

**CS FOR SENATE BILL NO. 104(FIN) am**  
**IN THE LEGISLATURE OF THE STATE OF ALASKA**  
**TWENTIETH LEGISLATURE - FIRST SESSION**

**BY THE SENATE FINANCE COMMITTEE**

**Amended: 4/28/97**  
**Offered: 4/25/97**

**Sponsor(s): SENATE RULES COMMITTEE**

**A BILL**

**FOR AN ACT ENTITLED**

**1 "An Act relating to regulation and examination of insurers and insurance agents;**  
**2 relating to kinds of insurance; relating to payment of insurance taxes and to**  
**3 required insurance reserves; relating to insurance policies; relating to regulation**  
**4 of capital, surplus, and investments by insurers; relating to hospital and medical**  
**5 service corporations; relating to the portability and availability of health care**  
**6 insurance; making amendments to the insurance statutes to conform to federal**  
**7 requirements regarding health insurance; relating to the repeal of certain small**  
**8 employer health care insurance provisions; requiring that uninsured and**  
**9 underinsured motor vehicle insurance apply to claims of an insured even if**  
**10 other policy limits are not exhausted; repealing delayed provisions relating to**  
**11 dental, vision, and hearing insurance in secs. 3 and 4, ch. 101, SLA 1992;**  
**12 repealing delayed provisions relating to small employer health care insurance in**

1 secs. 4, 7, 9, and 12, ch. 39, SLA 1993; repealing the delayed effective date in  
 2 sec. 5, ch. 101, SLA 1992, and in sec. 13, ch. 39, SLA 1993; and providing for  
 3 an effective date."

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

5 \* **Section 1. PURPOSE.** The purpose of secs. 3, 11, 12, 31 - 34, 43 - 57, 59 - 90, 99 -  
 6 102, 108, 111, 112, 115 - 119, and 122 of this Act is to implement the minimum federal  
 7 standards for health care insurance enacted under P.L. 104-191 (Health Insurance Portability  
 8 and Accountability Act of 1996).

9 \* **Sec. 2.** AS 21.06.030 is amended by adding a new subsection to read:

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

14 \* **Sec. 3.** AS 21.06.085 is amended to read:

15 **Sec. 21.06.085. Uniform data and procedures for health claims.** (a) The  
 16 director shall adopt by regulation uniform claims forms, uniform standards, and  
 17 uniform procedures for the processing of data relating to billing for and payment of  
 18 health care services provided to state residents. A health care insurer shall use the  
 19 uniform claims forms and comply with the uniform standards and procedures  
 20 established under this section.

21 (b) In this section,

22 (1) "health care services" has the meaning given in AS 21.86.900;

23 (2) ["HEALTH INSURANCE" HAS THE MEANING GIVEN IN  
 24 AS 21.12.050;

25 (3)] "health care insurer" has the meaning given in AS 21.54.500  
 26 [MEANS AN INSURER TRANSACTING THE BUSINESS OF HEALTH  
 27 INSURANCE, A HEALTH MAINTENANCE ORGANIZATION UNDER AS 21.86,  
 28 A HOSPITAL SERVICE CORPORATION UNDER AS 21.87, A MEDICAL  
 29 SERVICE CORPORATION UNDER AS 21.87, OR A COMBINED MEDICAL  
 30 SERVICE AND HOSPITAL SERVICE CORPORATION UNDER AS 21.87].

1 \* **Sec. 4.** AS 21.06.110 is amended to read:

2 **Sec. 21.06.110. Director's annual report.** As early in each calendar year as  
3 is reasonably possible, the director shall prepare and deliver an annual report to the  
4 commissioner, who shall notify the legislature that the report is available, showing,  
5 with respect to the preceding calendar year,

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

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

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

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

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

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

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

25 \* **Sec. 5.** AS 21.06.160(a) is amended to read:

26 (a) Each person examined, other than [AS TO] examinations under  
27 AS 21.06.130, shall pay a reasonable rate calculated on [ALL THE COSTS OF,  
28 AND EXPENSES INCURRED BY DIVISION STAFF EXAMINERS, INCLUDING]  
29 salary, [AND] benefit costs, and estimated division overhead for time spent directly  
30 or indirectly related to the examination. Each person examined, other than  
31 examinations under AS 21.06.130, shall pay actual out-of-pocket business

1 **expenses, including travel expenses, incurred by division staff examiners** [,] and  
 2 shall pay the compensation of a contract examiner, to be set at a reasonable customary  
 3 rate, for conducting the examination [,] upon presentation of a detailed account of the  
 4 charges and expenses by the director or under an order of the director. The  
 5 accounting may either be presented periodically during the course of the examination  
 6 or at the termination of the examination. A person may not pay and an examiner may  
 7 not accept additional compensation for an examination.

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

9 (b) Each insurer, and each formerly authorized insurer with respect to  
 10 premiums received while an authorized insurer in this state, shall pay a tax on the total  
 11 direct premium income received during the year ending on the preceding December  
 12 31 and paid for the insurance of property or risks resident or located in the state, other  
 13 than wet marine and transportation insurance, after deducting from the total direct  
 14 premium income the applicable cancellations, returned premiums, the unabsorbed  
 15 portion of any deposit premium, all policy dividends, unabsorbed premiums refunded  
 16 to policyholders, refunds, savings, savings coupons, and other similar returns paid or  
 17 credited to policyholders with respect to their policies. No deductions may be made  
 18 of cash surrender value of policies. Considerations received on annuity contracts are  
 19 not included in the direct premium income and are not subject to tax. The tax shall be  
 20 paid to the director **at least annually but not more often than once each quarter** on  
 21 **the dates specified by the director. The method of payment must be by the**  
 22 **electronic or other payment method specified by the director. The tax** [OR  
 23 BEFORE MARCH 1, AND] is computed at the rate of

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

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

28 \* **Sec. 7.** AS 21.09.210(d) is amended to read:

29 (d) An authorized insurer shall, with respect to all wet marine and  
 30 transportation contracts written in this state during the preceding calendar year, [ON  
 31 OR BEFORE MARCH 1 OF EACH YEAR,] pay to the director a tax of three-quarters

1 of one percent on its gross underwriting profit. **The director shall specify the dates**  
 2 **that payment is due and the electronic or other method by which payment is to**  
 3 **be made.** The gross underwriting profit is computed by deducting, from the net  
 4 premiums on wet marine and transportation insurance contracts, the net losses paid  
 5 during the calendar year under the contracts. In the case of an insurer issuing  
 6 participating contracts, the gross underwriting profit may not include, for computation  
 7 of the tax prescribed by this section, the amounts refunded or paid as participation  
 8 dividends by the insurers to the holders of the contracts. In this subsection,

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

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

13 \* **Sec. 8.** AS 21.09 is amended by adding a new section to read:

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

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

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

25 \* **Sec. 9.** AS 21.09 is amended by adding a new section to read:

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

30 (b) To meet the requirements of (a) of this section, the insurer shall keep the  
 31 records specified in AS 21.69.390(d) for 10 years from the date the record was created

1 or as required by the record maintenance requirements of the insurer's domicile  
2 jurisdiction, whichever is longer.

3 \* **Sec. 10.** AS 21.12.020(a)(4)(A)(iii) is amended to read:

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

13 \* **Sec. 11.** AS 21.12.050 is amended to read:

14 **Sec. 21.12.050. Health and health care insurance defined.** Health insurance  
15 is insurance of human beings (1) against bodily injury, disablement, or death by  
16 accident or accidental means; (2) against the resulting expenses of the injury,  
17 disablement, or death; (3) against disablement or expense resulting from sickness or  
18 childbirth; (4) against expense incurred in prevention of sickness; (5) for dental care;  
19 and (6) **including every insurance** that applies to injury, disablement, or death.  
20 Transaction of health insurance includes disability insurance **and stop-loss insurance**  
21 but does not include workers' compensation insurance. **Health care insurance**  
22 **described in (b) of this section is a type of health insurance under this subsection.**

23 \* **Sec. 12.** AS 21.15.050 is amended by adding new subsections to read:

24 (b) Health care insurance means that part of health insurance that provides  
25 benefits for medical care whether provided directly, through reimbursement, or other  
26 method.

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

29 \* **Sec. 13.** AS 21.14.010(a) is amended to read:

30 (a) A life and health domestic insurer, property and casualty domestic insurer,  
31 or other insurer required by the director shall, on or before March 1, submit to the

1 director a report of its risk based capital covering the previous calendar year [, IF  
2 REQUIRED BY THE DIRECTOR]. The report must be in a form and contain the  
3 information required by risk based capital instructions. A domestic insurer required  
4 to submit a report under this subsection shall file the report with

5 (1) the National Association of Insurance Commissioners; and

6 (2) the insurance regulatory agency in each state in which the insurer  
7 is authorized to transact business [,] if the insurance regulatory agency has requested  
8 the report in writing from the insurer; a report requested under this paragraph shall be  
9 delivered

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

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

14 \* **Sec. 14.** AS 21.14.200(18) is amended to read:

15 (18) "risk based capital instructions" means risk based capital  
16 instructions for a life and health insurer or for a property and casualty insurer adopted  
17 by **order of** [REGULATION BY] the director **after an open meeting as provided**  
18 under **AS 44.62.310** [AS 21.14.010];

19 \* **Sec. 15.** AS 21.18.050 is amended to read:

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

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

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

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

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

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

3 (C) reserves for accidental death benefits;

4 (D) additional reserves that may be required by the director,  
5 consistent with practice formulated or approved by the National Association of  
6 Insurance Commissioners, on account of the insurance;

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

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

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

15 \* **Sec. 16.** AS 21.18.080 is repealed and reenacted to read:

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

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

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

31 \* **Sec. 17.** AS 21.18 is amended by adding new sections to read:

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

4                   (1) with level premiums or with a gross premium pricing structure at  
5 time of issue that results in future benefits exceeding the corresponding future  
6 valuation net premiums at any time; or

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

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

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

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

20                   (1) 80 percent of the total termination rate used in the calculation of  
21 gross premiums; or

22                   (2) eight percent.

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

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

29           (g) Except as provided in (d) and (h) - (k) of this section, policy reserves for  
30 policies issued after July 1, 1997, must be determined based on

31                   (1) a maximum interest rate equal to the maximum interest rate allowed

1 under AS 21.18.110 for the valuation of whole life insurance issued on the same date  
2 as the health insurance policy;

3 (2) a termination assumption equal to the mortality table allowed under  
4 AS 21.18.110 for the valuation of whole life insurance issued on the same date as the  
5 health insurance policy or equal to a mortality table approved by the director for use  
6 in determining the policy reserves;

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

8 (A) a mortality assumption equal to the 1983 Group Annuity  
9 Mortality Table without projection;

10 (B) a lapse assumption for policy durations one through four  
11 equal to the lesser of 80 percent of the voluntary lapse rate used in the  
12 calculation of gross premiums or eight percent; and

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

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

18 (5) a morbidity assumption for

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

25 (B) group disability income insurance issued

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

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

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

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

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

6 (D) cancer expense benefits for policies issued

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

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

11 (E) accidental death benefits for policies issued

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

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

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

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

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

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

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

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

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

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

6                   (k) An alternative method or basis of determining policy reserves may be used  
7 if the aggregate policy reserve is not less than the aggregate policy reserves determined  
8 under (c) - (j) of this section.

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

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

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

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

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

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

28                   (d) Claim reserves must be determined as follows:

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

1 date the claim was incurred;

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

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

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

11 (B) group disability income insurance for policies issued

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

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

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

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

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

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

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

31 (B) a description of how all the insurer's experience is proposed

1 to be used in setting the reserves;

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

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

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

7 (F) all other information requested by the director;

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

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

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

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

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

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

1 required for a policy, the unearned modal premium is the gross modal premium for the  
2 policy.

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

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

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

16 \* **Sec. 18.** AS 21.21 is amended by adding a new section to read:

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

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

30 \* **Sec. 19.** AS 21.27.010(f) is amended to read:

31 (f) A person who performs management services under a written contract for

1 an admitted insurer is not required to be licensed as a managing general agent [,] if

2 (1) either

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

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

7 (2) the person

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

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

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

12 \* **Sec. 20.** AS 21.27.010(i) is amended to read:

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

18 \* **Sec. 21.** AS 21.27.040(a) is amended to read:

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

29 \* **Sec. 22.** AS 21.27.370(b) is amended to read:

30 (b) A **person** [LICENSEE] may not be promised or paid, directly or indirectly,  
31 compensation for procuring an application or for placing a kind or class of insurance

1 for which the **person** [LICENSEE] is not then licensed to procure or place or for  
 2 insurance that the **person** [LICENSEE] is prohibited by this title from procuring or  
 3 placing.

4 \* **Sec. 23.** AS 21.27.390(b) is amended to read:

5 (b) **Except as otherwise provided by law, a** [A] temporary license may not  
 6 be in effect for more than 90 consecutive days [,] and may not be renewed or reissued  
 7 for more than one additional 90-day period.

