:

(1) for policies that require policy reserves under AS 21.18.082(a), based on a maximum interest rate equal to the maximum interest rate allowed under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the date the claim was incurred;

(2) for policies that do not require policy reserves under AS 21.18.082(b), based on a maximum interest rate equal to the maximum interest rate allowed under AS 21.18.110 for the valuation of single premium immediate annuities issued on the same date as the date the claim was incurred less 100 basis points;

(3) except as provided in (4) and (5) of this subsection, a morbidity

assumption for

(A) individual disability income insurance must be equal to the morbidity assumption used in determining policy reserves under AS 21.18.082(g)(5);

(B) group disability income insurance for policies issued

(i) after December 31, 1997, must be equal to the 1987 Commissioners Group Disability Table; and

(ii) before January 1, 1998, must be equal to the morbidity assumption in use by the insurer before January 1, 1998;

(C) accidental death benefits must be equal to the actual amount of claims incurred; and

(D) all other individual or group policy benefits must be equal to a morbidity table approved by the director and established for reserve determination by an actuary qualified to determine the morbidity table;

(4) for individual or group disability claims with a duration from disablement of less than two years, mortality assumptions may be based on the insurer's experience if determined credible by the insurer or upon another basis designed to place a sound value on the liabilities as determined by the insurer;

(5) if approved by the director, reserves for group disability income claims with a duration from disablement of more than two years but less than five years may be based on the insurer's experience for which the insurer maintains control of underwriting and claim administration; request for approval to use this modified reserve basis must include

(A) an analysis of the credibility of the experience;

(B) a description of how all the insurer's experience is proposed to be used in setting the reserves;

(C) a description and quantification of the margins to be included;

(D) a summary of the financial impact that the proposed plan of modification would have on the insurer's last filed annual statement;

(E) a copy of the approval from the state of domicile; and

(F) all other information requested by the director;

(6) any generally accepted actuarial reserving method or other reasonable method approved by the director may be used; the method used to estimate liabilities may be an aggregate method; approximations based on groupings and averages may also be used.

(e) Claim reserves that are valued based on the 1964 or 1985 Commissioners' Individual Disability Tables must include a provision for a waiver of premium benefit with the minimum reserve for the benefit equal to the valuation net premium to be waived.

Sec. 21.18.086. Premium reserves for health insurance. (a) Unearned premium reserves must be established for the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(b) Due and unpaid premiums that are carried as an asset in the annual statement must be treated as premiums in force and are subject to the unearned premium reserve requirements of this section. Unpaid commissions, premium taxes, and costs of collection associated with due and unpaid premiums must be carried in the annual statement as an offsetting liability.

(c) Gross premiums paid in advance for a period of coverage starting after the next premium due date following the valuation date may be discounted to the valuation date and must be held as a separate liability in the annual statement or as an addition to the unearned premium reserve established in this section.

(d) The minimum unearned premium reserve for a policy is the pro rata unearned modal premium that applies to the valuation period beyond the date of valuation. If a policy reserve is required for a policy, the unearned modal premium is the valuation net modal premium on the policy reserve. If no policy reserve is required for a policy, the unearned modal premium is the gross modal premium for the policy.

(e) The sum of the unearned premium and policy reserves for all policies may not be less than the gross modal unearned premium reserve on all policies as of the date of valuation. The total unearned premium and policy reserves may not be less than the expected claims for the period after the valuation date represented by the

unearned premium reserve.

(f) An insurer may use approximations and estimates in determining premium reserves, including groupings, averages, and aggregate estimates. The approximations or estimates must be tested periodically and not less frequently than triennially to determine adequacy.

(g) Premium reserves based on the 1964 or 1985 Commissioners' Individual Disability Tables must include policies on premium waiver as in-force contracts and establish a minimum reserve for a waiver of premium benefit equal to the unearned modal valuation net premium being waived.

