

CS FOR SENATE BILL NO. 289(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered: 2/27/06

Referred: Finance

Sponsor(s): SENATE LABOR AND COMMERCE COMMITTEE BY REQUEST

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the payment of insurer examination expenses, to the regulation of**
2 **managed care insurance plans, to actuarial opinions and supporting documentation for**
3 **an insurer, to insurance firms, managing general agents, and third-party**
4 **administrators, to eligibility of surplus lines insurers, to suitability of life and health**
5 **insurance policies and annuity contracts, to unfair discrimination under a health**
6 **insurance policy, to prompt payment of health care insurance claims, to required notice**
7 **by an insurer, to individual deferred annuities, to direct payment to providers under a**
8 **health insurance policy, to mental health benefits under a health care insurance plan, to**
9 **the definitions of 'title insurance limited producer' and of other terms used in the title**
10 **regulating the practice of the business of insurance, and to small employer health**
11 **insurance; repealing the Small Employer Health Reinsurance Association; making**
12 **conforming amendments; and providing for an effective date."**

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

2 * **Section 1.** AS 21.06.110(8) is amended to read:

3 (8) the annual percentage of health claims paid in the state that meets
4 the requirements of **AS 21.36.128(a) and (d)** [AS 21.54.020(a) AND (d)]; and

5 * **Sec. 2.** AS 21.06.160(a) is amended to read:

6 (a) Each person examined, other than examinations under AS 21.06.130, shall
7 pay a reasonable rate calculated on salary, benefit costs, and estimated division
8 overhead for time spent directly or indirectly related to the examination. Each person
9 examined, other than examinations under AS 21.06.130, shall pay actual out-of-pocket
10 business expenses, including travel expenses, incurred by division staff examiners and
11 shall pay the compensation of a contract examiner, to be set at a reasonable customary
12 rate, for conducting the examination upon presentation of a detailed account of the
13 charges and expenses by the director or under an order of the director. The accounting
14 may either be presented periodically during the course of the examination or at the
15 termination of the examination. A person may not pay and an examiner may not
16 accept additional compensation for an examination. **A person shall pay examination**
17 **expenses to the division under this subsection using an electronic payment**
18 **method specified by the director.**

19 * **Sec. 3.** AS 21.07.010(a) is amended to read:

20 (a) A contract between a participating health care provider and a managed care
21 entity that offers a [GROUP] managed care plan must contain a provision that

22 (1) provides for a reasonable mechanism to identify all **medical**
23 [HEALTH] care services to be provided by the managed care entity;

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

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

29 (4) provides that, in the event of a dispute between the parties to the
30 contract, a fair, prompt, and mutual dispute resolution process must be used; at a
31 minimum, the process must provide

1 (A) for an initial meeting at which all parties are present or
 2 represented by individuals with authority regarding the matters in dispute; the
 3 meeting shall be held within 10 working days after the plan receives written
 4 notice of the dispute or gives written notice to the provider, unless the parties
 5 otherwise agree in writing to a different schedule;

6 (B) that if, within 30 days following the initial meeting, the
 7 parties have not resolved the dispute, the dispute shall be submitted to
 8 mediation directed by a mediator who is mutually agreeable to the parties and
 9 who is not regularly under contract to or employed by either of the parties;
 10 each party shall bear its proportionate share of the cost of mediation, including
 11 the mediator fees;

12 (C) that if, after a period of 60 days following commencement
 13 of mediation, the parties are unable to resolve the dispute, either party may
 14 seek other relief allowed by law;

15 (D) that the parties shall agree to negotiate in good faith in the
 16 initial meeting and in mediation;

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

21 (6) protects the ability of a health care provider to communicate openly
 22 with a covered person about all appropriate diagnostic testing and treatment options;
 23 and

24 (7) defines words in a clear and concise manner.

25 * **Sec. 4.** AS 21.07.010(b) is amended to read:

26 (b) A contract between a participating health care provider and a managed
 27 care entity that offers a [GROUP] managed care plan may not contain a provision that

28 (1) has as its predominant purpose the creation of direct financial
 29 incentives to the health care provider for withholding covered medical [HEALTH]
 30 care services that are medically necessary; nothing in this paragraph shall be construed
 31 to prohibit a contract between a participating health care provider and a managed care

1 entity from containing incentives for efficient management of the utilization and cost
2 of covered medical [HEALTH] care services;

3 (2) requires the provider to contract for all products that are currently
4 offered or that may be offered in the future by the managed care entity; or

5 (3) requires the health care provider to be compensated for medical
6 [HEALTH] care services performed at the same rate as the health care provider has
7 contracted with another managed care entity.

8 * **Sec. 5.** AS 21.07.020 is amended to read:

9 **Sec. 21.07.020. Required contract provisions for [GROUP] managed care**
10 **plans.** A [GROUP] managed care plan must contain

11 (1) a provision that preauthorization for a covered medical procedure
12 on the basis of medical necessity may not be retroactively denied unless the
13 preauthorization is based on materially incomplete or inaccurate information provided
14 by or on behalf of the provider;

15 (2) a provision for emergency room services if any coverage is
16 provided for treatment of a medical emergency;

17 (3) a provision that covered medical [HEALTH] care services be
18 reasonably available in the community in which a covered person resides or that, if
19 referrals are required by the plan, adequate referrals outside the community be
20 available if the medical [HEALTH] care service is not available in the community;

21 (4) a provision that any utilization review decision

22 (A) must be made within 72 hours after receiving the request
23 for preapproval for nonemergency situations; for emergency situations,
24 utilization review decisions for care following emergency services must be
25 made as soon as is practicable but in any event **not** [NO] later than 24 hours
26 after receiving the request for preapproval or for coverage determination; and

27 (B) to deny, reduce, or terminate a health care benefit or to
28 deny payment for a medical [HEALTH] care service because that service is
29 not medically necessary shall be made by an employee or agent of the
30 managed care entity who is a licensed health care provider;