8 \* **Sec. 24.** AS 21.27.405(b) is amended to read:

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

15 \* **Sec. 25.** AS 21.27.440(a) is amended to read:

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

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

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

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

25 \* **Sec. 26.** AS 21.27.640(b)(5) is amended to read:

26 (5) provide in or with its application

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

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

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

12 (D) certified financial statements for the prior two years, **or for**  
13 **each year and partial year that the applicant has been in business if less**  
14 **than two years**, prepared by an independent certified public accountant  
15 **establishing** [THAT ESTABLISH] that the applicant is solvent, that the  
16 applicant's system of accounting, internal control, and procedure is operating  
17 effectively to provide reasonable assurance that money is promptly accounted  
18 for and paid to the person entitled to the money, and any other information that  
19 the director may require to review the current financial condition of the  
20 applicant; and

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

26 \* **Sec. 27.** AS 21.34.040(c)(4) is amended to read:

27 (4) a Lloyd's **syndicate** or **an insurer belonging to a** [OTHER] similar  
28 group, including incorporated and individual unincorporated **insurers**  
29 [UNDERWRITERS], may qualify if it maintains a trust fund **jointly and severally**  
30 **with the other members of the group** in an amount not less than \$50,000,000, as  
31 security to the full amount, for the protection of all **policyholders** [ITS POLICY

1       HOLDERS] and creditors of each member of the group in the United States; the  
 2       incorporated members may not be engaged in any business other than underwriting as  
 3       a member of the group and shall be subject to the same level of solvency regulation  
 4       and control by the group's domiciliary regulator as are the unincorporated members;  
 5       the trust fund must consist of instruments of substantially the same character and  
 6       quality as those that are eligible investments for the capital and statutory reserves of  
 7       admitted insurers authorized to write like kinds of insurance in this state or of  
 8       irrevocable, clean, and unconditional letters of credit; the trust fund must have an  
 9       expiration date that at no time is less than five years;

10    \* **Sec. 28.** AS 21.34.040(c)(5) is amended to read:

11                   (5) **each syndicate or insurer belonging to** an insurance exchange  
 12       created by the laws of individual states may qualify if **the insurance exchange** [IT]  
 13       maintains capital and surplus, or the substantial equivalent, of not less than  
 14       \$50,000,000 in the aggregate; for insurance exchanges that maintain funds for the  
 15       protection of all insurance exchange policyholders, each individual syndicate shall  
 16       maintain minimum capital and surplus, or the substantial equivalent, of not less than  
 17       \$3,000,000; in the event the insurance exchange does not maintain funds for the  
 18       protection of all its policyholders, each individual syndicate shall meet the minimum  
 19       requirements of (1) or (2) of this subsection;

20    \* **Sec. 29.** AS 21.34.180(b) is amended to read:

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

27    \* **Sec. 30.** AS 21.34.190(a) is amended to read:

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

1 \* **Sec. 31.** AS 21.36.095(a) is amended to read:

2 (a) **A health care** [AN] insurer may not deny enrollment of a child under the  
3 health **care** insurance of the child's parent on the ground that the child

4 (1) was born out of wedlock;

5 (2) is not claimed as a dependent on the parent's federal income tax  
6 return;

7 (3) does not reside with the parent; or

8 (4) does not reside in the **health care** insurer's service area.

9 \* **Sec. 32.** AS 21.36.095(b) is amended to read:

10 (b) If a parent is required under AS 25.27.020(a)(9) or 25.27.060(c) to provide  
11 medical support for a child and the parent is eligible for family health **care insurance**  
12 coverage through an insurer, the parent's **health care** insurer

13 (1) shall allow the parent to enroll the child under the family **health**  
14 **care insurance** coverage without regard to restrictions relating to enrollment periods  
15 if the child is otherwise eligible;

16 (2) shall, if the parent fails to apply for enrollment of a child under (1)  
17 of this subsection, enroll the child under the parent's family **health care insurance**  
18 coverage upon application by the child's other parent or custodian, the child support  
19 enforcement agency, or the Department of Health and Social Services; and

20 (3) may not disenroll or eliminate **health care insurance** coverage of  
21 the child unless the insurer has received written evidence that

22 (A) the parent with the insurance coverage is no longer required  
23 by court order or administrative order to provide the child's medical support;  
24 or

25 (B) the child is or will be enrolled in comparable health **care**  
26 **insurance** coverage through another insurer that will take effect not later than  
27 the effective date of the disenrollment or elimination of coverage.

28 \* **Sec. 33.** AS 21.36.095(c) is amended to read:

29 (c) **A health care** [AN] insurer who provides health **care insurance** coverage  
30 of a child through family health **care insurance** coverage of a parent who does not  
31 have sole physical custody of the child shall

1 (1) provide to the child's other parent or custodian the information that  
 2 may be necessary for the child to obtain benefits through the family health care  
 3 insurance coverage;

4 (2) allow the child's other parent or custodian, or the child's health care  
 5 provider with the parent's or custodian's approval, to submit claims for covered  
 6 services without the approval of the parent whose health care insurance covers the  
 7 child; and

8 (3) make payment on claims submitted under (2) of this subsection  
 9 directly to the child's other parent or custodian, the health care provider, or a state  
 10 agency to which the child's medical support rights have been assigned under  
 11 AS 25.27.120 or AS 47.07.025.

12 \* **Sec. 34.** AS 21.36.095(e) is repealed and reenacted to read:

13 (e) In this section, "health care insurer" has the meaning given in  
 14 AS 21.54.500 and includes the Comprehensive Health Insurance Association as  
 15 described in AS 21.55.010.

16 \* **Sec. 35.** AS 21.36 is amended by adding a new section to read:

17 **Sec. 21.36.185. Maintenance of complaint handling records.** An insurer  
 18 shall maintain a complete record of all the complaints received by the insurer since the  
 19 date of the insurer's last market conduct examination under AS 21.06.120 or for four  
 20 years, whichever occurs first. This record must indicate the total number of  
 21 complaints, the classification of each complaint by line of insurance, the nature of each  
 22 complaint, the disposition of each complaint, and the time it took to process each  
 23 complaint. For purposes of this section, "complaint" means any written  
 24 communication primarily expressing a grievance.

25 \* **Sec. 36.** AS 21.36.240 is amended to read:

26 **Sec. 21.36.240. Failure to renew.** An insurer may only [NOT] fail to renew  
 27 a personal insurance policy on the policy's annual anniversary [IN FORCE FOR  
 28 LESS THAN 12 MONTHS]. An insurer may not fail to renew a policy unless a  
 29 written notice of nonrenewal is mailed to the named insured as required by  
 30 AS 21.36.260 at least 20 days for a personal insurance policy, and at least 45 days for  
 31 a business or commercial insurance policy, before the expiration date of the policy or

1 of the anniversary date of a policy written for a term longer than one year or with no  
 2 fixed expiration date. If notice of nonrenewal is not given as required by this section,  
 3 the existing policy shall continue until the insurer provides notice for the time period  
 4 required by this section for that policy. This section does not apply

- 5 (1) if the insurer has in good faith manifested its willingness to renew;  
 6 (2) in case of nonpayment of premium for the expiring policy; or  
 7 (3) if the insured fails to pay the premium as required by the insurer  
 8 for renewal.

9 \* **Sec. 37.** AS 21.36.290 is amended to read:

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

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

26 \* **Sec. 38.** AS 21.36.390 is repealed and reenacted to read:

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

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

1 of the provisions of AS 21.36.360 shall immediately send the director a report  
 2 disclosing the basis for that belief and any other information that the director may  
 3 require.

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

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

9 \* **Sec. 39.** AS 21.39.045(b) is amended to read:

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

15 \* **Sec. 40.** AS 21.42.130 is amended to read:

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

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

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

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

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

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

31 \* **Sec. 41.** AS 21.42 is amended by adding a new section to read:

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

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

10 \* **Sec. 42.** AS 21.42 is amended by adding a new section to read:

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

15 \* **Sec. 43.** AS 21.42.345 is repealed and reenacted to read:

16           **Sec. 21.42.345. Required provision for coverage of dependents.** (a) A  
 17 health care insurance plan providing coverage for a dependent of a covered individual  
 18 shall, as to the dependent's coverage, also provide that the health care insurance  
 19 benefits applicable for dependents shall be payable with respect to

20                   (1) a newly born child of a covered individual from the moment of  
 21 birth;

22                   (2) a child adopted by a covered individual from the date of adoption;

23                   (3) a child placed with a covered individual for adoption from the date  
 24 of placement for adoption; and

25                   (4) a spouse from not later than the first day of the first month  
 26 beginning after the date the request for enrollment is received, but the insurer may  
 27 require that a request for enrollment be received within 31 days of the date of  
 28 marriage.

29           (b) The coverage for a newly born child under this section shall consist of  
 30 coverage of injury or sickness, including the necessary care and treatment of medically  
 31 diagnosed congenital defects and birth abnormalities.

1 (c) If payment of a specific charge is required to provide coverage for a child  
 2 under this section, the policy or contract may require that notification of birth of a  
 3 newly born child, adopted child, or child placed for adoption and payment of the  
 4 required premium or fees may be required to be furnished to the health care insurer  
 5 within 31 days after the date of birth, adoption, or placement for adoption in order to  
 6 have the coverage continue beyond the 31-day period.

7 (d) Under (a) - (c) of this section, a health care insurer shall offer coverage for  
 8 a family member, including a newly born child, adopted child, or child placed for  
 9 adoption, regardless of the marital status of the covered individual.

10 \* **Sec. 44.** AS 21.42.347(a) is amended to read:

11 (a) **A health care** [AN] insurer who provides coverage for the costs of  
 12 childbirth shall also provide coverage for the costs of hospitalization or medical care  
 13 following childbirth for a period of not less than

14 (1) 48 hours after a vaginal birth; and

15 (2) 96 hours after a caesarean birth.

16 \* **Sec. 45.** AS 21.42.347(b) is amended to read:

17 (b) Except as otherwise required to provide coverage specified under (a) of this  
 18 section, this section does not affect a payment arrangement entered into between a  
 19 hospital or **health care provider** [PHYSICIAN] and **a health care** [AN] insurer.

20 \* **Sec. 46.** AS 21.42.347(d)(2) is repealed and reenacted to read:

21 (2) "health care insurer" has the meaning given in AS 21.54.500;  
 22 "health care insurer" includes the Comprehensive Health Insurance Association as  
 23 described in AS 21.55.010.

24 \* **Sec. 47.** AS 21.42.353 is repealed and reenacted to read:

25 **Sec. 21.42.353. Coverage for the costs of acupuncture treatment.** Except  
 26 for a fraternal benefit society, a health care insurer that offers, issues for delivery,  
 27 delivers, or renews in this state a health care insurance plan may offer coverage for  
 28 services of an acupuncturist licensed under AS 08.06 if the plan covers acupuncture  
 29 treatment by a health care provider who is subject to other provisions of AS 08.

30 \* **Sec. 48.** AS 21.42.355 is amended to read:

31 **Sec. 21.42.355. Coverage for cost of services provided by nurse midwives.**

1 (a) If **a health care insurance plan or an excepted benefits policy or contract** [AN  
 2 INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY, SUBSCRIBER'S  
 3 CONTRACT, ENROLLEE CONTRACT, OR FRATERNAL BENEFIT SOCIETY  
 4 CERTIFICATE] provides indemnity for the cost of services of a physician provided  
 5 to women during pregnancy, childbirth, and the period after childbirth, indemnity in  
 6 a reasonable amount shall also be provided for the cost of an advanced nurse  
 7 practitioner who provides the same services. Indemnity may be provided under this  
 8 subsection only if the advanced nurse practitioner is certified to practice as a nurse  
 9 midwife in accordance with regulations adopted under AS 08.68.100(a), and the  
 10 services provided are within the scope of practice authorized by that certification.

11 (b) If **a health care insurance plan or an excepted benefits policy or**  
 12 **contract** [AN INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY,  
 13 SUBSCRIBER'S CONTRACT, ENROLLEE CONTRACT, OR FRATERNAL  
 14 BENEFIT SOCIETY CERTIFICATE] provides for furnishing those services required  
 15 of a physician in the care of women during pregnancy, childbirth, and the period after  
 16 childbirth, the contract shall also provide that an advanced nurse practitioner may  
 17 furnish those same services instead of a physician. Services may be provided under  
 18 this subsection only if the advanced nurse practitioner is certified to practice as a nurse  
 19 midwife in accordance with regulations adopted under AS 08.68.100(a), and the  
 20 services provided are within the scope of practice authorized by that certification.

21 \* **Sec. 49.** AS 21.42.365 is repealed and reenacted to read:

22 **Sec. 21.42.365. Coverage for treatment of alcoholism or drug abuse.** (a)  
 23 Except for a fraternal benefit society, a health care insurer that offers, issues for  
 24 delivery, delivers, or renews in this state a health care insurance plan, except for  
 25 catastrophic illness insurance, providing coverage for five or more employees of an  
 26 employer in the group market shall provide a covered employee or the employee's  
 27 dependent the following coverage for treatment of alcoholism or drug abuse:

28 (1) benefits of at least \$9,600 over two consecutive benefit years; and

29 (2) lifetime benefits of at least \$19,200.

30 (b) The benefits described in (a) of this section shall be adjusted  
 31 January 1, 1999, by the director and every three years thereafter to correspond with the

1 change in the medical care component of the consumer price index for all urban  
 2 consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor  
 3 Statistics, United States Department of Labor. The base year for the first adjustment  
 4 shall be calendar year 1996.

5 (c) A health care insurer that offers a health care insurance plan providing  
 6 coverage under this section may not

7 (1) require that a covered employee or the employee's dependent be  
 8 responsible for a deductible or copayment that is different for the determination of  
 9 benefits relating to treating alcoholism or drug abuse than for the determination of  
 10 benefits for treating another covered illness;

11 (2) use a different claim payment methodology in determining the  
 12 benefits relating to treating alcoholism or drug abuse than that used in determining the  
 13 benefits for treating another covered illness;

14 (3) require prenotification of treatment or a second opinion unless the  
 15 requirement is applicable to other covered major illnesses;

16 (4) limit coverage by provisions of the insurance contract that are not  
 17 applicable to other covered major illnesses, including provisions concerning preexisting  
 18 illnesses or provisions requiring that the exact date of onset be known;

19 (5) limit treatment services under the insurance contract to either an  
 20 inpatient or outpatient service;

21 (6) exclude from coverage the cost of medically necessary treatment,  
 22 including medical or psychiatric evaluation, activity or family therapy, counseling, or  
 23 prescription drugs or supplies received at an approved treatment facility; or

24 (7) deny reimbursement for actual services rendered solely because  
 25 treatment was interrupted or not completed.