*** Sec. 16.** AS 21.21 is amended by adding a new section to read:

Sec. 21.21.410. Custodians. (a) A custodial agreement between an insurer and an institution holding the assets, securities, or investments of the insurer must provide that the custodian is obligated to indemnify the insurer for losses involving an insurance company asset or security in the custodian's custody resulting from the negligence or dishonesty of the custodian's officers, employees, or agents, or caused by burglary, robbery, holdup, theft, or mysterious disappearance, including loss by damage or destruction. The agreement must also provide that, in the event of a loss, an asset or security will be promptly replaced or the value of the asset or security and the value of a loss of rights or privileges resulting from the loss will be promptly replaced.

(b) The custodian for assets, securities, or investments of the insurer may only be a bank, trust company, or securities firm that is properly authorized by the insurer and approved by the director.

*** Sec. 17.** AS 21.27.010(f) is amended to read:

(f) A person who performs management services under a written contract for an admitted insurer is not required to be licensed as a managing general agent [,] if

(1) either

(A) the person is a United States manager of the United States branch of an alien admitted insurer; or

(B) the person's compensation is not based on the volume of premium written; and

(2) the person

(A) is a wholly-owned subsidiary of the admitted insurer;

(B) wholly owns the admitted insurer; **or**

(C) is a wholly-owned subsidiary of the insurance holding company subject to AS 21.22 that owns or controls the admitted insurer.

*** Sec. 18.** AS 21.27.010(i) is amended to read:

(i) A person licensed under AS 21.75 as an attorney-in-fact**, or a person who meets the requirements for exemption from licensure under AS 21.75,** is not required to be additionally licensed under this chapter while acting on behalf of subscribers and within the scope and authority of a subscribers agreement of a reciprocal insurer or exchange licensed under AS 21.75.

*** Sec. 19.** AS 21.27.040(a) is amended to read:

(a) Application for a license shall be made to the director upon forms prescribed by the director. As a part of or in connection with [,] the application, the applicant shall furnish information concerning the **applicant's** identity, personal history, experience, business record, purposes**,** [OF THE APPLICANT] and other pertinent facts [CONCERNING THE APPLICANT] that the director may reasonably require. The applicant shall declare under **oath and subject to** penalty of denial, nonrenewal, suspension, or revocation of a license issued by the director that the statements made in or in connection with the application are true, correct, and complete to the best of the applicant's knowledge and belief. Payment of an application fee established under AS 21.06.250 must be submitted with the application.

*** Sec. 20.** AS 21.27.370(b) is amended to read:

(b) A **person** [LICENSEE] may not be promised or paid, directly or indirectly, compensation for procuring an application or for placing a kind or class of insurance for which the **person** [LICENSEE] is not then licensed to procure or place or for insurance that the **person** [LICENSEE] is prohibited by this title from procuring or placing.

*** Sec. 21.** AS 21.27.390(b) is amended to read:

(b) **Except as otherwise provided by law, a** [A] temporary license may not be in effect for more than 90 consecutive days [,] and may not be renewed or reissued

for more than one additional 90-day period.

*** Sec. 22.** AS 21.27.405(b) is amended to read:

(b) If the director determines that a person has violated this chapter, the director shall serve an order upon the person charged requiring that person to cease and desist from engaging in the act or practice. [SERVICE REQUIRED UNDER THIS SUBSECTION SHALL BE BY MAIL WITH A CERTIFICATE OF MAILING FROM THE UNITED STATES POSTAL SERVICE.] A person aggrieved by the cease and desist order may demand a hearing under AS 21.06.170 - 21.06.240.

*** Sec. 23.** AS 21.27.440(a) is amended to read:

(a) In addition to any other penalty provided by law, a person that the director determines under AS 21.06.170 - 21.06.240 has violated the provisions of this chapter is subject to

(1) a civil penalty equal to the compensation promised, paid, or to be paid, directly or indirectly, to a **person** [LICENSEE] in regard to each violation;

(2) either a civil penalty of not more than $10,000 for each violation or a civil penalty of not more than $25,000 for each violation if the director determines that the person wilfully violated the provisions of this chapter; and

(3) denial, nonrenewal, suspension, or revocation of a license.