31 (5) a provision that provides for an internal appeal mechanism for a

1 covered person who disagrees with a utilization review decision made by a managed
2 care entity; except as provided under (6) of this section, this appeal mechanism must
3 provide for a written decision

4 (A) from the managed care entity within 18 working days after
5 the date written notice of an appeal is received; and

6 (B) on the appeal by an employee or agent of the managed care
7 entity who holds the same professional license as the health care provider who
8 is treating the covered person;

9 (6) a provision that provides for an internal appeal mechanism for a
10 covered person who disagrees with a utilization review decision made by a managed
11 care entity in any case in which delay would, in the written opinion of the treating
12 provider, jeopardize the covered person's life or materially jeopardize the covered
13 person's health; the managed care entity shall

14 (A) decide an appeal described in this paragraph within 72
15 hours after receiving the appeal; and

16 (B) provide for a written decision on the appeal by an
17 employee or agent of the managed care entity who holds the same professional
18 license as the health care provider who is treating the covered person;

19 (7) a provision that discloses the existence of the right to an external
20 appeal of a utilization review decision made by a managed care entity; the external
21 appeal shall be as conducted in accordance with AS 21.07.050;

22 (8) a provision that discloses covered benefits, optional supplemental
23 benefits, and benefits relating to and restrictions on nonparticipating provider services;

24 (9) a provision that describes the preapproval requirements and
25 whether clinical trials or experimental or investigational treatment are covered;

26 (10) a provision describing a mechanism for assignment of benefits for
27 health care providers and payment of benefits;

28 (11) a provision describing availability of prescription medications or a
29 formulary guide, and whether medications not listed are excluded; if a formulary guide
30 is made available, the guide must be updated annually; and

31 (12) a provision describing available translation or interpreter services,

1 including audiotape or braille information.

2 * **Sec. 6.** AS 21.07.030 is amended to read:

3 **Sec. 21.07.030. Choice of health care provider.** (a) If a managed care entity
4 offers a managed care [GROUP HEALTH] plan that provides for coverage of
5 medical [HEALTH] care services only if the services are furnished through a network
6 of health care providers that have entered into a contract with the managed care entity,
7 the managed care entity shall also offer a non-network option to covered persons
8 [ENROLLEES] at initial enrollment, as provided under (c) of this section. The non-
9 network option may require that a covered person pay a higher deductible, copayment,
10 or premium for the plan if the higher deductible, copayment, or premium results from
11 increased costs caused by the use of a non-network provider. The managed care entity
12 shall provide an actuarial demonstration of the increased costs to the director at the
13 director's request. If the increased costs are not justified, the director shall require the
14 managed care entity to recalculate the appropriate costs allowed and resubmit the
15 appropriate deductible, copayment, or premium to the director. This subsection does
16 not apply to a covered person [AN ENROLLEE] who is offered non-network
17 coverage through another managed care [GROUP HEALTH] plan or through another
18 managed care entity [IN THE GROUP MARKET].

19 (b) The amount of any additional premium charged by the managed care entity
20 for the additional cost of the creation and maintenance of the option described in (a) of
21 this section and the amount of any additional cost sharing imposed under this option
22 shall be paid by the covered person [ENROLLEE] unless it is paid by an [THE]
23 employer or other person through agreement with the managed care entity.

24 (c) A covered person [AN ENROLLEE] may make a change to the medical
25 [HEALTH] care coverage option provided under this section only during a time period
26 determined by the managed care entity. The time period described in this subsection
27 must occur at least annually and last for at least 15 working days.

28 (d) If a managed care entity that offers a [GROUP] managed care plan
29 requires or provides for a designation by a covered person [AN ENROLLEE] of a
30 participating primary care provider, the managed care entity shall permit the covered
31 person [ENROLLEE] to designate any participating primary care provider that is

1 available to accept the **covered person** [ENROLLEE].

2 (e) Except as provided in this subsection, a managed care entity that offers a
3 [GROUP] managed care plan shall permit **a covered person** [AN ENROLLEE] to
4 receive medically necessary or appropriate specialty care, subject to appropriate
5 referral procedures, from any qualified participating health care provider that is
6 available to accept the individual for medical care. This subsection does not apply to
7 specialty care if the managed care entity clearly informs **covered persons**
8 [ENROLLEES] of the limitations on choice of participating health care providers with
9 respect to medical care. In this subsection,

10 (1) "appropriate referral procedures" means procedures for referring
11 patients to other health care providers as set out in the applicable member contract and
12 as described under (a) of this section;

13 (2) "specialty care" means care provided by a health care provider with
14 training and experience in treating a particular injury, illness, or condition.

15 (f) If a contract between a health care provider and a managed care entity is
16 terminated, a covered person may continue to be treated by that health care provider as
17 provided in this subsection. If a covered person is pregnant or being actively treated by
18 a provider on the date of the termination of the contract between that provider and the
19 managed care entity, the covered person may continue to receive **medical** [HEALTH]
20 care services from that provider as provided in this subsection, and the contract
21 between the managed care entity and the provider shall remain in force with respect to
22 the continuing treatment. The covered person shall be treated for the purposes of
23 benefit determination or claim payment as if the provider were still under contract
24 with the managed care entity. However, treatment is required to continue only while
25 the [GROUP] managed care plan remains in effect and

26 (1) for the period that is the longest of the following:

27 (A) the end of the current plan year;

28 (B) up to 90 days after the termination date, if the event
29 triggering the right to continuing treatment is part of an ongoing course of
30 treatment; [OR]

31 (C) through completion of postpartum care, if the covered

1 person is pregnant on the date of termination; or

2 (2) until the end of the medically necessary treatment for the condition,
3 disease, illness, or injury if the person has a terminal condition, disease, illness, or
4 injury; in this paragraph, "terminal" means a life expectancy of less than one year.

5 (g) The requirements of this section do not apply to medical [HEALTH] care
6 services covered by Medicaid.