26 (d) Notwithstanding (a) of this section, if an employer employs fewer than 20  
 27 permanent, full-time employees for each working day during each of at least 20  
 28 calendar workweeks in either the current calendar year or the preceding calendar year,  
 29 a health care insurer is not required to provide the coverage specified in (a) of this  
 30 section to the employer but shall offer that coverage to the employer as optional  
 31 coverage.

- 1 (e) In this section,
- 2 (1) "alcoholism or drug abuse" means an illness characterized by
- 3 (A) a physiological or psychological dependency, or both, on
- 4 alcoholic beverages or controlled substances as defined in AS 11.71.900; or
- 5 (B) habitual lack of self-control in using alcoholic beverages or
- 6 controlled substances to the extent that the person's health is substantially
- 7 impaired or the person's social or economic function is substantially disrupted;
- 8 (2) "approved treatment facility" means treatment in a facility that is
- 9 either approved under AS 47.37.140 or located and licensed for treatment of
- 10 alcoholism or drug abuse in another state;
- 11 (3) "catastrophic illness insurance" means a health care insurance plan
- 12 that provides benefits for hospital and medical care with a lifetime maximum benefit
- 13 per insured of at least \$250,000 and that has a deductible of at least \$5,000;
- 14 (4) "cost" means the least of the following:
- 15 (A) the actual charge for the treatment received for alcoholism
- 16 or drug abuse;
- 17 (B) the usual, customary, and reasonable charge for the
- 18 treatment as determined by the contract of coverage; or
- 19 (C) the charged agreed to by contract between the treatment
- 20 provider and the health care insurer;
- 21 (5) "treatment" means medical care, including detoxification, as an
- 22 inpatient or outpatient at an approved treatment facility.

23 \* **Sec. 50.** AS 21.42.375(a) is repealed and reenacted to read:

24 (a) Except for a fraternal benefit society, a health care insurer that offers,

25 issues for delivery, delivers, or renews in this state a health care insurance plan shall

26 provide coverage for low-dose mammography screening under the schedule described

27 in (b) of this section if the plan covers mastectomies and prosthetic devices and

28 reconstructive surgery incident to mastectomies.

29 \* **Sec. 51.** AS 21.42.375(b) is amended to read:

30 (b) The minimum coverage required under (a) of this section includes

31 (1) a baseline mammogram for a **covered individual** [PERSON] who

1 is at least 35 years of age but less than 40 years of age;

2 (2) one mammogram every two years for a **covered individual**  
3 [PERSON] who is at least 40 years of age but less than 50 years of age;

4 (3) an annual mammogram for a **covered individual** [PERSON] who  
5 is at least 50 years of age;

6 (4) a mammogram at any age for a **covered individual** [PERSON] with  
7 a history of breast cancer or whose parent or sibling has a history of breast cancer,  
8 upon referral by a physician.

9 \* **Sec. 52.** AS 21.42.375(c) is amended to read:

10 (c) The coverage required by this section

11 (1) must be included in the **health care insurance plan** [POLICY OR  
12 CONTRACT] on a basis that is not less favorable than for other radiological  
13 examinations;

14 (2) may be subject to standard policy provisions applicable to other  
15 benefits, such as deductible or copayment provisions.

16 \* **Sec. 53.** AS 21.42.380 is repealed and reenacted to read:

17 **Sec. 21.42.380. Coverage for treatment of phenylketonuria.** (a) Except for  
18 a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers,  
19 or renews in this state a health care insurance plan shall provide coverage under the  
20 plan for the formulas necessary for the treatment of phenylketonuria. This subsection  
21 does not apply to a health care insurance plan that the director has determined by order  
22 should be excluded from this subsection.

23 (b) A health care insurer providing coverage under this section may impose  
24 reasonable contract limitations but may not refuse coverage based on a preexisting  
25 condition of phenylketonuria or require that an individual covered under the plan pay  
26 a higher deductible or copayment for the cost of treating phenylketonuria than for the  
27 cost of treating another condition or illness.

28 (c) In this section, "cost" means the lowest of the following:

29 (1) the actual charge for the treatment received for phenylketonuria;

30 (2) the usual, customary, and reasonable charge for the treatment as  
31 determined by the contract of coverage; or

1 (3) the charge agreed to by contract between the treatment provider and  
2 the health care insurer.

3 \* **Sec. 54.** AS 21.42.385 is repealed and reenacted to read:

4 **Sec. 21.42.385. Dental, vision, and hearing coverage.** (a) Except for a  
5 fraternal benefit society, a health care insurer that offers, issues for delivery, delivers,  
6 or renews in this state a health care insurance plan, including a Medicare supplement  
7 policy to the extent not prohibited by 42 U.S.C. 1395, shall offer to each plan sponsor  
8 or individual minimum dental, vision, and hearing coverage described in (b) of this  
9 section. Coverage required under this subsection may be offered as a rider or in a  
10 separate policy.

11 (b) The minimum coverage required under (a) of this section may

12 (1) be provided under contract with another health care insurer; and

13 (2) not be less than the dental, vision, and hearing coverage provided  
14 on January 1, 1992, to an individual entitled to medical benefits under AS 39.35.535  
15 (public employees' retirement system of Alaska).

16 (c) This section does not apply to a health care insurer that has written less  
17 than \$300,000 in premiums in the previous calendar year. A health care insurer  
18 exempt under this subsection shall disclose the exemption when offering, issuing for  
19 delivery, delivering, or renewing a health care insurance plan or an excepted benefits  
20 contract, and shall advise the individual covered under the plan that health care  
21 insurers that have written more than \$300,000 in premiums in the previous calendar  
22 year are required to offer coverage under (a) and (b) of this section.

23 (d) This section does not require an insurer who offers only group insurance  
24 coverage under AS 21.54 to offer dental, vision, and hearing coverage to an individual.

25 \* **Sec. 55.** AS 21.42.395(a) is repealed and reenacted to read:

26 (a) Except for a fraternal benefit society, a health care insurer that offers,  
27 issues for delivery, delivers, or renews in this state a health care insurance plan shall  
28 provide coverage for the costs of prostate cancer screening tests as required under the  
29 schedule described in (b) of this section and shall provide coverage for the costs of  
30 cervical cancer screening tests as required under (c) of this section. The coverage  
31 required by this section is subject to standard policy provisions applicable to other

1 benefits, including deductible or copayment provisions. If a physician recommends  
 2 that a covered individual undergo prostate cancer screening by taking a prostate  
 3 antigen blood test, coverage may not be denied because the covered individual has  
 4 already had a digital rectal examination and the examination results were negative.

5 \* **Sec. 56.** AS 21.42 is amended by adding a new section to read:

6 **Sec. 21.42.500. Definitions.** In AS 21.42.345 - 21.42.395,

7 (1) "copayment" means the portion of medical care expenses in excess  
 8 of the deductible to be paid by a covered individual;

9 (2) "deductible" means the portion of medical care expenses for which  
 10 a covered individual must pay before benefits become payable;

11 (3) "excepted benefits" has the meaning given in AS 21.54.160;

12 (4) "fraternal benefit society" has the meaning given in AS 21.84.900;

13 (5) "health care insurance plan" has the meaning given in  
 14 AS 21.54.500;

15 (6) "health care insurer" has the meaning given in AS 21.54.500;

16 (7) "placed for adoption" has the meaning given in AS 21.54.500.

17 \* **Sec. 57.** AS 21.53.090 is amended to read:

18 **Sec. 21.53.090. Required regulations.** The director shall adopt regulations  
 19 regarding

20 **(1)** the sale of long-term care insurance that provide **minimum**  
 21 standards for

22 **(A)** [(1)] terms of renewability;

23 **(B)** [(2)] initial and subsequent conditions of eligibility;

24 **(C)** [(3)] nonduplication of coverage provisions;

25 **(D)** [(4)] coverage of dependents;

26 **(E) benefit triggers;**

27 **(F)** [(5)] preexisting conditions **and recurrent conditions;**

28 **(G)** [(6)] termination of insurance;

29 **(H)** [(7)] continuation or conversion;

30 **(I)** [(8)] probationary periods, limitations, exceptions,  
 31 reductions, **and** elimination periods; [,] and

- 1                                    (J) requirements for replacement;
- 2                                    (2) standard definitions of long-term care insurance terms;
- 3                                    (3) nonforfeiture or minimum value requirements; and
- 4                                    (4) consumer protection standards, including standards for full and
- 5                                    fair disclosure setting out the manner and content of required disclosures.

6 \* **Sec. 58.** AS 21.54 is amended by adding a new section to read:

7                                    **Sec. 21.54.015. Rate requirements.** Rates charged for a group health

8                                    insurance policy may not be excessive, inadequate, or unfairly discriminatory.

9 \* **Sec. 59.** AS 21.54 is amended by adding new sections to read:

10                                    **Article 2. Health Care Insurance Provisions.**

11                                    **Sec. 21.54.100. Unfair discrimination.** (a) A health care insurer that offers,

12                                    issues for delivery, delivers, or renews a health care insurance plan in the group market

13                                    may not establish rules for eligibility, including continued eligibility and waiting

14                                    periods under the plan, for an individual or dependent of an individual based on

15                                    (1) health status;

16                                    (2) medical condition, including physical and mental illnesses;

17                                    (3) claims experience;

18                                    (4) receipt of health care;

19                                    (5) medical history;

20                                    (6) genetic information;

21                                    (7) evidence of insurability, including conditions arising from acts of

22                                    domestic violence; or

23                                    (8) disability.

24                                    (b) A health care insurer may not require an individual, as a condition of

25                                    enrollment or continued enrollment under a health care insurance plan offered in the

26                                    group market, to pay a premium, contribution, or policy fee greater than a premium,

27                                    contribution, or policy fee for a similarly situated individual already enrolled in the

28                                    plan on the basis of a health status factor for the individual or a dependent of the

29                                    individual.

30                                    **Sec. 21.54.110. Preexisting condition exclusion.** (a) A health care insurance

31                                    plan offered, issued for delivery, delivered, or renewed in the group market may not

1 contain a preexisting condition exclusion that

2 (1) relates to a condition, regardless of cause, for which medical advice,  
3 diagnosis, care, or treatment was recommended or received more than six months  
4 before the enrollment date;

5 (2) considers genetic information as a condition for which a preexisting  
6 condition exclusion may be imposed in absence of a diagnosis of the condition related  
7 to the information;

8 (3) extends for more than 12 months after the enrollment date of a  
9 covered individual; or

10 (4) excludes a condition relating to pregnancy.

11 (b) A period of a preexisting condition exclusion permissible under (a) of this  
12 section must be reduced by the aggregate of periods of creditable coverage, if any, as  
13 determined in AS 21.54.120, applicable to the participant or beneficiary as of the  
14 enrollment date. The aggregate of periods of creditable coverage is determined by  
15 adding together all periods of creditable coverage before the enrollment date, excluding  
16 periods of creditable coverage before a continuous break in coverage of more than 90  
17 days. A waiting period or affiliation period may not be considered in determining the  
18 90-day period. This subsection does not apply if an individual's most recent period  
19 of creditable coverage ended on a date more than 90 days before the enrollment date.  
20 This subsection does not preclude application of a waiting period to all new enrollees  
21 under a health care insurance plan.

22 (c) A health care insurance plan offered, issued for delivery, delivered, or  
23 renewed in this state in the group market may not apply a preexisting condition  
24 exclusion to an individual who is (1) a newborn covered under creditable coverage as  
25 of the last day of the 30-day period beginning with the date of birth; or (2) adopted  
26 or placed for adoption before attaining 18 years of age and who is covered under  
27 creditable coverage as of the last day of the 30-day period beginning with the date of  
28 adoption or placement for adoption. This subsection does not apply to an individual  
29 after the end of the first continuous 90-day period during all of which the individual  
30 was not covered under creditable coverage.

31 (d) A health care insurance plan offered, issued for delivery, delivered, or

1 renewed in this state in the group market may exclude coverage for late enrollees for  
 2 the greater of 18 months or an 18-month preexisting condition exclusion. If both a  
 3 waiting period and a preexisting condition exclusion under (a) of this section are  
 4 applicable to a late enrollee, the combined period may not exceed 18 months from the  
 5 date the individual enrolls for coverage under a health care insurance plan.

6 **Sec. 21.54.120. Creditable coverage.** (a) A health care insurer that offers,  
 7 issues for delivery, delivers, or renews in this state a health care insurance plan in the  
 8 group market shall count a period of creditable coverage based on

9 (1) the standard method authorized by 42 U.S.C. 300gg (Health  
 10 Insurance Portability and Accountability Act of 1996) for determining creditable  
 11 coverage without regard to the specific benefits covered during the period; or

12 (2) an alternative method based on coverage of benefits within each of  
 13 several classes or categories of benefits specified in federal regulation if

14 (A) made on a uniform basis for all participants and  
 15 beneficiaries; and

16 (B) the insurer counts a period of creditable coverage with  
 17 respect to any class or category of benefits if any level of benefits is covered  
 18 within the class or category.

19 (b) A health care insurer that offers, issues for delivery, delivers, or renews in  
 20 this state a health care insurance plan in the group market shall provide a certification  
 21 of coverage

22 (1) at the time an individual ceases to be covered under a health care  
 23 insurance plan or becomes covered under a federal continuation provision;

24 (2) at the time an individual ceases to be covered under a federal  
 25 continuation provision; and

26 (3) upon request by an individual or on behalf of an individual with 24  
 27 months after the date coverage under the health care insurance plan or a federal  
 28 continuation provision ceases.

29 (c) A health care insurer that offers, issues for delivery, delivers, or renews in  
 30 this state a health care insurance plan in the group market shall establish periods of  
 31 creditable coverage with respect to an individual through certification under (b) of this

1 section or as specified in federal regulation.

2 (d) A health care insurer that offers, issues for delivery, delivers, or renews in  
3 this state a health care insurance plan in the group market shall prominently state and  
4 describe the effect of the health care insurer's election to count a period of creditable  
5 coverage using a permissible alternative method

6 (1) in any disclosure statement concerning the health care insurance  
7 plan or coverage;

8 (2) to each enrollee at the time of enrollment; and

9 (3) to each employer at the time of offer or sale of coverage.