*** Sec. 24.** AS 21.27.640(b)(5) is amended to read:

(5) 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 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 prior 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 ESTABLISH] 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;

*** Sec. 25.** AS 21.34.040(c)(4) is amended to read:

(4) a Lloyd's **syndicate** or **an insurer belonging to a** [OTHER] similar group**,** including incorporated and individual unincorporated **insurers** [UNDERWRITERS], may qualify if it maintains a trust fund **jointly and severally with the other members of the group** in an amount not less than $50,000,000, as security to the full amount, for the protection of all **policyholders** [ITS POLICY HOLDERS] and creditors of each member of the group in the United States; the incorporated members may not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; the trust fund must consist of instruments of substantially the same character and quality as those that are eligible investments for the capital and statutory reserves of

admitted insurers authorized to write like kinds of insurance in this state or of irrevocable, clean, and unconditional letters of credit; the trust fund must have an expiration date that at no time is less than five years;

*** Sec. 26.** AS 21.34.040(c)(5) is amended to read:

(5) **each syndicate or insurer belonging to** an insurance exchange created by the laws of individual states may qualify if **the insurance exchange** [IT] maintains capital and surplus, or the substantial equivalent, of not less than $50,000,000 in the aggregate; for insurance exchanges that maintain funds for the protection of all insurance exchange policyholders, each individual syndicate shall maintain minimum capital and surplus, or the substantial equivalent, of not less than $3,000,000; in the event the insurance exchange does not maintain funds for the protection of all its policyholders, each individual syndicate shall meet the minimum requirements of (1) or (2) of this subsection;

*** Sec. 27.** AS 21.34.180(b) is amended to read:

(b) The surplus lines tax is due on the **date specified by the director and may** [SECOND DAY OF MARCH FOLLOWING THE CALENDAR YEAR IN WHICH THE PREMIUM IS WRITTEN. THE TAX SHALL] be paid **by electronic or other means as specified by the director. The tax shall be** [TO AND] reported on forms prescribed by the director [,] or**,** upon the director's order**,** paid to and reported on forms prescribed by the surplus lines association.

*** Sec. 28.** AS 21.34.190(a) is amended to read:

(a) The fee for filing the statement under AS 21.34.180(b) is an amount equal to one percent on gross premium charged less any return premiums **as reported on the statement** [DURING THE PRECEDING CALENDAR YEAR]. The surplus lines broker shall pay the fee at the time of filing of the statement.

*** Sec. 29.** AS 21.36.095(e) is amended to read:

(e) In this section, "insurer" includes

(1) an insurer, as defined in AS 21.90.900;

(2) a group health plan, as defined in 29 U.S.C. 1167(l) (Employee Retirement Income Security Act of 1974);

(3) a health maintenance organization, as defined in AS 21.86.900;

(4) a hospital service corporation or medical service corporation, as defined in AS 21.87.330;

(5) **Comprehensive Health Insurance Association, established in AS 21.55.010** [A WRITING CARRIER, AS DEFINED IN AS 21.55.500]; and

(6) an entity offering a service benefit plan, as referred to in 42 U.S.C. 1396g-1.

*** Sec. 30.** AS 21.36 is amended by adding a new section to read:

Sec. 21.36.185. Maintenance of complaint handling records. 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. 31.** AS 21.36.240 is amended to read:

Sec. 21.36.240. Failure to renew. An insurer may **only** [NOT] fail to renew a personal insurance policy **on the policy's annual anniversary** [IN FORCE FOR LESS THAN 12 MONTHS]. An insurer may not fail to renew a policy unless a written notice of nonrenewal is mailed to the named insured as required by AS 21.36.260 at least 20 days for a personal insurance policy, and at least 45 days for a business or commercial insurance policy, before the expiration date of the policy or of the anniversary date of a policy written for a term longer than one year or with no fixed expiration date. If notice of nonrenewal is not given as required by this section, the existing policy shall continue until the insurer provides notice for the time period required by this section for that policy. This section does not apply

(1) if the insurer has in good faith manifested its willingness to renew;

(2) in case of nonpayment of premium for the expiring policy; or

(3) if the insured fails to pay the premium as required by the insurer for renewal.