7 * **Sec. 7.** AS 21.07.040(c) is amended to read:

8 (c) Nothing in this section may be construed to prohibit the exchange of
9 medical information between and among health care providers of an applicant or a
10 person currently or formerly covered by a managed care plan for purposes of
11 providing medical [HEALTH] care services.

12 * **Sec. 8.** AS 21.07.050(a) is amended to read:

13 (a) A managed care entity offering a managed care plan [GROUP HEALTH
14 INSURANCE COVERAGE] shall provide for an external appeal process that meets
15 the requirements of this section in the case of an externally appealable decision for
16 which a timely appeal is made in writing either by the managed care entity or by the
17 covered person [ENROLLEE].

18 * **Sec. 9.** AS 21.07.050(c) is amended to read:

19 (c) Except as provided in this subsection, the external appeal process shall be
20 conducted under a contract between the managed care entity and one or more external
21 appeal agencies that have qualified under AS 21.07.060. The managed care entity shall
22 provide

23 (1) that the selection process among external appeal agencies
24 qualifying under AS 21.07.060 does not create any incentives for external appeal
25 agencies to make a decision in a biased manner;

26 (2) for auditing a sample of decisions by external appeal agencies to
27 ensure [ASSURE] that decisions are not made in a biased manner; and

28 (3) that all costs of the process, except those incurred by the covered
29 person [ENROLLEE] or treating professional in support of the appeal, shall be paid
30 by the managed care entity and not by the covered person [ENROLLEE].

31 * **Sec. 10.** AS 21.07.050(d) is amended to read:

1 (d) An external appeal process must include at least the following:

2 (1) a fair, de novo determination based on coverage provided by the
3 plan and by applying terms as defined by the plan; however, nothing in this paragraph
4 may be construed as providing for coverage of items and services for which benefits
5 are excluded under the plan or coverage;

6 (2) an external appeal agency shall determine whether the managed
7 care entity's decision is (A) in accordance with the medical needs of the patient
8 involved, as determined by the managed care entity, taking into account, as of the time
9 of the managed care entity's decision, the patient's medical needs and any relevant and
10 reliable evidence the agency obtains under (3) of this subsection, and (B) in
11 accordance with the scope of the covered benefits under the plan; if the agency
12 determines the decision complies with this paragraph, the agency shall affirm the
13 decision, and, to the extent that the agency determines the decision is not in
14 accordance with this paragraph, the agency shall reverse or modify the decision;

15 (3) the external appeal agency shall include among the evidence taken
16 into consideration

17 (A) the decision made by the managed care entity upon internal
18 appeal under AS 21.07.020 and any guidelines or standards used by the
19 managed care entity in reaching a decision;

20 (B) any personal health and medical information supplied with
21 respect to the individual whose denial of claim for benefits has been appealed;

22 (C) the opinion of the individual's treating physician or health
23 care provider; and

24 (D) the [GROUP] managed care plan;

25 (4) the external appeal agency may also take into consideration the
26 following evidence:

27 (A) the results of studies that meet professionally recognized
28 standards of validity and replicability or that have been published in peer-
29 reviewed journals;

30 (B) the results of professional consensus conferences
31 conducted or financed in whole or in part by one or more government

- 1 agencies;
- 2 (C) practice and treatment guidelines prepared or financed in
- 3 whole or in part by government agencies;
- 4 (D) government-issued coverage and treatment policies;
- 5 (E) generally accepted principles of professional medical
- 6 practice;
- 7 (F) to the extent that the agency determines it to be free of any
- 8 conflict of interest, the opinions of individuals who are qualified as experts in
- 9 one or more fields of health care that are directly related to the matters under
- 10 appeal;
- 11 (G) to the extent that the agency determines it to be free of any
- 12 conflict of interest, the results of peer reviews conducted by the managed care
- 13 entity involved;
- 14 (H) the community standard of care; and
- 15 (I) anomalous utilization patterns;
- 16 (5) an external appeal agency shall determine
- 17 (A) whether a denial of a claim for benefits is an externally
- 18 appealable decision;
- 19 (B) whether an externally appealable decision involves an
- 20 expedited appeal; and
- 21 (C) for purposes of initiating an external review, whether the
- 22 internal appeal process has been completed;
- 23 (6) a party to an externally appealable decision may submit evidence
- 24 related to the issues in dispute;
- 25 (7) the managed care entity involved shall provide the external appeal
- 26 agency with access to information and to provisions of the plan or health insurance
- 27 coverage relating to the matter of the externally appealable decision, as determined by
- 28 the external appeal agency; and
- 29 (8) a determination by the external appeal agency on the decision must
- 30 (A) be made orally or in writing and, if it is made orally, shall
- 31 be supplied to the parties in writing as soon as possible;

1 (B) be made in accordance with the medical exigencies of the
 2 case involved, but in no event later than 21 working days after the appeal is
 3 filed, or, in the case of an expedited appeal, 72 hours after the time of
 4 requesting an external appeal of the managed care entity's decision;

5 (C) state, in layperson's language, the basis for the
 6 determination, including, if relevant, any basis in the terms or conditions of the
 7 plan or coverage; and

8 (D) inform the covered person [ENROLLEE] of the
 9 individual's rights, including any time limits, to seek further review by the
 10 courts of the external appeal determination.

11 * **Sec. 11.** AS 21.07.050(h) is amended to read:

12 (h) In this section, "externally appealable decision"

13 (1) means

14 (A) a denial of a claim for benefits that is based in whole or in
 15 part on a decision that the item or service is not medically necessary or
 16 appropriate or is investigational or experimental, or in which the decision as to
 17 whether a benefit is covered involves a medical judgment; or

18 (B) a denial that is based on a failure to meet an applicable
 19 deadline for internal appeal under AS 21.07.020;

20 (2) does not include a decision based on specific exclusions or express
 21 limitations on the amount, duration, or scope of coverage that do not involve medical
 22 judgment, or a decision regarding whether an individual is a participant, beneficiary,
 23 or other covered person [ENROLLEE] under the plan or coverage.