10 (e) A health care insurer issuing a certification under (b) of this section shall  
11 disclose information regarding coverage of classes and categories of health benefits  
12 available under the health care insurer's plan at the request of an entity that

13 (1) enrolls an individual who has provided the certification of coverage;

14 (2) elects to count a period of creditable coverage according to a  
15 permissible alternative method under (a)(2) of this section; and

16 (3) pays the health care insurer for the reasonable cost, if any, of  
17 disclosing the information described in this subsection.

18 **Sec. 21.54.130. Renewability, termination, and modification of coverage.**

19 (a) Except for a multiple employer welfare arrangement, a health care insurer that  
20 offers, issues for delivery, delivers, or renews in this state a health care insurance plan  
21 in the group market shall renew or continue in force the coverage under the plan at the  
22 option of the plan sponsor unless

23 (1) the plan sponsor has failed to pay premiums or contributions in  
24 accordance with the terms of the health care insurance plan or the health care insurer  
25 has not received timely premium payments;

26 (2) the plan sponsor has performed an act or practice that constitutes  
27 fraud or made an intentional misrepresentation of material fact under the terms of the  
28 coverage;

29 (3) the plan sponsor has failed to comply with a material plan provision  
30 relating to minimum participation or employer contribution requirements;

31 (4) the health care insurer ceases to offer coverage in accordance with

1 (b) and (c) of this section;

2 (5) the health care insurer offers the plan only through a network plan  
3 and there is no longer an enrollee in connection with the plan who lives, resides, or  
4 works in the service area of the insurer or in the area for which the insurer is  
5 authorized to transact business; or

6 (6) in the case of a plan that is made available only through a bona fide  
7 association, the employer's membership in the association ceases and coverage is  
8 terminated uniformly without regard to a health status factor of a covered individual.

9 (b) A health care insurer may discontinue offering a particular type of health  
10 care insurance plan in the group market as permitted by this title if the insurer

11 (1) provides written notice of the decision to discontinue coverage to  
12 all affected plan sponsors, participants, and beneficiaries and to the insurance  
13 regulatory official in each state in which an affected covered employee or dependent  
14 is known to reside; notice required under this paragraph must be given at least 180  
15 days before the insurer fails to renew the health care insurance plan;

16 (2) provides written notice of the decision to discontinue coverage to  
17 the director and to the insurance regulatory official in each state in which the insurer  
18 is licensed at least 30 days before notice is given to the affected plan sponsors,  
19 participants, and beneficiaries as described under (1) of this subsection;

20 (3) offers to each plan sponsor who is provided the particular type of  
21 health care insurance plan the option to purchase another health care insurance plan  
22 currently being offered by the insurer to plan sponsors in the same market in the state;  
23 and

24 (4) acts uniformly without regard to the claims experience of those plan  
25 sponsors or to any health status factor of a covered participant or beneficiary or a new  
26 participant or beneficiary who may become eligible for coverage.

27 (c) A health care insurer may discontinue offering and renewing all health care  
28 insurance plans in the group market as permitted by this title if the insurer

29 (1) provides written notice of the decision to discontinue coverage to  
30 all affected plan sponsors, participants, and beneficiaries and to the insurance  
31 regulatory official in each state in which an affected covered employee or dependent

1 is known to reside; notice required under this paragraph must be given at least 180  
2 days before discontinuation of the plans;

3 (2) provides written notice of the decision to discontinue coverage to  
4 the director and to the insurance regulatory official in each state in which the insurer  
5 is licensed at least 30 days before the notice is given to the affected plan sponsors,  
6 participants, and beneficiaries as described under (1) of this subsection; and

7 (3) does not issue a health care insurance plan in the group market in  
8 this state for five years from the date the last group health care insurance plan was  
9 discontinued.

10 (d) A health care insurer may modify a large employer's health care insurance  
11 plan at the time of plan renewal.

12 (e) Except for coverage available only through a bona fide association, a health  
13 care insurer may modify a small employer's health care insurance plan consistent with  
14 this title at the time of plan renewal only if the modification is uniform for all small  
15 employers with the same health care insurance plan.

16 (f) If a covered employee or dependent has committed a fraudulent act or  
17 made an intentional misrepresentation of a material fact in regard to a health care  
18 insurance plan, a health care insurer may terminate the coverage of the employee or  
19 the dependent under the plan.

20 (g) For purposes of this section, a plan sponsor includes an employer member  
21 of a bona fide association for a health care insurance plan made available by the health  
22 care insurer only through a bona fide association.

23 **Sec. 21.54.140. Renewability of coverage for a multiple employer welfare**  
24 **arrangement.** A health benefit plan that is a multiple employer welfare arrangement  
25 subject to this title may not deny an employer whose employees are covered under the  
26 plan continued access to the same or a different plan according to the terms of the  
27 plan, except

28 (1) for nonpayment of contributions;

29 (2) for fraud or other intentional misrepresentation of material fact by  
30 the employer;

31 (3) for noncompliance with material plan provisions;

1 (4) where the plan is ceasing to offer any coverage in a geographic  
2 area;

3 (5) for a health benefit plan that offers benefits through a network plan  
4 if

5 (A) there is no longer an individual enrolled through the  
6 employer who lives, resides, or works in the service area of the network plan;  
7 and

8 (B) the multiple employer welfare arrangement applies this  
9 paragraph without regard to the claims experience of the employer or a health  
10 status factor in relation to an individual or an individual's dependent; and

11 (6) for failure to meet the terms of an applicable collective bargaining  
12 agreement to renew a collective bargaining or other agreement requiring or authorizing  
13 contributions to the plan or to employ employees covered by a collective bargaining  
14 agreement.

15 **Sec. 21.54.150. Mental health benefits.** (a) Except as provided in (d) of this  
16 section, a health care insurance plan sold in the large employer group market that  
17 provides both medical and surgical benefits and mental health benefits shall meet the  
18 following requirements:

19 (1) if the plan does not include an aggregate lifetime limit on  
20 substantially all medical and surgical benefits, the plan may not provide for an  
21 aggregate lifetime limit on mental health benefits;

22 (2) if the plan includes an aggregate lifetime limit on substantially all  
23 medical and surgical benefits, the plan must

24 (A) include the mental health benefits within the aggregate  
25 lifetime limit and may not distinguish in the application of the limit between  
26 medical and surgical benefits and mental health benefits; or

27 (B) provide an aggregate lifetime limit for mental health  
28 benefits that is not less than the aggregate lifetime limit for medical and  
29 surgical benefits;

30 (3) if the plan includes different aggregate lifetime limits or none on  
31 different categories of medical and surgical benefits, the plan must provide for

1 aggregate lifetime limits on mental health benefits consistent with federal law;

2 (4) if the plan does not include an annual limit on substantially all  
3 medical and surgical benefits, the plan may not provide for an annual limit on mental  
4 health benefits;

5 (5) if the plan includes an annual limit on substantially all medical and  
6 surgical benefits, the plan must

7 (A) include the mental health benefits with the annual limit and  
8 may not distinguish in the application of the limit between medical and surgical  
9 benefits and mental health benefits; or

10 (B) provide an annual limit for mental health benefits that is not  
11 less than the annual limit for medical and surgical benefits; and

12 (6) if the plan includes different annual limits or none on different  
13 categories of medical and surgical benefits, the plan must provide for annual limits on  
14 mental health benefits consistent with federal law.

15 (b) Except as provided otherwise in this title, a health care insurance plan is  
16 not required to provide mental health benefits.

17 (c) Except as otherwise provided in this title, this section does not affect the  
18 terms and conditions relating to the amount, duration, or scope of mental health  
19 benefits under a health care insurance plan that provides mental health benefits,  
20 including cost sharing, limits on number of visits or days of coverage, and  
21 requirements relating to medical necessity.

22 (d) This section does not apply if application of this section would result in  
23 an increase in the cost under the health care insurance plan of at least one percent.

24 **Sec. 21.54.160. "Excepted benefits" defined.** "Excepted benefits" means  
25 benefits under one or more or any combination of the following:

26 (1) benefits under

27 (A) coverage only for accident, disability income insurance, or  
28 both;

29 (B) coverage issued as a supplement to liability insurance;

30 (C) liability insurance, including general liability insurance and  
31 automobile liability insurance;

- 1 (D) workers' compensation or substantially similar insurance;  
 2 (E) automobile medical payment insurance;  
 3 (F) credit-only insurance;  
 4 (G) coverage for on-site medical clinics; or  
 5 (H) other similar insurance coverage, as specified in federal law,  
 6 under which benefits for medical care are secondary or incidental to other  
 7 insurance benefits;

8 (2) if offered as a separate insurance policy and otherwise not an  
 9 integral part of a health care insurance plan, benefits under

10 (A) limited scope dental or vision coverage;

11 (B) coverage for long-term care, nursing home care, home  
 12 health care, community-based care, or any combination; or

13 (C) other similar limited benefits as specified in federal law;

14 (3) if offered as independent noncoordinated benefits, benefits under  
 15 coverage only for a specified disease or illness, or hospital indemnity or other fixed  
 16 indemnity insurance; as used in this paragraph, "independent, noncoordinated benefits"  
 17 means benefits that are provided under a separate policy if

18 (A) there is no coordination between the provision of the  
 19 benefits and an exclusion of benefits under a health care insurance plan  
 20 maintained by the same plan sponsor; and

21 (B) the benefits are paid with respect to an event without regard  
 22 to whether benefits are provided for the event under a health care insurance  
 23 plan maintained by the same plan sponsor;

24 (4) if offered as a separate insurance policy, benefits under

25 (A) Medicare supplement health insurance as defined in 42  
 26 U.S.C. 1345ss(g)(1) (Social Security Act);

27 (B) coverage supplemental to the coverage provided under 10  
 28 U.S.C. 1071 - 1090; or

29 (C) similar supplemental coverage provided to coverage under  
 30 a health benefit plan.

31 **Sec. 21.54.170. Determination of size of employer.** The determination of

1 whether an employer is a large or small employer is subject to the following:

2 (1) the size of an employer that was not in existence throughout the  
3 preceding calendar year must be based on the average number of employees that the  
4 employer is reasonably expected to employ on the business days in the current  
5 calendar year;

6 (2) all persons treated as a single employer under 26 U.S.C. 414(b), (c),  
7 (m), or (o) must be treated as one employer; and

8 (3) a reference to a large or small employer includes by reference any  
9 predecessor of that employer.

### 10 **Article 3. Definitions.**

11 **Sec. 21.54.500. Definitions.** In this chapter,

12 (1) "aggregate lifetime limit" means a dollar limit on the total amount  
13 that may be paid for benefits under a health care insurance plan offered in the group  
14 market with respect to an individual or unit of coverage;

15 (2) "annual limit" means a dollar limit on the total amount that may be  
16 paid for benefits in a 12-month period under the plan with respect to an individual or  
17 unit of coverage;

18 (3) "beneficiary" has the meaning given under 29 U.S.C. 1002(8)  
19 (Employee Retirement Income Security Act of 1974);

20 (4) "bona fide association" means an association that

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

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

24 (C) does not condition membership in the association on a  
25 health status factor relating to an individual;

26 (D) makes health care insurance available to all members and  
27 dependents of members regardless of a health status factor in relation to the  
28 member or dependent;

29 (E) does not offer a health care insurance plan to an individual  
30 other than in connection with a member of the association; and

31 (F) meets any other requirement established by the director in

1 regulations;

2 (5) "certification of coverage" means a written certification of

3 (A) the period of creditable coverage of an individual under a  
4 health benefit plan or health care insurance plan offered in the group market,  
5 including coverage under a federal continuation provision; and

6 (B) the waiting period imposed with respect to the individual  
7 for coverage under the health benefit plan or health care insurance plan offered  
8 in the group market;

9 (6) "church plan" has the meaning given under 29 U.S.C. 1002(33)  
10 (Employee Retirement Income Security Act of 1974);

11 (7) "creditable coverage" means, with respect to an individual,  
12 coverage, excluding excepted benefits, calculated as required under AS 21.54.120 and  
13 applicable under

14 (A) a health care insurance plan offered in the group market;

15 (B) a health benefit plan;

16 (C) 42 U.S.C. 1395c or 1395j (Part A or Part B of Title XVIII  
17 of the Social Security Act):

18 (D) 42 U.S.C. 1396 (Title XIX of the Social Security Act),  
19 other than coverage consisting solely of benefits under 42 U.S.C. 1396s;

20 (E) 10 U.S.C. 1071 - 1090;

21 (F) a medical care program of the Indian Health Service or of  
22 a tribal organization;

23 (G) AS 21.55;

24 (H) 5 U.S.C. 8901 - 8914;

25 (I) a public health plan as defined under federal law; or

26 (J) a health benefit plan under 22 U.S.C. 2504(e) (Peace Corps  
27 Act);

28 (8) "employee" has the meaning given under 29 U.S.C. 1002(6)  
29 (Employee Retirement Income Security Act of 1974);

30 (9) "employer" has the meaning given under 29 U.S.C. 1002(5)  
31 (Employee Retirement Income Security Act of 1974); for purposes of this chapter,

1 "employer" includes a large or small employer, including a person, firm, corporation,  
2 partnership, association, or political subdivision, that is actively engaged in business;

3 (10) "enrollment date" means the date of enrollment of an individual  
4 in a health benefit plan or health care insurance plan offered in the group market or  
5 the first day of the waiting period for enrollment, whichever occurs first;

6 (11) "federal continuation provision" means a "COBRA continuation  
7 provision" as defined in 42 U.S.C. 300gg-91(d) (Health Insurance Portability and  
8 Accountability Act of 1996);

9 (12) "federal governmental plan" means a governmental plan  
10 established or maintained for employees of the United States government or by an  
11 agency or instrumentality of the United States government;