*** Sec. 32.** AS 21.36.290 is amended to read:

Sec. 21.36.290. Policy period. (a) **A** [EXCEPT AS DESCRIBED IN (b) OF THIS SECTION, A] policy with a policy period or term [OF LESS THAN 12 MONTHS SHALL, FOR THE PURPOSES OF AS 21.36.210 - 21.36.310, BE CONSIDERED TO BE WRITTEN FOR A POLICY PERIOD OR TERM OF 12 MONTHS EXCEPT IN CASE OF CANCELLATION UNDER ANY OF THE CIRCUMSTANCES SPECIFIED IN AS 21.36.210, AND A POLICY WRITTEN FOR A TERM] longer than one year or a policy with no fixed expiration date shall be considered to be written for successive policy periods or terms of one year**,** and termination by an insurer effective on an anniversary date of the policy shall be considered a failure to renew.

(b) **The rate for** [FOR DETERMINING THE APPROPRIATE RATE OR PREMIUM,] a personal automobile insurance policy **may not be changed more frequently than once every** [WITH A POLICY PERIOD OR TERM OF LESS THAN SIX MONTHS SHALL, FOR THE PURPOSES OF AS 21.36.210 - 21.36.310, BE CONSIDERED TO BE WRITTEN FOR A POLICY PERIOD OR TERM OF] six months.

*** Sec. 33.** AS 21.36.390 is repealed and reenacted to read:

Sec. 21.36.390. Notice to director. (a) An insurer or licensee that has reason to believe that a fraudulent claim has been made against it shall send the director a report disclosing information that the director may require.

(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 21.36.360 shall immediately send the director a report disclosing the basis for that belief and any other information that the director may require.

(c) An insurer or licensee, its employee or agent, or another person acting in good faith is not civilly liable for damages resulting from the filing of the report or the furnishing of information required by this section or by the director.

(d) The director shall investigate facts reported under this section and shall refer facts indicating a violation of law to the appropriate prosecutor or agency.

*** Sec. 34.** AS 21.39.045(b) is amended to read:

(b) The director shall accept a rate filing for workers' compensation insurance if the filing includes a reasonable method of recognizing differences in rates of pay **for the construction industry,** and the method uses a credit scale that begins at an amount equal to the average weekly wage in this state **for the construction industry** as determined by the Department of Labor.

*** Sec. 35.** AS 21.42.130 is amended to read:

Sec. 21.42.130. Grounds for disapproval. The director shall disapprove a form filed under AS 21.42.120 or withdraw a previous approval of the form [,] only if the form

(1) is in any respect in violation of or does not comply with this title;

(2) contains or incorporates by reference, where incorporation is permissible, an inconsistent, ambiguous, or misleading clause, or exception and condition that deceptively affects the risk purported to be assumed in the general coverage of the contract;

(3) has a title, heading, or other indication of its provisions that is misleading;

(4) is printed or otherwise reproduced in a manner that renders a provision of the form substantially illegible;

(5) provides benefits for Medicare **supplement** [SUPPLEMENTAL AND INDIVIDUAL HEALTH] insurance that are unreasonable in relation to the premium charged.

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

Sec. 21.42.205. Coordination of benefits. (a) Unless prohibited by federal law, an insurer authorized under AS 21.09 to offer, issue for delivery, deliver, or renew an individual or group health insurance policy for major medical coverage on an expense incurred basis; a health maintenance organization authorized under AS 21.86 to offer a contract to provide major medical health care services on a prepaid basis; or a service corporation authorized under AS 21.87 to offer or renew an individual or group subscriber's contract for major medical coverage shall include a coordination of benefits provision in a major medical policy or contract.

(b) The director may adopt regulations to implement this section.

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

Sec. 21.42.265. Effective date of coverage. Unless otherwise provided by law, the effective date of a change relating to coverage under an insurance contract as a result of a change to this title is the issue date for a new policy or the renewal date for a renewal policy.

*** Sec. 38.** AS 21.54 is amended by adding a new section to read:

Sec. 21.54.015. Rate requirements. Rates charged for a group health insurance policy may not be excessive, inadequate, or unfairly discriminatory.