24 * **Sec. 12.** AS 21.07.060(a) is amended to read:

25 (a) An external appeal agency qualifies to consider external appeals if, with
 26 respect to a managed care [GROUP HEALTH] plan, the agency is certified by a
 27 qualified private standard-setting organization approved by the director or by a health
 28 insurer operating in this state as meeting the requirements imposed under (b) of this
 29 section.

30 * **Sec. 13.** AS 21.07.060(b) is amended to read:

31 (b) An external appeal agency is qualified to consider appeals of managed

1 **care** [GROUP HEALTH] plan health care decisions if the agency meets the following
2 requirements:

- 3 (1) the agency meets the independence requirements of this section;
4 (2) the agency conducts external appeal activities through a panel of
5 two clinical peers, unless otherwise agreed to by both parties; and
6 (3) the agency has sufficient medical, legal, and other expertise and
7 sufficient staffing to conduct external appeal activities for the managed care entity on
8 a timely basis consistent with this chapter.

9 * **Sec. 14.** AS 21.07.060(d) is amended to read:

10 (d) In this section, "related party" means

11 (1) with respect to

12 (A) a **managed care** [GROUP HEALTH] plan [OR HEALTH
13 INSURANCE COVERAGE OFFERED IN CONNECTION WITH A PLAN],
14 the plan or the insurer offering the coverage; or

15 (B) individual health insurance coverage, the insurer offering
16 the coverage, or any plan sponsor, fiduciary, officer, director, or management
17 employee of the plan or issuer;

18 (2) the health care professional that provided the health care involved
19 in the coverage decision;

20 (3) the institution at which the health care involved in the coverage
21 decision is provided;

22 (4) the manufacturer of any drug or other item that was included in the
23 health care involved in the coverage decision;

24 (5) the covered person; or

25 (6) any other party that, under the regulations that the director may
26 prescribe, is determined by the director to have a substantial interest in the coverage
27 decision.

28 * **Sec. 15.** AS 21.07.080 is amended to read:

29 **Sec. 21.07.080. Religious nonmedical providers.** This chapter may not be
30 construed to

31 (1) restrict or limit the right of a managed care entity to include

1 [HEALTH CARE] services provided by a religious nonmedical provider as **medical**
 2 [HEALTH] care services covered by the managed care plan;

3 (2) require a managed care entity, when determining coverage for
 4 [HEALTH CARE] services provided by a religious nonmedical provider, to

5 (A) apply medically based eligibility standards;

6 (B) use health care providers to determine access by a covered
 7 person;

8 (C) use health care providers in making a decision on an
 9 internal or external appeal; or

10 (D) require a covered person to be examined by a health care
 11 provider as a condition of coverage; or

12 (3) require a managed care plan to exclude coverage for [HEALTH
 13 CARE] services provided by a religious nonmedical provider because the religious
 14 nonmedical provider is not providing medical or other data required from a health care
 15 provider if the medical or other data is inconsistent with the religious nonmedical
 16 treatment or nursing care being provided.

17 * **Sec. 16.** AS 21.07.250(1) is amended to read:

18 (1) "clinical peer" means a health care provider who is licensed to
 19 provide the same or similar **medical** [HEALTH] care services and who is trained in
 20 the specialty or subspecialty applicable to the **medical** [HEALTH] care services that
 21 are provided;

22 * **Sec. 17.** AS 21.07.250(3) is amended to read:

23 (3) "emergency room services" means **medical** [HEALTH] care
 24 services provided by a hospital or other emergency facility after the sudden onset of a
 25 medical condition that manifests itself by symptoms of sufficient severity, including
 26 severe pain, that the absence of immediate medical attention would reasonably be
 27 expected by a prudent person who possesses an average knowledge of health and
 28 medicine to result in

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

30 (B) a serious impairment to bodily functions; or

31 (C) a serious dysfunction of a bodily organ or part;

1 * **Sec. 18.** AS 21.07.250(5) is amended to read:

2 (5) "health care provider" means a person licensed in this state or
3 another state of the United States to provide medical [HEALTH] care services;

4 * **Sec. 19.** AS 21.07.250(10) is amended to read:

5 (10) "managed care entity" means an insurer, a hospital or medical
6 service corporation, a health maintenance organization, an employer or employee
7 health care organization, a managed care contractor that operates a [GROUP]
8 managed care plan, or a person who has a financial interest in medical [HEALTH]
9 care services provided to an individual;

10 * **Sec. 20.** AS 21.07.250(12) is amended to read:

11 (12) "participating health care provider" means a health care provider
12 who has entered into an agreement with a managed care entity to provide services or
13 supplies to a patient covered by a [GROUP] managed care plan;

14 * **Sec. 21.** AS 21.07.250(13) is amended to read:

15 (13) "primary care provider" means a health care provider who
16 provides general medical [HEALTH] care services and does not specialize in treating
17 a single injury, illness, or condition or who provides obstetrical, gynecological, or
18 pediatric medical [HEALTH] care services;

19 * **Sec. 22.** AS 21.07.250(15) is amended to read:

20 (15) "religious nonmedical provider" means a person who [DOES
21 NOT PROVIDE MEDICAL CARE, BUT WHO] provides only religious nonmedical
22 treatment or nursing care for an illness or injury;

23 * **Sec. 23.** AS 21.07.250(16) is amended to read:

24 (16) "utilization review" means a system of reviewing the medical
25 necessity, appropriateness, or quality of medical [HEALTH] care services and
26 supplies provided under a [GROUP] managed care plan using specified guidelines,
27 including preadmission certification, the application of practice guidelines, continued
28 stay review, discharge planning, preauthorization of ambulatory procedures, and
29 retrospective review;

30 * **Sec. 24.** AS 21.07.250 is amended by adding new paragraphs to read:

31 (18) "managed care plan" or "plan" means an individual or group

1 health insurance plan operated by a managed care entity;

2 (19) "medical care" has the meaning given in AS 21.90.900.