12 (13) "governmental plan" has the meaning given under 29 U.S.C.  
13 1002(32) Employee Retirement Income Security Act of 1974);

14 (14) "group market" means the health care insurance market in which  
15 individuals obtain health care insurance coverage on behalf of themselves and their  
16 dependents through a health benefit plan maintained by a large or small employer;  
17 "group market" includes a health benefit plan for a small employer in the group market  
18 that includes an arrangement under which

19 (A) a portion of the premium or benefits is paid by a small  
20 employer;

21 (B) a covered individual or dependent is reimbursed, through  
22 wage adjustments or otherwise, by or on behalf of a small employer for all or  
23 a portion of the premium; or

24 (C) the health benefit plan is treated by the employer or any of  
25 the eligible employees or dependents as part of a plan or program for the  
26 purposes of 26 U.S.C. 106 or 26 U.S.C. 162 (Internal Revenue Code);

27 (15) "health benefit plan" means an employee welfare benefit plan as  
28 defined in 29 U.S.C. 1002(1) (Employee Retirement Income Security Act of 1974),  
29 and includes a plan, fund, or program established or maintained by a partnership, to  
30 the extent that the plan, fund, or program provides medical care, including items and  
31 services paid for as medical care to employees, present or former partners, or their

1 dependents, as defined under the terms of the plan, fund, or program, directly or  
2 through insurance, reimbursement, or other method;

3 (16) "health care insurance plan" means a health care insurance policy  
4 or contract provided by a health care insurer but does not include an excepted benefits  
5 policy or contract;

6 (17) "health care insurer" means a person transacting the business of  
7 health care insurance, including an insurance company licensed under AS 21.09, a  
8 hospital or medical service corporation licensed under AS 21.87, a fraternal benefit  
9 society licensed under AS 21.84, a health maintenance organization licensed under  
10 AS 21.86, a multiple employer welfare arrangement, a church plan, and a  
11 governmental plan, except for a nonfederal governmental plan that elects to be  
12 excluded under 40 U.S.C. 300gg-21(b)(2) (Health Insurance Portability and  
13 Accountability Act of 1996);

14 (18) "health status factor" means any of the factors described in  
15 AS 21.54.100(a);

16 (19) "large employer" means an employer that employed an average of  
17 at least 51 employees on the business days during the preceding calendar year and that  
18 employs at least two employees on the first day of a health benefit plan year;

19 (20) "late enrollee" means a participant or beneficiary who requests  
20 enrollment in an employer's health care insurance plan following the initial enrollment  
21 period for which the participant or beneficiary was eligible to enroll under the terms  
22 of a health care insurance plan, except that a participant or beneficiary may not be  
23 considered a late enrollee if

24 (A) the individual requests enrollment within 30 days after the  
25 termination of the creditable coverage or the exhaustion of coverage and

26 (i) was covered under creditable coverage at the time of  
27 the initial enrollment;

28 (ii) has lost creditable coverage as a result of the  
29 termination of employer contributions toward coverage or the  
30 termination of eligibility, including death, divorce, dissolution of  
31 marriage, legal separation, or a reduction in number of hours of

1 employment; or

2 (iii) had coverage under a federal continuation provision  
3 and the coverage under that provision was exhausted;

4 (B) the individual is employed by an employer who offers  
5 multiple health care insurance plans and the individual elects a different health  
6 care insurance plan during an open enrollment period; or

7 (C) a court has ordered coverage to be provided for a spouse  
8 or minor child under a covered employee's plan and request for enrollment is  
9 made within 30 days after issuance of the court order;

10 (21) "medical and surgical benefits" means benefits provided for  
11 medical or surgical services, but does not include mental health benefits;

12 (22) "mental health benefits" means benefits provided for mental health  
13 services as defined under the terms of the health care insurance plan, but does not  
14 include benefits for treatment of substance abuse or chemical dependency;

15 (23) "network plan" means a health care insurance plan offered in the  
16 group market or by an insurer under which the financing and delivery of medical care,  
17 including items and services paid for as medical care, are provided in whole or in part  
18 through a defined set of providers under contract with the insurer;

19 (24) "participant" has the meaning given under 29 U.S.C. 1002(7)  
20 (Employee Retirement Income Security Act of 1974); "participant" includes a

21 (A) partner in relation to a partnership; or

22 (B) self-employed individual if the individual or the individual's  
23 beneficiaries are or may become eligible to receive benefits under a health  
24 benefit plan maintained by the self-employed individual;

25 (25) "placed for adoption" means the assumption and retention by an  
26 individual of a legal obligation for total or partial support of a child in anticipation of  
27 adopting the child;

28 (26) "plan sponsor" has the meaning given under 29 U.S.C.  
29 1002(16)(B) (Employee Retirement Income Security Act of 1974);

30 (27) "preexisting condition exclusion" means a limitation or exclusion  
31 of benefits relating to a physical or mental condition that was present before the

1 enrollment date, regardless of whether medical advice, diagnosis, care, or treatment  
2 was recommended or received before the enrollment date;

3 (28) "small employer" means an employer that employed an average  
4 of at least two but not more than 50 employees on the business days during the  
5 preceding calendar year and that employs at least two employees on the first day of  
6 a health benefit plan year;

7 (29) "waiting period" means the period that must pass before an  
8 individual who is a potential participant or beneficiary in a health care insurance plan  
9 offered in the group market is eligible to be covered for benefits under the terms of  
10 the plan.

11 \* **Sec. 60.** AS 21.55.100(a) is amended to read:

12 (a) The association shall make available to residents who are high risks **or to**  
13 **federally defined eligible individuals** an individual state plan of health insurance.

14 The association shall offer three alternatives related to deductibles as described in  
15 AS 21.55.120 and may offer additional deductible alternatives.

16 \* **Sec. 61.** AS 21.55.100(c) is amended to read:

17 (c) The association may not refuse to offer coverage under a state plan to  
18 residents who are high risks, **or to federally defined eligible individuals,** [AND] who  
19 are eligible under this chapter. The association may not refuse coverage under a state  
20 plan to residents who are high risks, **or to federally defined eligible individuals, who**  
21 **[.]** are eligible under this chapter, apply for coverage, and pay the required premium.

22 \* **Sec. 62.** AS 21.55.100(d) is amended to read:

23 (d) The association may make available to residents who are high risks **and**  
24 **to federally defined eligible individuals** coverage through a health maintenance  
25 organization or other managed care arrangement as approved by the director.

26 \* **Sec. 63.** AS 21.55.130 is amended by adding a new subsection to read:

27 (d) A state plan issued to a federally defined eligible individual may not  
28 impose a preexisting condition exclusion.

29 \* **Sec. 64.** AS 21.55.300(a) is amended to read:

30 (a) Except as provided in this section, a state resident who is a high risk **or**  
31 **a federally defined eligible individual** is eligible to enroll in a state plan described

1 in AS 21.55.100.

2 \* **Sec. 65.** AS 21.55.300(b) is amended to read:

3 (b) **Except for a federally defined eligible individual, a** [A] person may not  
4 be covered by the state plan

5 (1) while covered by another health insurance policy or subscriber  
6 contract; or

7 (2) if the person is eligible to be covered by a plan subject to the  
8 requirements of AS 21.56.110 - 21.56.250.

9 \* **Sec. 66.** AS 21.55.310 is amended to read:

10 **Sec. 21.55.310. Enrollment by an eligible person.** A person may enroll in  
11 a state plan by applying to the writing carrier. The application must include the  
12 following:

13 (1) name, address, age, and length of residency of the applicant;

14 (2) a designation of the plan desired, including deductible option  
15 chosen;

16 (3) information relevant to whether the person is a high risk **or a**  
17 **federally defined eligible individual;** and

18 (4) payment of the first premium.

19 \* **Sec. 67.** AS 21.55.500(9) is repealed and reenacted to read:

20 (9) "resident" means

21 (A) except for a federally defined eligible individual and an  
22 individual who is absent from the state for more than 90 consecutive days for  
23 reasons other than for medical treatment or education, an individual who

24 (i) is physically present in the state, has lived in the  
25 state for at least the 12 consecutive months immediately preceding the  
26 application for a state plan, and intends to remain permanently in the  
27 state; or

28 (ii) is not physically present in the state if the person  
29 lived in the state for at least nine of the 12 months immediately  
30 preceding application for a state plan and the person's absence from the  
31 state is for medical treatment or education;

1 (B) for a federally defined eligible individual, an individual who  
2 is legally domiciled in this state.

3 \* **Sec. 68.** AS 21.55.500 is amended by adding new paragraphs to read:

4 (14) "creditable coverage" has the meaning given in AS 21.54.500;

5 (15) "federal continuation provision" has the meaning given in  
6 AS 21.54.500;

7 (16) "federally defined eligible individual" means an individual

8 (A) with an aggregate of all periods of creditable coverage as  
9 provided under AS 21.54.110(b) that is greater than 18 months as of the date  
10 that the individual seeks coverage under this chapter;

11 (B) whose most recent prior creditable coverage was under a  
12 health benefit plan or health care insurance plan offered in the group market;

13 (C) who is not eligible for coverage under a health benefit plan,  
14 42 U.S.C. 1395c or 42 U.S.C. 1395j (Part A or Part B of Title XVIII of the  
15 Social Security Act), or a state plan under 42 U.S.C. 1396 (Title XIX of the  
16 Social Security Act), and who does not have other health care insurance  
17 coverage;

18 (D) whose most recent coverage within the period of aggregate  
19 creditable coverage as provided under AS 21.54.110(b) was not terminated  
20 based on a factor relating to nonpayment of premiums or fraud;

21 (E) who, having been offered and having elected continuation  
22 coverage under a federal continuation provision or a similar state program, has  
23 exhausted coverage under the continuation provision or program;

24 (17) "group market" has the meaning given in AS 21.54.500;

25 (18) "health benefit plan" has the meaning given in AS 21.54.500;

26 (19) "health care insurance plan" has the meaning given in  
27 AS 21.54.500;

28 (20) "health care insurer" has the meaning given in AS 21.54.500;

29 (21) "preexisting condition exclusion" has the meaning given in  
30 AS 21.54.500.

31 \* **Sec. 69.** AS 21.56.010 is amended to read:

1           **Sec. 21.56.010. Creation; membership.** A nonprofit incorporated legal entity  
 2 to be known as the Small Employer Health Reinsurance Association is established.  
 3 Membership consists of all **health care** insurers [LICENSED TO TRANSACT  
 4 HEALTH INSURANCE IN THE STATE THAT OFFER A HEALTH BENEFIT  
 5 PLAN]. All members shall maintain membership in the **reinsurance** association as  
 6 a condition of **transacting** [DOING] health **care** insurance business [, OR BEING  
 7 ABLE TO OFFER SUBSCRIBER CONTRACTS,] in the state.

8 \* **Sec. 70.** AS 21.56.020(a) is amended to read:

9           (a) The board of directors of the **reinsurance** association consists of nine  
 10 individuals selected by participating members, subject to approval by the director. The  
 11 director shall endeavor to appoint at least six board members who are also small  
 12 employer insurers. If the director is unable to appoint six board members who are also  
 13 small employer insurers, the director may fill the remaining seats with any insurer. In  
 14 selecting members of the board, the director shall consider, among other things,  
 15 whether all types of participating members are fairly represented.

16 \* **Sec. 71.** AS 21.56.020(b) is amended to read:

17           (b) To the extent possible, one board member shall represent a health  
 18 maintenance organization, one board member shall represent a hospital or medical  
 19 service corporation, one board member's principal health insurance business shall be  
 20 in the small employer **group** market, and one board member's principal health  
 21 insurance business shall be in the large employer **group** market. Members of the  
 22 board may be reimbursed from the **reinsurance** association for expenses incurred by  
 23 them as members, but may not otherwise be compensated by the **reinsurance**  
 24 association for their services. The costs of conducting meetings of the **reinsurance**  
 25 association and its board of directors shall be borne by the **reinsurance** association.

26 \* **Sec. 72.** AS 21.56.030 is amended to read:

27           **Sec. 21.56.030. General powers.** The **reinsurance** association may

- 28                   (1) exercise the powers granted to insurers under the laws of the state,  
 29 except that the **reinsurance** association may not issue insurance;  
 30                   (2) sue or be sued;  
 31                   (3) enter into contracts with insurers, similar **reinsurance** associations

1 in other states, or with other persons for the performance of administrative functions;

2 (4) establish administrative and accounting procedures for the operation  
3 of the **reinsurance** association;

4 (5) take legal action as necessary to avoid the payment of improper  
5 claims against the **reinsurance** association;

6 (6) define the array of health coverage products for which reinsurance  
7 will be provided and issue reinsurance policies;

8 (7) establish rules, conditions, and procedures pertaining to the  
9 reinsurance of members' risks by the **reinsurance** association;

10 (8) establish actuarial functions appropriate to the operation of the  
11 **reinsurance** association;

12 (9) assess members under the provisions of this chapter and make  
13 advance interim assessments as may be reasonable and necessary for organizational  
14 and interim operating expenses; interim assessments shall be credited as offsets against  
15 regular assessments due following the close of the calendar year;

16 (10) appoint appropriate legal, actuarial, and other committees as are  
17 necessary to provide technical assistance in the operation of the **reinsurance**  
18 association, design of a policy or contract, or to assist in other functions of the  
19 **reinsurance** association;

20 (11) borrow money to accomplish the purposes of the **reinsurance**  
21 association; notes or other evidence of indebtedness of the **reinsurance** association that  
22 are not in default are investments for insurers and may be carried as admitted assets.

23 \* **Sec. 73.** AS 21.56.040 is amended to read:

24 **Sec. 21.56.040. Plan of operation.** (a) The **reinsurance** association shall  
25 submit to the director a plan of operation and amendments necessary or suitable to  
26 assure the fair, reasonable, and equitable administration of the **reinsurance** association.  
27 The director may, after notice and hearing, approve the plan of operation if the director  
28 determines it to be suitable to assure the fair, reasonable, and equitable administration  
29 of the program on a proportionate basis under the provisions of this section and it does  
30 not shift program costs to other insured persons or the state. The plan of operation  
31 and amendments become effective upon approval in writing by the director.