*** Sec. 39.** AS 21.66.110(a) is amended to read:

(a) **Each** [ANNUALLY EACH] title insurance company shall pay [ON OR BEFORE MARCH 1,] a tax of one percent of the amount of gross title insurance premiums received by it**,** including as premium income received from guaranteed certificates of title and other guarantees of title [DURING THE PRECEDING CALENDAR YEAR] covering property in this state, as shown by its annual statement to the director. **The director shall specify the due dates and the method of payment.**

*** Sec. 40.** AS 21.66.390(a) is amended to read:

(a) A title insurance company shall make rates that are not excessive or inadequate**,** [AND] that do not unfairly discriminate between risks in this state that involve essentially the same exposure to loss and expense elements, and that give due consideration to

(1) the desirability for stability of rate structures;

(2) the necessity of assuring the financial solvency of title insurance companies in periods of economic depression by encouraging growth in assets of title insurance companies in periods of high business activity; [AND]

(3) the necessity for assuring a reasonable margin of underwriting and operating profit**; and**

(4) investment income.

*** Sec. 41.** 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. 42.** AS 21.69.520(a) is amended to read:

(a) **Subject to the director's prior written approval, a** [A] domestic stock or mutual insurer may borrow money to defray the expenses of its organization **or** [,] provide it with surplus funds [, OR FOR ANY PURPOSE OF ITS BUSINESS,] upon a written agreement that the money is required to be repaid only out of the insurer's surplus in excess of that stipulated in the agreement. The agreement may provide for interest not exceeding six per cent a year, which interest may or may not constitute a liability of the insurer as to its funds other than the excess of surplus, as stipulated in the agreement. A commission or promotion expense may not be paid in connection with the loan.

*** Sec. 43.** AS 21.75.045(a) is amended to read:

(a) A person may not act in the capacity of attorney-in-fact for a subscriber regarding a subject that is resident, located, or to be performed in this state or for a reciprocal insurer licensed to do business in this state unless the person is licensed under this chapter. The director may adopt regulations that establish qualifications for being licensed as an attorney-in-fact. The attorney-in-fact for a [DOMESTIC] reciprocal insurer [TRANSACTING ALL OF ITS INSURANCE ACTIVITIES ON A SUBJECT RESIDENT, LOCATED, AND TO BE PERFORMED IN THIS STATE] is exempt from licensing under this title if the attorney-in-fact

(1) is a wholly-owned subsidiary of the reciprocal; and

(2) does not act as attorney-in-fact for another unaffiliated reciprocal insurer.

*** Sec. 44.** AS 21.76.020(b) is amended to read:

(b) By October 1 of each year**,** the administrator of a joint insurance arrangement shall prepare and deliver to the Legislative Budget and Audit Committee **and the director** a report showing the true and correct financial condition of the joint insurance arrangement. The report must

(1) be attested to by the administrator and the board of directors;

(2) include an analysis**,** certified by a member of the American

Academy of Actuaries, of the sufficiency of the loss reserves; and

(3) be certified by a certified public accountant.

*** Sec. 45.** AS 21.76.080(e) is amended to read:

(e) Within **150** [60] days of the end of the fiscal year, the administrator shall furnish a detailed report of the operation and condition of the fund to the board of directors and the director of **the division of** insurance. [THE REPORT FURNISHED TO THE DIRECTOR OF INSURANCE SHALL BE

(1) FILED IN THE GENERAL FORM AND CONTEXT ACCEPTABLE TO THE DIRECTOR;

(2) IN ACCORDANCE WITH ACCOUNTING PRINCIPLES ESTABLISHED UNDER THIS TITLE; AND

(3) AVAILABLE FOR PUBLIC INSPECTION.]

*** Sec. 46.** AS 21.78.293(b) is amended to read:

(b) The court **shall review and adopt** [MAY APPROVE, DISAPPROVE, OR MODIFY] the receiver's report on claims **by approving those claims that are supported by substantial evidence and disapproving allowed claims that are not supported by substantial evidence**. Claims in a report that are not **disapproved** [MODIFIED] by the court within a period of **120** [60] days following submission by the receiver shall be treated by the receiver as allowed claims.