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

4 **Sec. 21.09.207. Statement of actuarial opinion and supporting**
 5 **documentation.** (a) An insurer authorized to write property, casualty, surety, marine,
 6 wet marine, transportation, or mortgage guaranty insurance shall file annually with the
 7 director a statement of actuarial opinion, unless the insurer is exempt or otherwise not
 8 required to file an opinion in the insurer's state of domicile. The statement of actuarial
 9 opinion must

10 (1) be issued by an actuary appointed by the insurer;

11 (2) follow, for a given year, the reporting format and requirements
 12 specified in the annual financial statement instructions most recently approved by the
 13 National Association of Insurance Commissioners; and

14 (3) be supplemented with additional information as may be required by
 15 the director.

16 (b) A domestic insurer that is required to file a statement under (a) of this
 17 section shall file annually with the director an actuarial opinion summary written by
 18 the insurer's appointed actuary. A foreign insurer that is required to file a statement
 19 under (a) of this section shall, on written request of the director, file an actuarial
 20 opinion summary with the director. The actuarial opinion summary must follow, for a
 21 given year, the reporting format and requirements specified in the annual financial
 22 statement instructions most recently approved by the National Association of
 23 Insurance Commissioners and must be supplemented with additional information as
 24 required by the director.

25 (c) An insurer that is required to file a statement under (a) of this section shall
 26 prepare an actuarial report and work papers to support each statement of actuarial
 27 opinion as required by the annual financial statement instructions most recently
 28 approved by the National Association of Insurance Commissioners. If an insurer fails
 29 to provide a supporting actuarial report or work papers at the request of the director, or
 30 the director determines that the supporting actuarial report or work papers provided by
 31 the insurer are incomplete or otherwise unacceptable to the director, the director may

1 engage a qualified actuary at the expense of the insurer to review the statement of
 2 actuarial opinion and the basis for the statement and to prepare the supporting actuarial
 3 report or work papers.

4 (d) An actuarial report, actuarial opinion summary, or work paper provided in
 5 support of a statement of actuarial opinion and any other information provided by an
 6 insurer to the director in connection with the statement of actuarial opinion, the
 7 actuarial opinion summary, or the actuarial report issued under this section is
 8 confidential; however, nothing in this section limits the director's authority to release
 9 the documents to a national professional organization that disciplines actuaries that is
 10 recognized by the director, as long as the material is required for the purpose of
 11 professional disciplinary proceedings and the national professional organization
 12 establishes procedures satisfactory to the director for preserving the confidentiality of
 13 the documents.

14 (e) In this section,

15 (1) "appointed actuary" means a qualified actuary who is appointed or
 16 retained by a company to provide a statement of actuarial opinion and the related
 17 actuarial opinion summary, actuarial report, and work papers;

18 (2) "qualified actuary" means a member in good standing of the

19 (A) Casualty Actuarial Society; or

20 (B) American Academy of Actuaries who has been approved as
 21 qualified for signing casualty loss reserve opinions by the Casualty Practice
 22 Council of the American Academy of Actuaries.

23 * **Sec. 26.** AS 21.27.020(c) is amended to read:

24 (c) To qualify for issuance or renewal of a license as a firm insurance
 25 producer, a firm managing general agent, a firm reinsurance intermediary broker, a
 26 firm reinsurance intermediary manager, a firm surplus lines broker, or a firm
 27 independent adjuster, an applicant or licensee shall

28 (1) comply with (b)(4) and (5) of this section;

29 (2) maintain a lawfully established place of business in this state,
 30 except when licensed as a nonresident under AS 21.27.270;

31 (3) ~~[DISCLOSE TO THE DIRECTOR ALL OWNERS, OFFICERS,~~

1 DIRECTORS, OR PARTNERS OF THE FIRM;

2 (4)] designate one or more compliance officers for the firm;

3 **(4)** [(5)] provide to the director documents necessary to verify the
4 information contained in or made in connection with the application; and

5 **(5)** [(6)] notify the director, in writing, within 30 days of a change in
6 the firm's compliance officer or of the termination of employment of an individual in
7 the firm licensee.

8 * **Sec. 27.** AS 21.27.020(g) is amended to read:

9 (g) The director shall establish a continuing education advisory committee.
10 The committee consists of one representative from the division of insurance, one life
11 and health insurance representative, [ONE LIMITED LINES INSURANCE
12 REPRESENTATIVE,] one property and casualty insurance representative, and one
13 independent insurance adjuster representative. Each committee representative from the
14 insurance industry must possess a valid, current insurance license issued in this state
15 for the field to be represented.

16 * **Sec. 28.** AS 21.27.040 is amended by adding a new subsection to read:

17 (f) If, through inaction, an applicant fails to complete the application process,
18 the applicant's application filed with the director under (a) of this section is considered
19 withdrawn. The withdrawal becomes effective 120 days after the filing of the
20 application. If the director has initiated administrative action with respect to an
21 application, withdrawal becomes effective at the time and on the conditions required
22 by an order issued under this chapter.