1 (b) All members of the reinsurance association shall comply with the plan of  
2 operation.

3 (c) The plan of operation must establish procedures for

4 (1) handling and accounting of program assets and money of the  
5 reinsurance association and for an annual fiscal report to the director;

6 (2) reinsuring risks under the provisions of this section;

7 (3) collecting assessments from all members to provide for claims  
8 reinsured by the reinsurance association and for administrative expenses incurred or  
9 estimated to be incurred by the reinsurance association;

10 (4) selection of an administering insurer and establishing the  
11 administering insurer's powers and duties;

12 (5) effectuating a methodology for applying the dollar thresholds  
13 contained in this section for insurers that pay or reimburse health care providers by  
14 capitation or salary; and

15 (6) provisions necessary or proper for the execution of the powers and  
16 duties of the reinsurance association.

17 \* **Sec. 74.** AS 21.56.050 is amended to read:

18 **Sec. 21.56.050. Health care reinsurance.** (a) A member may reinsure health  
19 care coverage of an eligible employee of a small employer or a dependent of an  
20 eligible employee of a small employer with the reinsurance association only under the  
21 following provisions:

22 (1) regarding a small employer basic or standard health care insurance  
23 [BENEFIT] plan, the reinsurance association shall reinsure the level of coverage  
24 provided;

25 (2) regarding a health care plan other than a small employer health care  
26 insurance [BENEFIT] plan, the reinsurance association shall reinsure the level of  
27 coverage provided up to, but not exceeding, the level of coverage provided in a small  
28 employer basic or standard health benefit plan;

29 (3) a small employer insurer may reinsure an entire employer group  
30 within 60 days of the commencement of the group's coverage under a health care  
31 insurance [BENEFIT] plan;

1 (4) a small employer insurer may reinsure an eligible employee or  
2 dependent within a period of 60 days following the commencement of the coverage  
3 with the small employer; a newly eligible employee or dependent of a reinsured small  
4 employer may be reinsured within 60 days of the commencement of coverage;

5 (5) the reinsurance association may not reimburse a reinsuring insurer  
6 regarding the claims of a reinsured employee or dependent until the insurer has paid  
7 an initial level of claims for the employee or dependent of \$5,000 in a calendar year  
8 for benefits covered by the reinsurance association;

9 (6) a small employer insurer may terminate reinsurance for one or more  
10 of the reinsured employees or dependents of a small employer on any plan anniversary.

11 (b) Premium rates charged for coverage reinsured by the reinsurance  
12 association shall be established as required under (e) of this section and adjusted as  
13 follows:

14 (1) for whole group small employer reinsurance coverage, 1.5  
15 multiplied by the base premium rate established by the reinsurance association for  
16 eligible employees, and dependents of eligible employees, of a small employer all of  
17 whose health insurance coverage is reinsured with the reinsurance association;

18 (2) for eligible employee or dependent health reinsurance coverage, 5.0  
19 multiplied by the base premium rate established by the reinsurance association.

20 (c) If a health care insurance [BENEFIT] plan coverage for a small employer  
21 is entirely or partially reinsured with the reinsurance association, the premium charged  
22 to the small employer for a rating period for the coverage issued under this section  
23 shall meet the premium rate requirements established under AS 21.56.120.

24 (d) On or before March 1 of each year, the board shall determine and report  
25 to the director the reinsurance association's net loss for the previous calendar year,  
26 including administrative expenses and incurred losses for the year, taking into account  
27 investment income and other appropriate gains and losses. A net loss for the year  
28 shall be recovered by assessments collected from reinsuring insurers. The board shall  
29 establish, as part of the plan of operation, a formula by which to make assessments  
30 against reinsuring insurers. The assessment formula must be based on each reinsuring  
31 insurer's share of the total premiums earned in the preceding calendar year from health

1 **care insurance** [BENEFIT] plans delivered or issued for delivery to small employers  
2 in this state by reinsuring carriers and each reinsuring insurer's share of the premiums  
3 earned in the preceding calendar year from newly issued health **care insurance**  
4 [BENEFIT] plans delivered or issued for delivery during the calendar year to small  
5 employers in this state by reinsuring insurers. In determining an assessment, if any,  
6 that is collected from a member, the following provisions apply:

7 (1) the formula established under this subsection may not result in a  
8 reinsuring insurer having an assessment share that is less than 50 percent or more than  
9 150 percent of an amount that is based on the proportion of the reinsuring insurer's  
10 total premiums earned in the preceding calendar year from health **care insurance**  
11 [BENEFIT] plans delivered or issued for delivery to small employers in this state by  
12 reinsuring insurers to total premiums earned in the preceding calendar year from health  
13 **care insurance** [BENEFIT] plans delivered or issued for delivery to small employers  
14 in this state by all reinsuring carriers;

15 (2) the board may, with approval of the director, change the assessment  
16 formula established under this section from time to time, as appropriate; the board may  
17 provide for the shares of the assessment base attributable to premiums from all health  
18 **care insurance** [BENEFIT] plans and to premiums from newly issued health **care**  
19 **insurance** [BENEFIT] plans to vary during a transition period;

20 (3) subject to the approval of the director, the board shall make an  
21 adjustment to the assessment formula for reinsuring carriers that are approved health  
22 maintenance organizations that are federally qualified under 42 U.S.C. 300, to the  
23 extent, if any, that restrictions are imposed on those organizations that are not imposed  
24 on other small employer **insurers** [CARRIERS];

25 (4) annually before March 1, the board shall determine and file with  
26 the director an estimate of the assessments needed to fund losses incurred by the  
27 **reinsurance** association in the previous calendar year;

28 (5) if the board determines that the assessments needed to fund the  
29 losses incurred by the **reinsurance** association in the previous calendar year will  
30 exceed five percent of total premiums earned in the previous year from health **care**  
31 **insurance** [BENEFIT] plans delivered or issued for delivery to small employers in this

1 state by reinsuring insurers, the board shall evaluate the operation of the program and  
2 report its findings, including any recommendations for changes to the plan of  
3 operation, to the director within 90 days following the end of the calendar year in  
4 which the losses were incurred; the evaluation must include an estimate of future  
5 assessments, the administrative costs of the program, the appropriateness of the  
6 premiums charged, and the level of insurer retention under the program and the costs  
7 of coverage for small employers; if the board fails to file a report with the director  
8 within 90 days following the end of the applicable calendar year, the director may  
9 evaluate the operations of the program and implement amendments to the plan of  
10 operation the director determines necessary to reduce future losses and assessments;

11 (6) if assessments exceed net losses of the reinsurance association, the  
12 excess shall be held in an interest bearing account and used by the board to offset  
13 future losses or to reduce reinsurance association premiums; in this paragraph, "future  
14 losses" include a reserve for incurred but not reported claims;

15 (7) the board shall annually determine a member's proportion of  
16 participation in the reinsurance association based on annual statements and other  
17 reports determined necessary by the board and filed by the member with the board; an  
18 insurer shall report to the board a claim payment made and administrative expense  
19 incurred in this state on a semi-annual basis on a form prescribed by the director;

20 (8) the plan of operation must include a provision for the imposition  
21 of an interest penalty for late payment of assessments;

22 (9) a member may request a deferment from the director, in whole or  
23 in part, from an assessment issued by the board; the director may defer, in whole or  
24 in part, the assessment of a member if, in the opinion of the director payment of the  
25 assessment would endanger the ability of the member to fulfill the member's  
26 contractual obligations;

27 (10) in the event an assessment against a member is deferred in whole  
28 or in part, the amount by which the assessment is deferred may be assessed against the  
29 other members in a manner consistent with the basis for assessments set out in this  
30 subsection; the member receiving a deferment shall remain liable to the reinsurance  
31 association for the amount deferred; the director may attach conditions to a deferment;

1 a member receiving a deferment may not reinsure an individual or group as provided  
2 under this section until the assessment is paid.

3 (e) The board, as part of the plan of operation, shall establish a methodology  
4 for determining premium rates to be charged by the program for reinsuring small  
5 employers and individuals under this section. The methodology must include a system  
6 for classification of small employers that reflects the types of case characteristics  
7 commonly used by small employer insurers in the state. The methodology must  
8 provide for the development of base reinsurance premium rates that shall be multiplied  
9 by the factors set out in (b) of this section to determine the premium rates for the  
10 reinsurance association. The base reinsurance premium rates shall be established by  
11 the board, subject to the approval of the director, and shall be set at levels that  
12 reasonably approximate gross premiums charged to small employers by small employer  
13 insurers for health care insurance [BENEFIT] plans with benefits similar to the  
14 standard health care insurance [BENEFIT] plan. The board shall review the  
15 methodology established under this subsection to ensure that the methodology  
16 reasonably reflects the claims experience of the program. Changes to the methodology  
17 may be proposed by the board [,] and are subject to approval by the director. In this  
18 subsection, "gross premiums" means the premium charged for insurance before  
19 reducing the premium for a dividend or rate credit.

20 \* **Sec. 75.** AS 21.56.060 is amended to read:

21 **Sec. 21.56.060. Health care insurance [BENEFIT] plan committee.** (a)  
22 The health care insurance [BENEFIT] plan committee is established in the  
23 reinsurance association. The committee is composed of seven members selected by  
24 the director as follows:

- 25 (1) three members who are representatives of participating insurers;
- 26 (2) one member who represents small employers;
- 27 (3) one member who represents employees of small employers;
- 28 (4) one member who represents health care providers; and
- 29 (5) one member who represents agents or brokers.

30 (b) The committee shall recommend benefit levels, cost sharing levels,  
31 exclusions and limitations for the basic and standard health care insurance

1 [BENEFIT] plan offered under AS 21.56.140. The committee shall also design a basic  
 2 health care insurance [BENEFIT] plan and a standard health care insurance  
 3 [BENEFIT] plan that contain benefit and cost sharing levels that are consistent with  
 4 the basic method of operation and the benefit plans of health maintenance  
 5 organizations, including restrictions imposed by federal law. The plans recommended  
 6 by the committee may include the following cost containment features:

7 (1) utilization review of health care services, including review of the  
 8 medical necessity of hospital and physician services;

9 (2) case management;

10 (3) selective contracting with hospitals, physicians, and other health  
 11 care providers;

12 (4) reasonable benefit differentials applicable to providers that  
 13 participate or do not participate in arrangements using restricted network provisions;  
 14 and

15 (5) other managed care provisions.

16 \* **Sec. 76.** AS 21.56.070 is amended to read:

17 **Sec. 21.56.070. Required report.** The board shall study and report at least  
 18 once every two years to the director on the effectiveness of this chapter. The report  
 19 must analyze the effectiveness of the chapter in promoting rate stability, product  
 20 availability, and coverage affordability. The report may contain recommendations for  
 21 actions to improve the overall effectiveness, efficiency, and fairness of the small group  
 22 health care insurance marketplace. The report must address whether insurers, agents,  
 23 brokers, managing general agents, and third-party administrators are fairly and actively  
 24 marketing or issuing health care insurance [BENEFIT] plans to small employers in  
 25 fulfillment of the purposes of the chapter. The report may contain recommendations  
 26 for market conduct or other regulatory standards or action. The board shall notify the  
 27 legislature that the report is available.

28 \* **Sec. 77.** AS 21.56 is amended by adding a new section to read:

29 **Sec. 21.56.075. Premium report.** A member shall file not later than  
 30 March 15 of each year in a form prescribed by the director a report of total premiums  
 31 earned in the preceding calendar year and other information required by the director

1 for health care insurance plans delivered or issued for delivery to small employers in  
2 this state.

3 \* **Sec. 78.** AS 21.56.080 is amended to read:

4 **Sec. 21.56.080. Administrative Procedure Act.** The reinsurance association  
5 is exempt from AS 44.62 (Administrative Procedure Act).

6 \* **Sec. 79.** AS 21.56.090 is amended to read:

7 **Sec. 21.56.090. Tax exemption.** The reinsurance association is exempt from  
8 the payment of fees and taxes levied by the state or any of its political subdivisions  
9 except taxes levied on real or personal property.

10 \* **Sec. 80.** AS 21.56.100 is amended to read:

11 **Sec. 21.56.100. Limitation of liability.** A member of the reinsurance  
12 association is not liable for civil damages resulting from an act or omission of the  
13 member on behalf of the reinsurance association unless the member acts with gross  
14 negligence or intentional misconduct.

15 \* **Sec. 81.** AS 21.56.110(a) is repealed and reenacted to read:

16 (a) A health care insurance plan offered, issued for delivery, delivered, or  
17 renewed to small employers in this state is subject to the provisions of this chapter.

18 \* **Sec. 82.** AS 21.56.110(c) is amended to read:

19 (c) Except as provided in this subsection, for purposes of this chapter, insurers  
20 that are affiliated companies or that are eligible to file a consolidated tax return shall  
21 be treated as one insurer and a restriction or limitation imposed under this chapter shall  
22 apply as if all health care insurance [BENEFIT] plans delivered or issued for delivery  
23 to a small employer in this state by an affiliated insurer were issued by one insurer.  
24 An affiliated insurer that is a health maintenance organization having a certificate of  
25 authority under AS 21.86 may be considered to be a separate insurer for the purposes  
26 of this chapter.