*** Sec. 47.** AS 21.87.140(c) is amended to read:

(c) Each service agreement shall further effectively provide in substance that

(1) the participant provider shall be compensated for services rendered to a subscriber in accordance with **terms** [A SCHEDULE OF FEES] contained in the agreement or attached to and made a part of the agreement [,] and that the participant provider may not request or receive from the service corporation compensation for the services **that** [WHICH] is not in accord with the **terms** [SCHEDULE];

(2) compensation for services may be prorated and settled under the circumstances and in the manner referred to in AS 21.87.300;

(3) if the participant provider withdraws from the agreement, the withdrawal may not be effective as to a subscriber's contract in force on the date of the withdrawal until the termination of the subscriber's contract or the next anniversary

of the subscriber's contract, whichever date is the earlier.

*** Sec. 48.** AS 21.87.150(c) is amended to read:

(c) Each service agreement must further effectively in substance provide that

(1) the participant hospitals shall be compensated for services rendered to a subscriber in accordance with **terms** [A SCHEDULE OF CHARGES] contained in the agreement or attached to and made a part of the agreement [,] and that the hospital may not request or receive from the service corporation compensation for the services that is not in accord with the **terms** [SCHEDULE];

(2) compensation for services may be prorated and settled under the circumstances and in the manner referred to in AS 21.87.300;

(3) if the participant hospital withdraws from the agreement, the withdrawal may not be effective as to a subscriber's contract in force on the date of the withdrawal until the termination of the subscriber's contract or the next anniversary of the subscriber's contract, whichever date is the earlier.

*** Sec. 49.** AS 21.87.180(a) is amended to read:

(a) A service corporation may not issue or use a basic form of service agreement or subscriber's contract, or application, identification, supplement, or endorsement to be connected with the agreement or contract, until the form has been filed with and approved by the director. This provision does not apply to **riders** [AGREEMENTS, CONTRACTS, APPLICATIONS, IDENTIFICATION SUPPLEMENTS], endorsements, or other forms of unique character designed for and used with relation to a particular **subject** [SET OF CIRCUMSTANCES].

*** Sec. 50.** AS 21.87.190(b) is amended to read:

(b) The service corporation shall, before use, file with the director **(1)** a schedule of subscription rates, fees, or payments of any kind to be charged subscribers**; (2) every rating manual, schedule, plan, rule, or formula;** and **(3)** [SHALL FILE] before use**, any modification to the rating manual, schedule, plan, rule, or formula. Each filing must state the effective date and must provide a comprehensive description of the coverage. The director may withhold the rating formula from public inspection for as long as the director determines that withholding the rating formula is necessary to protect the service corporation against unwarranted**

injury or is in the public interest [EVERY PROPOSED CHANGE OR MODIFICATION IN THE RATES, FEES, OR PAYMENTS].

*** Sec. 51.** AS 21.87.200 is repealed and reenacted to read:

Sec. 21.87.200. Reserves. In addition to the surplus fund provided for in AS 21.87.210, each service corporation shall establish and maintain unimpaired reserves and liabilities required under AS 21.18.050.

*** Sec. 52.** AS 21.89.020(g) is amended to read:

(g) An insurance company offering automobile liability insurance in this state shall offer a short term policy valid for no more than seven days. The coverage available for the short term policy must be comparable to coverage available for longer term policies. **The provisions of AS 21.36.210 - 21.36.310 do not apply to short term policies issued under this subsection.**

*** Sec. 53.** AS 21.90.900(29) is amended to read:

(29) "policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements, and papers attached to it and a part of it; **for a group, trust, association, or similar entity, it also means a certificate or other evidence of insurance that establishes the written contract of or written agreement for or effecting insurance for an insured or other beneficiary of the entity;**

*** Sec. 54.** AS 21.90.900 is amended by adding a new paragraph to read:

(41) "certified financial statement" means a financial statement upon which an independent certified public accountant, or an accountant holding a substantially equivalent designation as determined by the director, renders or disclaims an opinion after performance of an audit.

*** Sec. 55.** AS 21.81 is repealed.

*** Sec. 56.** Sections 4, 5, 25 - 28, and 39 of this Act take effect January 1, 1998.

*** Sec. 57.** Except as provided in sec. 56 of this Act, this Act takes effect on July 1, 1997.