23 * **Sec. 29.** AS 21.27.620(a) is amended to read:

24 (a) An insurer may not transact business with a managing general agent unless
25 (1) the insurer holds a certificate of authority in this state;
26 (2) the managing general agent is licensed under this chapter or **has**
27 **filed a certification with the director certifying that** [, WHEN] the managing
28 general agent is operating only for a foreign insurer **and** [,] is licensed by its resident
29 insurance regulator in a state that the director has determined has enacted provisions
30 substantially similar to those contained in this chapter and the state is accredited by the
31 National Association of Insurance Commissioners;

1 (3) a written contract is in effect between the parties that establishes
2 the responsibilities of each party, indicates both party's share of responsibility for a
3 particular function, and specifies the division of responsibilities;

4 (4) a written contract between an insurer and a managing general agent
5 contains the following provisions:

6 (A) the insurer may terminate the contract for cause upon
7 written notice sent by certified mail to the managing general agent and may
8 suspend the underwriting authority of the managing general agent during a
9 dispute regarding the cause for termination;

10 (B) the managing general agent shall render accounts to the
11 insurer detailing all transactions and remit all money due under the contract to
12 the insurer at least monthly;

13 (C) all money collected for the account of an insurer shall be
14 held by the managing general agent as a fiduciary;

15 (D) all payments on behalf of the insurer shall be held by the
16 managing general agent as a fiduciary;

17 (E) the managing general agent may not retain more than three
18 months [MONTHS] estimated claims payments and allocated loss adjustment
19 expenses;

20 (F) the managing general agent shall maintain separate records
21 for each insurer in a form usable by the insurer; the insurer or its authorized
22 representative shall have the right to audit and the right to copy all accounts
23 and records related to the insurer's business; the director, in addition to
24 authority granted in this title, shall have access to all books, bank accounts, and
25 records of the managing general agent in a form usable to the director;

26 (G) the contract may not be assigned in whole or in part by the
27 managing general agent;

28 (H) if the contract permits the managing general agent to do
29 underwriting, the contract must include the following:

30 (i) the managing general agent's maximum annual
31 premium volume;

1 (ii) the rating system and basis of the rates to be
2 charged;

3 (iii) the types of risks that may be written;

4 (iv) maximum limits of liability;

5 (v) applicable exclusions;

6 (vi) territorial limitations;

7 (vii) policy cancellation provisions;

8 (viii) the maximum policy term; and

9 (ix) that the insurer shall have the right to cancel or not
10 renew a policy of insurance subject to applicable state law;

11 (I) if the contract permits the managing general agent to settle
12 claims on behalf of the insurer, the contract must include the following:

13 (i) written settlement authority must be provided by the
14 insurer and may be terminated for cause upon the insurer's written
15 notice sent by certified mail to the managing general agent or upon the
16 termination of the contract, but the insurer may suspend the settlement
17 authority during a dispute regarding the cause of termination;

18 (ii) claims shall be reported to the insurer within 30
19 days;

20 (iii) a copy of the claim file shall be sent to the insurer
21 upon request or as soon as it becomes known that the claim has the
22 potential to exceed an amount determined by the director or exceeds the
23 limit set by the insurer, whichever is less, involves a coverage dispute,
24 may exceed the managing general agent's claims settlement authority,
25 is open for more than six months, involves extra contractual
26 allegations, or is closed by payment in excess of an amount set by the
27 director or an amount set by the insurer, whichever is less;

28 (iv) each party shall comply with unfair claims
29 settlement statutes and regulations;

30 (v) transmission of electronic data at least monthly if
31 electronic claim files are in existence; and

1 (vi) claim files shall be the property of both the insurer
 2 and managing general agent; upon an order of liquidation of the
 3 insurer, the files shall become the sole property of the insurer or the
 4 insurer's estate; the managing general agent shall have reasonable
 5 access to and the right to copy the files on a timely basis;

6 (J) if the contract provides for sharing of interim profits by the
 7 managing general agent and the managing general agent has the authority to
 8 determine the amount of the interim profits by establishing loss reserves, by
 9 controlling claim payments, or in any other manner, interim profits may not be
 10 paid to the managing general agent until

11 (i) one year after they are earned for property insurance
 12 business and five years after they are earned on casualty business;

13 (ii) a later period established by the director for
 14 specified kinds or classes of insurance; and

15 (iii) not until the profits have been verified under (d) of
 16 this section;

17 (K) [IF] the insurer **shall provide** [IS DOMICILED IN THIS
 18 STATE OR THE MANAGING GENERAL AGENT HAS A PLACE OF
 19 BUSINESS IN THIS STATE,] a copy of the contract **to** [MUST BE FILED
 20 WITH AND APPROVED BY] the director **within** [AT LEAST] 30 days **after**
 21 **entering into a contract with a** [BEFORE THE] managing general agent
 22 [TRANSACTS BUSINESS ON BEHALF OF THE INSURER; IF THE
 23 INSURER IS NOT DOMICILED IN THIS STATE OR THE MANAGING
 24 GENERAL AGENT TRANSACTS BUSINESS RELATIVE TO A SUBJECT
 25 RESIDENT, LOCATED, OR TO BE PERFORMED IN THIS STATE FROM
 26 A PLACE OF BUSINESS NOT PHYSICALLY LOCATED IN THIS STATE,
 27 A COPY OF THE CONTRACT REQUIRED IN THIS SECTION MUST BE
 28 FILED WITH AND APPROVED BY THE DIRECTOR AT LEAST 30
 29 DAYS BEFORE THE MANAGING GENERAL AGENT TRANSACTS
 30 BUSINESS ON BEHALF OF THE INSURER IN THIS STATE OR
 31 RELATIVE TO A SUBJECT RESIDENT, LOCATED, OR TO BE

1 PERFORMED IN THIS STATE IF THE INSURER OR THE MANAGING
 2 GENERAL AGENT ARE DOMICILED IN A STATE NOT ACCREDITED
 3 BY THE NATIONAL ASSOCIATION OF INSURANCE
 4 COMMISSIONERS]; and

5 (L) [IF THE CONTRACT IS NOT REQUIRED TO BE
 6 APPROVED IN ADVANCE BY THE DIRECTOR,] the insurer shall provide
 7 written notification to the director within 30 days of the [ENTRY INTO OR]
 8 termination of a contract with a managing general agent [; THE NOTICE
 9 MUST INCLUDE A STATEMENT OF DUTIES TO BE PERFORMED BY
 10 THE MANAGING GENERAL AGENT ON BEHALF OF THE INSURER,
 11 THE KINDS AND CLASSES OF INSURANCE FOR WHICH THE
 12 MANAGING GENERAL AGENT HAS AUTHORIZATION TO ACT, AND
 13 OTHER INFORMATION REQUIRED BY THE DIRECTOR].