27 \* **Sec. 83.** AS 21.56.120(a) is amended to read:

28 (a) A premium rate for a health care insurance [BENEFIT] plan subject to  
29 this chapter is subject to the following provisions:

30 (1) the premium rate charged or offered during a rating period to small  
31 employers with similar case characteristics as determined by the insurer for the same

1 or similar coverage may not vary from the applicable index rate by more than 35  
2 percent of the applicable index rate;

3 (2) regarding a health care insurance [BENEFIT] plan issued before  
4 July 1, 1993, if premium rates charged or offered for the same or similar coverage  
5 under a health care insurance [BENEFIT] plan covering a small employer with  
6 similar case characteristics as determined by the insurer exceeds the applicable index  
7 rate by more than 35 percent, an increase in premium rates for a new rating period  
8 may not exceed the sum of

9 (A) a percentage change in the base premium rate measured  
10 from the first day of the prior rating period to the first day of the new rating  
11 period; plus

12 (B) adjustments due to changes in case characteristics or plan  
13 design of the small employer, as determined by the insurer;

14 (3) the percentage increase in the premium rate charged to a small  
15 employer for a new rating period may not exceed the sum of the following:

16 (A) the percentage change in the new business premium rate  
17 measured from the first day of the prior rating period to the first day of the  
18 new rating period; in the case of a health benefit plan into which the small  
19 employer insurer is no longer enrolling new small employers, the small  
20 employer insurer shall use the percentage change in the base premium rate,  
21 provided that the change does not exceed, on a percentage basis, the change in  
22 the new business premium rate for the most similar health care insurance  
23 [BENEFIT] plan into which the small employer insurer is actively enrolling  
24 new small employers;

25 (B) any adjustment, not to exceed 15 percent annually and  
26 adjusted pro rata for rating periods of less than one year, due to the claim  
27 experience, health status, or duration of coverage of the employees or  
28 dependents of the small employer as determined from the small employer  
29 insurer's rate manual; and

30 (C) any adjustment due to change in coverage or change in the  
31 case characteristics of the small employer, as determined from the small

1 employer insurer's rate manual;

2 (4) adjustments in rates for claim experience, health status, and duration  
3 of coverage may not be charged to individual employees or dependents; any  
4 adjustment must be applied uniformly to the rates charged for all employees and  
5 dependents of the small employer;

6 (5) a premium rate for a health care insurance [BENEFIT] plan shall  
7 comply with the requirements of this section notwithstanding an assessment paid or  
8 payable by small employer insurers under AS 21.56.050(d);

9 (6) a small employer insurer may use [UTILIZE] industry as a case  
10 characteristic in establishing premium rates, provided that the rate factor associated  
11 with an industry classification may not vary by more than 15 percent from the  
12 arithmetic average of the highest and lowest rate factors associated with all industry  
13 classifications;

14 (7) a small employer insurer shall

15 (A) apply rating factors, including case characteristics,  
16 consistently with respect to all small employers; rating factors must produce  
17 premiums for identical groups that differ only by amounts attributable to plan  
18 design and do not reflect differences due to the nature of the groups assumed  
19 to select particular health care insurance [BENEFIT] plans; and

20 (B) treat all health care insurance [BENEFIT] plans issued or  
21 renewed in the same calendar month as having the same rating period;

22 (8) for the purposes of this subsection, a health care insurance  
23 [BENEFIT] plan that contains a restricted provider network may not be considered  
24 similar coverage to a health care insurance [BENEFIT] plan that does not use  
25 [UTILIZE] a restricted provider network if the restriction of benefits to network  
26 providers results in substantial differences in claim costs;

27 (9) a small employer insurer may not use case characteristics, other  
28 than age, sex, industry, geographic area, family composition, and group size without  
29 prior approval of the director.

30 \* **Sec. 84.** AS 21.56.120(b) is amended to read:

31 (b) In connection with the offering for sale of a health care insurance

1 [BENEFIT] plan to a small employer, a small employer insurer shall [MAKE A  
 2 REASONABLE DISCLOSURE], as part of its solicitation and sales materials, **disclose**  
 3 **in a manner understandable by the average small employer and sufficient to**  
 4 **reasonably inform small employers of their rights and obligations under the**  
 5 **health care insurance plan** [OF THE FOLLOWING:]

6 (1) the extent that premium rates for a specified small employer are  
 7 established or adjusted based upon the actual or expected variation in claims costs or  
 8 actual or expected variation in health status of the employees of the small employer  
 9 and their dependents; and

10 (2) the provisions of the health **care insurance** [BENEFIT] plan

11 (A) concerning the small employer insurer's right to change  
 12 premium rates and factors [, OTHER THAN CLAIM EXPERIENCE] that  
 13 affect changes in premium rates;

14 (B) relating to renewability of policies and contracts; [AND]

15 (C) relating to any preexisting condition provision; **and**

16 **(D) concerning the benefits and premiums available under**  
 17 **all health care insurance plans for which the small employer qualifies.**

18 \* **Sec. 85.** AS 21.56.120(d) is amended to read:

19 (d) The director may adopt regulations to implement the provisions of this  
 20 section and to ensure that rating practices used by small employer insurers are  
 21 consistent with the purposes of this chapter, including ensuring that differences in rates  
 22 charged for health **care insurance** [BENEFIT] plans by small employer insurers are  
 23 reasonable and reflect objective differences in plan design, not including differences  
 24 due to the nature of the groups assumed to select particular health **care insurance**  
 25 [BENEFIT] plans.

26 \* **Sec. 86.** AS 21.56.140 is repealed and reenacted to read:

27 **Sec. 21.56.140. Required offer of coverage.** (a) Except as provided under  
 28 AS 21.56.160, a small employer insurer shall, as a condition of transacting business  
 29 in this state with small employers, offer to small employers all health care insurance  
 30 plans the small employer actively markets to small employers in this state, including  
 31 a basic health care insurance plan and a standard health care insurance plan.

1 (b) A small employer insurer shall issue a health care insurance plan to a small  
2 employer that applies for a plan and shall accept for enrollment under the health care  
3 insurer coverage all eligible employees and their dependents who apply for enrollment  
4 during the period in which the employee first becomes eligible to enroll under the  
5 terms of the plan. A small employer insurer may not place a restriction on an eligible  
6 employee or dependent with respect to being a participant or beneficiary that is  
7 inconsistent with AS 21.54.100.

8 (c) A small employer insurer may not increase a requirement for minimum  
9 employee participation or for minimum employer contribution applicable to a small  
10 employer at any time after the small employer has been accepted for coverage, except  
11 that a small employer insurer may vary application of minimum participation and  
12 employer contribution requirements by the size of the small employer group.

13 (d) If a small employer insurer offers coverage to a small employer, the small  
14 employer insurer shall offer coverage to all of the eligible employees of the small  
15 employer and their dependents. A small employer insurer may not offer coverage to  
16 only certain individuals in a small employer group or to only part of the group, except  
17 in the case of late enrollees as provided in AS 21.54.110(d).

18 (e) The small employer insurer shall apply this section uniformly to all small  
19 employers without regard to the claims experience of the small employers and their  
20 employees and dependents or a health status factor of an employee or dependent.

21 (f) A small employer insurer may not, directly or indirectly, encourage or  
22 direct small employers to refrain from filing an application for coverage with a small  
23 employer insurer or to seek coverage from another insurer because of a health status  
24 factor, the claims experience, the industry, the occupation, or the geographic location  
25 of the small employer.

26 (g) Except as provided in AS 21.54.110, a small employer insurer may not, by  
27 a rider or amendment applicable to a specific individual, restrict or exclude coverage  
28 or benefits by type of illness, treatment, medical condition, or service otherwise  
29 covered by the plan.

30 (h) This section does not apply to health care insurance plans offered by a  
31 small employer insurer if the insurer makes the health care insurance plans available

1 in the small employer market only through a bona fide association.

2 \* **Sec. 87.** AS 21.56.160 is repealed and reenacted to read:

3 **Sec. 21.56.160. Exemption from required offer of coverage.** (a) A small  
4 employer insurer offering health care insurance through a network plan is not required  
5 to offer or renew coverage or accept applications under AS 21.56.140(a) if

6 (1) the small employer does not have eligible employees or dependents  
7 who live, work, or reside in the service area for the network plan; or

8 (2) the small employer insurer demonstrates to the director that the  
9 small employer insurer

10 (A) will not have the capacity to deliver services adequately to  
11 eligible employees or dependents of additional groups because of the small  
12 employer insurer's obligation to existing group contract holders and covered  
13 employees or dependents; and

14 (B) applies this subsection uniformly without regard to the  
15 claims experience of the employers and their employees and dependents or to  
16 a health status factor relating to the employees and dependents.

17 (b) A small employer insurer offering health care insurance is not required to  
18 offer or accept applications under AS 21.56.140(a) if

19 (1) the small employer insurer is only maintaining in-force business and  
20 has ceased enrolling new employer groups on or before January 1, 1993; or

21 (2) the certificate of authority or bylaws of an insurer does not permit  
22 the insurer to issue coverage on a marketwide basis; however, an insurer described in  
23 this paragraph shall comply with AS 21.56.140 regarding small employers that meet  
24 the requirements of the insurer's certificate of authority or bylaws.

25 (c) A small employer insurer who denies health care insurance coverage in a  
26 service area under (a) of this section may not offer coverage in the small employer  
27 market within that service area for a period of 180 days after the date the coverage is  
28 denied.

29 (d) If a small employer insurer demonstrates or the director determines under  
30 AS 21.09.175 that a small employer insurer does not have the financial reserves  
31 necessary to underwrite additional coverage, the small employer insurer may not offer

1 or renew health care insurance coverage in the small employer group market. The  
 2 small employer insurer may not reenter the small employer group market until the  
 3 director has determined that the insurer has sufficient financial reserves to underwrite  
 4 additional coverage.

5 \* **Sec. 88.** AS 21.56.180 is repealed and reenacted to read:

6 **Sec. 21.56.180. Fair marketing standards.** (a) A small employer insurer  
 7 may not, directly or indirectly, enter into a contract, agreement, or arrangement with  
 8 an insurance producer, a managing general agent, or a third-party administrator that  
 9 provides for or results in the compensation paid to an insurance producer for the sale  
 10 of a health care insurance plan to vary based on the health status, claims experience,  
 11 industry, occupation, or geographic location of the small employer. This subsection  
 12 does not apply to a compensation arrangement that provides compensation to an  
 13 insurance producer, a managing general agent, or a third-party administrator on the  
 14 basis of a percentage of premium that does not vary based on the health status, claims  
 15 experience, industry, occupation, or geographic area of the small employer.

16 (b) A small employer insurer shall provide reasonable compensation, as  
 17 provided under the plan of operation of the program, to an insurance producer, a  
 18 managing general agent, or a third-party administrator, if any, for the sale of a basic  
 19 or standard health care insurance plan.

20 (c) A small employer insurer, an insurance producer, a managing general  
 21 agent, or a third-party administrator may not induce or otherwise encourage a small  
 22 employer to separate or otherwise exclude an employee from health coverage or  
 23 benefits provided in connection with the employee's employment.

24 (d) A small employer insurer may only deny an application for coverage from  
 25 a small employer in writing, and the writing must state the reasons for the denial.

26 (e) The director may establish by regulation additional standards to provide for  
 27 the fair marketing of health care insurance plans to small employers in this state.

28 (f) A person who enters into a contract, agreement, or other arrangement with  
 29 a small employer insurer to provide administrative, marketing, or other services related  
 30 to the offering of health care insurance plans to small employers in this state is subject  
 31 to this section as if it were a small employer insurer.

1 (g) A violation of this section by a person is an unfair trade practice for  
2 purposes of AS 21.36.

3 \* **Sec. 89.** AS 21.56.190 is amended to read:

4 **Sec. 21.56.190. Mandatory reissue of coverage.** The director may adopt  
5 regulations to require small employer insurers, as a condition of transacting business  
6 with small employers in this state after July 1, 1993, to reissue a health **care**  
7 **insurance** [BENEFIT] plan to a small employer who has had its health **care insurance**  
8 [BENEFIT] plan terminated or not renewed by the insurer after January 1, 1993. The  
9 director may prescribe the terms for the reissue of coverage that the director  
10 determines are reasonable and necessary to provide continuity of coverage to small  
11 employers.

12 \* **Sec. 90.** AS 21.56.250 is repealed and reenacted to read:

13 **Sec. 21.56.250. Definitions.** In this chapter,

14 (1) "actuarial certification" means a written statement by a member of  
15 the American Academy of Actuaries or another individual acceptable to the director  
16 indicating that, based on the person's examination, including a review of the  
17 appropriate records, actuarial assumptions, and methods used by the insurer in  
18 establishing premium rates for applicable health insurance plans, a small employer  
19 insurer is in compliance with the provisions of AS 21.56.120;

20 (2) "affiliated" means a person who directly or indirectly, through one  
21 or more intermediaries, controls or is controlled by or is under common control with  
22 a specified person;

23 (3) "base premium rate" means the lowest premium rate charged or that  
24 could have been charged under the rating system by the small employer insurer to  
25 small employers with similar case characteristics for health care insurance plans with  
26 the same or similar coverage;

27 (4) "basic health care insurance plan" means a lower cost plan offered  
28 under AS 21.56.140;

29 (5) "beneficiary" has the meaning given in AS 21.54.500;

30 (6) "board" means the board of directors of the Small Employer Health  
31 Reinsurance Association;

1 (7) "bona fide association" has the meaning given in AS 21.54.500;

2 (8) "case characteristics" means demographic or other objective  
3 characteristics of a small employer that are considered by the small employer insurer  
4 in the determination of premium rates for the small employer, except that claim  
5 experience, health status, and duration of coverage may not be case characteristics for  
6 the purposes of this chapter;

7 (9) "committee" means the health benefit plan committee established  
8 in AS 21.56.060;

9 (10) "eligible employee" means an employee who works on a full-time  
10 basis, with a normal work week of 30 or more hours; "eligible employee" includes a  
11 sole proprietor, a partner of a partnership, or an independent contractor if the sole  
12 proprietor, partner, or contractor is included as an employee under a health care  
13 insurance plan of a small employer, but does not include an employee who works on  
14 a part-time, temporary, or substitute basis;

15 (11) "employee" has the meaning given in AS 21.54.500;

16 (12) "group market" has the meaning given in AS 21.54.500;

17 (13) "health care insurance plan" has the meaning given in  
18 AS 21.54.500;

19 (14) "health care insurer" has the meaning given in AS 21.54.500;

20 (15) "health status factor" has the meaning given in AS 21.54.500;

21 (16) "index rate" means, for small employers with similar case  
22 characteristics and plan designs as determined by the insurer for a rating period, the  
23 arithmetic average of the applicable base premium rate and the corresponding highest  
24 premium rate,

25 (17) "large employer" has the meaning given in AS 21.54.500;

26 (18) "late enrollee" has the meaning given in AS 21.54.500;

27 (19) "member" means a health care insurer;

28 (20) "network plan" has the meaning given in AS 21.54.500;

29 (21) "new business premium rate" means the lowest premium rate  
30 charged or offered, or that could have been charged or offered, by the small employer  
31 insurer to small employers with similar case characteristics for newly issued health

1 care insurance plans with the same or similar coverage;

2 (22) "plan of operation" means the plan of operation of the reinsurance  
3 association adopted by the board under AS 21.56.040;

4 (23) "rating period" means the calendar period for which premium rates  
5 established by a small employer insurer are assumed to be in effect;

6 (24) "reinsurance association" means the Small Employer Health  
7 Reinsurance Association created in AS 21.56.010;

8 (25) "reinsuring insurer" means a small employer insurer participating  
9 in the reinsurance association created in AS 21.56.010;

10 (26) "small employer" has the meaning given in AS 21.54.500;

11 (27) "small employer insurer" means a health care insurer offering,  
12 issuing for delivery, delivering, or renewing health care insurance to small employers  
13 in the state;

14 (28) "standard health care insurance plan" means a health care  
15 insurance plan offered under AS 21.56.140 that includes more comprehensive benefits  
16 than under a basic health care insurance plan.