14 * **Sec. 30.** AS 21.27.650(a) is amended to read:

15 (a) An insurer may not transact business with a third-party administrator
 16 unless

17 (1) the insurer holds a certificate of authority in this state if required
 18 under this title;

19 (2) the third-party administrator is registered under this chapter or the
 20 third-party administrator has filed a certification with the director certifying that the
 21 third-party administrator is operating only for a foreign insurer other than a self-
 22 funded multiple employer welfare arrangement regulated under AS 21.85 and is
 23 registered as a third-party administrator by the third-party administrator's resident
 24 insurance regulator in a state that the director has determined has enacted provisions
 25 substantially similar to those contained in AS 21.27.630 - 21.27.650 and that is
 26 accredited by the National Association of Insurance Commissioners;

27 (3) the third-party administrator provides the director on January 1,
 28 April 1, July 1, and October 1 of each year

29 (A) a list of persons who supervise or have responsibility
 30 over personnel performing administrative functions, including claims
 31 administration and payment, marketing administrative functions,

1 premium accounting, premium billing, coverage verification,
 2 underwriting, or certificate issuance [CURRENT EMPLOYEES,
 3 IDENTIFYING THOSE TRANSACTING BUSINESS IN THIS STATE OR]
 4 upon a subject resident, located, or to be performed in this state;

5 (B) a list of current insurers under contract; and

6 (C) other information the director may require;

7 (4) a written contract is in effect between the parties that establishes
 8 the responsibilities of each party, indicates both parties' share of responsibility for a
 9 particular function, and specifies the division of responsibilities;

10 (5) there is in effect a written contract between the insurer and third-
 11 party administrator that contains the following provisions:

12 (A) the insurer may terminate the contract for cause upon
 13 written notice sent by certified mail to the third-party administrator and may
 14 suspend the underwriting authority of the third-party administrator during a
 15 dispute regarding the cause for termination; but the insurer must fulfill all
 16 lawful obligations with respect to policies affected by the written agreement,
 17 regardless of any dispute between the insurer and the third-party administrator;

18 (B) the third-party administrator shall render accounts to the
 19 insurer detailing all transactions and remit all money due under the contract to
 20 the insurer at least monthly;

21 (C) all money collected for the account of an insurer shall be
 22 held by the third-party administrator as a fiduciary;

23 (D) all payments on behalf of the insurer shall be held by the
 24 third-party administrator as a fiduciary;

25 (E) the third-party administrator may not retain more than three
 26 months' [MONTHS] estimated claims payments and allocated loss adjustment
 27 expenses;

28 (F) the third-party administrator shall maintain separate records
 29 for each insurer in a form usable by the insurer; the insurer or its authorized
 30 representative shall have the right to audit and the right to copy all accounts
 31 and records related to the insurer's business; the director, in addition to other

1 authority granted in this title, shall have access to all books, bank accounts, and
2 records of the third-party administrator in a form usable to the director; any
3 trade secrets contained in books and records reviewed by the director,
4 including the identity and addresses of policyholders and certificate holders,
5 shall be kept confidential, except that the director may use the information in a
6 proceeding instituted against the third-party administrator or the insurer;

7 (G) the contract may not be assigned in whole or in part by the
8 third-party administrator;

9 (H) if the contract permits the third-party administrator to do
10 underwriting, the contract must include the following:

11 (i) the third-party administrator's maximum annual
12 premium volume;

13 (ii) the rating system and basis of the rates to be
14 charged;

15 (iii) the types of risks that may be written;

16 (iv) maximum limits of liability;

17 (v) applicable exclusions;

18 (vi) territorial limitations;

19 (vii) policy cancellation provisions;

20 (viii) the maximum policy term; and

21 (ix) that the insurer shall have the right to cancel or not
22 renew a policy of insurance subject to applicable state law;

23 (I) if the contract permits the third-party administrator to
24 administer claims on behalf of the insurer, the contract must include the
25 following:

26 (i) written settlement authority must be provided by the
27 insurer and may be terminated for cause upon the insurer's written
28 notice sent by certified mail to the third-party administrator or upon the
29 termination of the contract, but the insurer may suspend the settlement
30 authority during a dispute regarding the cause of termination;

31 (ii) claims shall be reported to the insurer within 30

1 days;

2 (iii) a copy of the claim file shall be sent to the insurer
 3 upon request or as soon as it becomes known that the claim has the
 4 potential to exceed an amount determined by the director or exceeds the
 5 limit set by the insurer, whichever is less, involves a coverage dispute,
 6 may exceed the third-party administrator's claims settlement authority,
 7 is open for more than six months, involves extra contractual
 8 allegations, or is closed by payment in excess of an amount set by the
 9 director or an amount set by the insurer, whichever is less;

10 (iv) each party to the contract shall comply with unfair
 11 claims settlement statutes and regulations;

12 (v) transmission of electronic data must occur at least
 13 monthly if electronic claim files are in existence; and

14 (vi) claim files shall be the sole property of the insurer;
 15 upon an order of liquidation of the insurer, the third-party administrator
 16 shall have reasonable access to and the right to copy the files on a
 17 timely basis; and

18 (J) the contract may not provide for commissions, fees, or
 19 charges contingent upon savings obtained in the adjustment, settlement, and
 20 payment of losses covered by the insurer's obligations; but a third-party
 21 administrator may receive performance-based compensation for providing
 22 hospital or other auditing services or may receive compensation based on
 23 premiums or charges collected or the number of claims paid or processed.