17 \* **Sec. 91.** AS 21.66.110(a) is amended to read:

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

25 \* **Sec. 92.** AS 21.66.390(a) is amended to read:

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

30 (1) the desirability for stability of rate structures;

31 (2) the necessity of assuring the financial solvency of title insurance

1 companies in periods of economic depression by encouraging growth in assets of title  
 2 insurance companies in periods of high business activity; [AND]

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

5 **(4) investment income.**

6 \* **Sec. 93.** AS 21.69.310(a) is amended to read:

7 (a) Meetings of stockholders or members of a domestic insurer shall be held  
 8 in the city or town of its principal office or place of business in this state. **The**  
 9 **meetings may be held, for good cause, in another location within the state upon**  
 10 **approval of the director.**

11 \* **Sec. 94.** AS 21.69.520(a) is amended to read:

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

21 \* **Sec. 95.** AS 21.75.045(a) is amended to read:

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

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

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

1 insurer.

2 \* **Sec. 96.** AS 21.76.020(b) is amended to read:

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

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

8 (2) include an analysis, certified by a member of the American  
9 Academy of Actuaries, of the sufficiency of the loss reserves; and

10 (3) be certified by a certified public accountant.

11 \* **Sec. 97.** AS 21.76.080(e) is amended to read:

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

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

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

20 (3) AVAILABLE FOR PUBLIC INSPECTION.]

21 \* **Sec. 98.** AS 21.78.293(b) is amended to read:

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

28 \* **Sec. 99.** AS 21.84.590 is amended to read:

29 **Sec. 21.84.590. Other provisions applicable.** In addition to the provisions  
30 contained in this chapter, the following provisions of this title apply to fraternal benefit  
31 societies to the extent applicable and not in conflict with the express provisions of this

1 chapter and the reasonable implications of this chapter:

- 2 (1) AS 21.03;  
 3 (2) AS 21.06;  
 4 (3) AS 21.09.050 and 21.09.100;  
 5 (4) AS 21.09.200 and 21.09.205;  
 6 (5) AS 21.18;  
 7 (6) AS 21.21;  
 8 (7) AS 21.27;  
 9 (8) AS 21.33;  
 10 (9) AS 21.36;  
 11 (10) AS 21.42.290, 21.42.347, and 21.42.355;  
 12 (11) AS 21.53;  
 13 (12) AS 21.54;  
 14 (13) AS 21.56;  
 15 (14) AS 21.69.370 and 21.69.640;  
 16 (15) [(13)] AS 21.78;  
 17 (16) [(14)] AS 21.89.060.

18 \* **Sec. 100.** AS 21.86.150 is amended by adding new subsections to read:

19 (g) A health maintenance organization that offers, renews, issues for delivery,  
 20 or delivers in this state a health care insurance plan in the group market that does not  
 21 impose a preexisting condition exclusion with respect to a particular coverage option  
 22 under the plan may impose an affiliation period for that coverage option only if the  
 23 affiliation period

24 (1) is applied uniformly without regard to a health status factor;  
 25 (2) does not exceed two months for new enrollees and three months for  
 26 late enrollees;

27 (3) begins on the enrollment date; and

28 (4) runs concurrently with any waiting period under the plan.

29 (h) A health maintenance organization may use a method other than a  
 30 preexisting condition exclusion or an affiliation period to lessen the risk of adverse  
 31 selection only with prior written approval of the director.

1 \* **Sec. 101.** AS 21.86.260(a) is amended to read:

2 (a) Except as provided in AS 21.36, AS 21.42, AS 21.54, AS 21.56 and in this  
3 chapter, this title does not apply to a health maintenance organization that obtains a  
4 certificate of authority under this chapter. This subsection does not apply to an insurer  
5 licensed under AS 21.09 or a hospital or medical service corporation licensed under  
6 AS 21.87 except with respect to its health maintenance organization activities  
7 authorized by and regulated under this chapter.

8 \* **Sec. 102.** AS 21.86.900 is amended by adding new paragraphs to read:

9 (10) "affiliation period" means a period of time under a contract with  
10 a health maintenance organization

11 (A) that must expire before coverage becomes effective;

12 (B) during which the health maintenance organization is not  
13 required to provide health care services or benefits; and

14 (C) for which no premium is charged to the participant or  
15 beneficiary for coverage during the period;

16 (11) "beneficiary" has the meaning given in AS 21.54.500;

17 (12) "enrollment date" has the meaning given in AS 21.54.500;

18 (13) "group market" has the meaning given in AS 21.54.500;

19 (14) "health status factor" has the meaning given in AS 21.54.500;

20 (15) "participant" has the meaning given in AS 21.54.500;

21 (16) "preexisting condition exclusion" has the meaning given in  
22 AS 21.54.500;

23 (17) "waiting period" has the meaning given in AS 21.54.500.

24 \* **Sec. 103.** AS 21.87.140(c) is amended to read:

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

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

31 (2) compensation for services may be prorated and settled under the

1 circumstances and in the manner referred to in AS 21.87.300;

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

6 \* **Sec. 104.** AS 21.87.150(c) is amended to read:

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

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

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

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

19 \* **Sec. 105.** AS 21.87.180(a) is amended to read:

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

27 \* **Sec. 106.** AS 21.87.190(b) is amended to read:

28 (b) The service corporation shall, before use, file with the director **(1)** a  
29 schedule of subscription rates, fees, or payments of any kind to be charged subscribers;  
30 **(2) every rating manual, schedule, plan, rule, or formula;** and **(3)** [SHALL FILE]  
31 before use, **any modification to the rating manual, schedule, plan, rule, or formula.**

1 Each filing must state the effective date and must provide a comprehensive  
 2 description of the coverage. The director may withhold the rating formula from  
 3 public inspection for as long as the director determines that withholding the  
 4 rating formula is necessary to protect the service corporation against unwarranted  
 5 injury or is in the public interest [EVERY PROPOSED CHANGE OR  
 6 MODIFICATION IN THE RATES, FEES, OR PAYMENTS].

7 \* **Sec. 107.** AS 21.87.200 is repealed and reenacted to read:

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

11 \* **Sec. 108.** AS 21.87.340 is amended to read:

12 **Sec. 21.87.340. Other provisions applicable.** In addition to the provisions  
 13 contained or referred to previously in this chapter, the following chapters and  
 14 provisions of this title also apply with respect to service corporations to the extent  
 15 applicable and not in conflict with the express provisions of this chapter and the  
 16 reasonable implications of the express provisions, and, for the purposes of the  
 17 application, the corporations shall be considered to be mutual "insurers":

18 (1) AS 21.03;

19 (2) AS 21.06;

20 (3) AS 21.09, except AS 21.09.090;

21 (4) AS 21.18.010;

22 (5) AS 21.18.030;

23 (6) AS 21.18.040;

24 (7) AS 21.18.120;

25 (8) AS 21.21.321;

26 (9) AS 21.36;

27 (10) AS 21.42.345 - 21.42.365 and 21.42.375 - 21.42.395 [, 21.42.375,  
 28 21.42.380, AND 21.42.385];

29 (11) AS 21.51.120;

30 (12) AS 21.53;

31 (13) AS 21.54 [AS 21.54.020];

- 1 (14) AS 21.56;  
 2 (15) AS 21.69.400;  
 3 (16) AS 21.69.520;  
 4 (17) AS 21.69.600, 21.69.620, and 21.69.630;  
 5 (18) AS 21.78;  
 6 (19) AS 21.89.040;  
 7 (20) AS 21.89.060;  
 8 (21) AS 21.90.

9 \* **Sec. 109.** AS 21.89.020(f) is amended to read:

10 (f) An automobile liability insurance policy must provide

11 (1) that all expenses and fees, not including counsel fees or adjuster  
 12 fees, incurred because of arbitration or mediation shall be paid as determined by the  
 13 arbitrator;

14 (2) liability coverage in the amount set out in AS 28.22.101(d) for  
 15 motor vehicles rented in the United States or Canada by a person insured under the  
 16 policy;

17 (3) physical damage coverage for motor vehicles rented in the United  
 18 States or Canada, if the policy provides physical damage coverage; if the insured  
 19 declines physical damage coverage, the insurer shall offer physical damage coverage  
 20 for rented vehicles;

21 **(4) that payments from applicable coverage provided under (2) and**  
 22 **(3) of this subsection will be made in the following order of priority:**

23 **(A) from a policy or coverage purchased by the operator**  
 24 **from the person who has the vehicle available for rent;**

25 **(B) from a policy or coverage covering the operator of a**  
 26 **rented vehicle but not purchased from the person who has the vehicle**  
 27 **available for rent; and**

28 **(C) from a policy or coverage of the person who has the**  
 29 **vehicle available for rent.**

30 \* **Sec. 110.** AS 21.89.020(g) is amended to read:

31 (g) An insurance company offering automobile liability insurance in this state

1 shall offer a short term policy valid for no more than seven days. The coverage  
 2 available for the short term policy must be comparable to coverage available for longer  
 3 term policies. **The provisions of AS 21.36.210 - 21.36.310 do not apply to short**  
 4 **term policies issued under this subsection.**

5 \* **Sec. 111.** AS 21.90.900(29) is amended to read:

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

12 \* **Sec. 112.** AS 21.90.900 is amended by adding new paragraphs to read:

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

17 (42) "medical care" means amounts paid for

18 (A) diagnosis, care, mitigation, treatment, or prevention of  
 19 disease, or amounts paid for the purpose of affecting any structure or function  
 20 of the body;

21 (B) transportation primarily for and essential to medical care  
 22 described in (A) of this paragraph; and

23 (C) insurance covering medical care described in (A) and (B)  
 24 of this paragraph.

25 \* **Sec. 113.** AS 28.20.440 is amended by adding a new subsection to read:

26 (l) Notwithstanding any other provisions of law, a person who resides in the  
 27 same household as the person named as insured or a person who is a relative of the  
 28 person named as insured shall be excluded from coverage under a motor vehicle  
 29 liability policy if the person named as insured requests that that person be excluded  
 30 from coverage.

31 \* **Sec. 114.** AS 28.22.201(a) is amended to read:

1 (a) The uninsured and underinsured motorists coverage required under this  
2 chapter

3 (1) **applies** [DOES NOT APPLY] to bodily injury, sickness, disease,  
4 or death of an insured or damage to or destruction of property of an insured **even if**  
5 [UNTIL] the limits of liability bonds and policies that apply have **not** been used up  
6 by payments or judgments or settlements; **however, the insurer shall, in each**  
7 **instance, receive a credit against the insured's total damages for amounts actually**  
8 **received by the insured for covered claims from other sources, including liability**  
9 **bonds, other insurance policies, judgments, or settlements;**

10 (2) must be a single combined coverage; and

11 (3) may be rejected by the insured in writing; if the insured has rejected  
12 uninsured or underinsured coverage, the coverage may not be included in a  
13 supplemental, renewal, or replacement policy unless the insured subsequently requests  
14 uninsured or underinsured coverage in writing.

15 \* **Sec. 115.** AS 21.42.375(d), 21.42.395(d); AS 21.56.110(b), 21.56.110(d), 21.56.130,  
16 21.56.150, 21.56.170; AS 21.81; AS 28.20.445(c), 28.20.445(h); AS 28.22.211; and  
17 AS 28.40.100(a)(22) are repealed.

18 \* **Sec. 116.** AS 21.54.150, enacted by sec. 59 of this Act, is repealed.

19 \* **Sec. 117.** Sections 3, 4, and 5, ch. 101, SLA 1992, are repealed.

20 \* **Sec. 118.** Sections 4, 7, 9, 12, and 13, ch. 39, SLA 1993, are repealed.

21 \* **Sec. 119.** AS 21.54.150, enacted by sec. 59 of this Act, takes effect January 1, 1998.

22 \* **Sec. 120.** Sections 6, 7, 27 - 30, and 91 of this Act take effect January 1, 1998.

23 \* **Sec. 121.** Except as provided in secs. 119, 120, and 122 of this Act, this Act takes effect  
24 July 1, 1997.

25 \* **Sec. 122.** Section 116 of this Act takes effect September 20, 2001.