24 * **Sec. 31.** AS 21.34.050 is repealed and reenacted to read:

25 **Sec. 21.34.050. Listing eligible surplus lines insurers.** (a) In addition to
 26 meeting the requirements of AS 21.34.040, a nonadmitted insurer shall be considered
 27 an eligible surplus lines insurer if it pays fees required by regulation and appears on
 28 the most recent list of eligible surplus lines insurers published by the director. The list
 29 is to be published at least semi-annually by

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

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

1 (b) Nothing in this section requires the director to place or maintain the name
2 of a nonadmitted insurer on the list of eligible surplus lines insurers.

3 (c) A nonadmitted insurer shall be removed from the list of eligible surplus
4 lines insurers if the nonadmitted insurer fails to pay, before July 1 of each year, the fee
5 authorized under this section or fails to meet the requirement under AS 21.34.040(d).
6 However, the director may reinstate a nonadmitted insurer on the list of eligible
7 surplus lines insurers if

8 (1) the nonadmitted insurer inadvertently failed to pay the fee or meet
9 the requirement under AS 21.34.040(d);

10 (2) the nonadmitted insurer has remedied the reason for removal from
11 the list; and

12 (3) the nonadmitted insurer pays a late fee as established by regulation.

13 * **Sec. 32.** AS 21.36 is amended by adding a new section to read:

14 **Sec. 21.36.052. Suitability.** (a) A person may not recommend to a consumer
15 the purchase, sale, or replacement of a life or health insurance policy or annuity
16 contract, or any rider, endorsement, or amendment to the policy or annuity contract,
17 without reasonable grounds to believe that the recommendation or transaction is
18 suitable for the consumer based on reasonable inquiry concerning the consumer's
19 insurance objectives, financial situation and needs, age, and other relevant information
20 known by the person.

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

22 * **Sec. 33.** AS 21.36.090(d) is amended to read:

23 (d) Except to the extent necessary to comply with AS 21.42.365 and
24 AS 21.56, a person may not practice or permit unfair discrimination against a person
25 who provides a service covered under a [GROUP] health insurance policy that extends
26 coverage on an expense incurred basis, or under a [GROUP] service or indemnity type
27 contract issued by a health maintenance organization or a nonprofit corporation, if the
28 service is within the scope of the provider's occupational license. In this subsection,
29 "provider" means a state licensed physician, physician assistant, dentist, osteopath,
30 optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath,
31 physical therapist, occupational therapist, marital and family therapist, psychologist,

1 psychological associate, licensed clinical social worker, or certified direct-entry
2 midwife.

3 * **Sec. 34.** AS 21.36 is amended by adding a new section to read:

4 **Sec. 21.36.128. Prompt payment of health care insurance claims.** (a) A
5 health care insurer shall pay or deny indemnities under a health care insurance policy,
6 whether or not services were provided by a participating provider, within 30 calendar
7 days after the insurer or a third-party administrator under contract with the insurer
8 receives a clean claim.

9 (b) If a health care insurer does not pay or denies a health care insurance
10 claim, the insurer shall give notice to the covered person, or to the provider of the
11 medical care services or supplies if the claim was assigned or if the covered person
12 elected direct payment under AS 21.51.120(a)(2) or AS 21.54.020(a), of the basis for
13 denial or the specific information that is needed for the insurer to adjudicate the claim.
14 The health care insurer shall provide the notice required under this subsection within
15 30 calendar days after the insurer or third-party administrator under contract with the
16 insurer receives the claim.

17 (c) If a health care insurer does not provide the notice as required under (b) of
18 this section, the claim is presumed a clean claim, and interest shall accrue at a rate of
19 15 percent annually beginning on the day following the day that the notice was due
20 and continues to accrue until the date that the claim is paid.

21 (d) If a health care insurer provides the notice required under (b) of this
22 section and requests specific information that is needed to adjudicate the claim, the
23 insurer shall pay the claim not later than 15 calendar days after receipt of the
24 information specified in the notice or within 30 days after receipt of the claim. If a
25 health care insurer does not pay the claim within the time period required under this
26 subsection, the claim is presumed to be a clean claim, interest at a rate of 15 percent
27 accrues, and interest continues to accrue until the date the claim is paid.

28 (e) For purposes of (c) and (d) of this section, if only a portion of a claim is
29 covered under the terms of the insurance policy, interest accrues based only on the
30 portion of the claim that is covered.

31 (f) For the purposes of this section, a claim is considered paid on the day

1 payment is mailed or transmitted electronically.

2 (g) If interest is accrued on a claim under (c) or (d) of this section, a health
3 care insurer may not include the amount of interest accrued in calculating an
4 applicable limit on benefits payable to a covered person or other person claiming
5 payments under the health insurance policy.

6 (h) A health care insurer is not required to pay interest due as a result of the
7 application of (c) or (d) of this section if the amount of the interest is \$1 or less.

8 (i) In this section,

9 (1) "clean claim" means a claim that does not have a defect or
10 impropriety, including a lack of any required substantiating documentation, or a
11 particular circumstance requiring special treatment that prevents timely payment of the
12 claim;

13 (2) "health care insurer" has the meaning given in AS 21.54.500.

14 * **Sec. 35.** AS 21.36.260 is amended to read:

15 **Sec. 21.36.260. Proof and method of mailing notice.** If a notice is required
16 from an insurer under this chapter, the insurer shall

17 (1) mail the notice by first class mail to the last known address of the
18 insured [;] and

19 [(2)] obtain a certificate of mailing from the **United States** [U.S.]
20 Postal Service; **or**

21 **(2) transmit the notice by electronic means, to the last known**
22 **electronic address of the intended recipient, if the insurer can obtain an**
23 **electronic confirmation of receipt by the intended recipient.**

24 * **Sec. 36.** AS 21.45.305(b) is amended to read:

25 (b) In the case of contracts issued on or after the operative date of this section
26 as defined in (k) of this section, no contract of annuity, except as stated in (a) of this
27 section, may be delivered or issued for delivery in this state unless it contains in
28 substance the following provisions, or corresponding provisions that, in the opinion of
29 the director, are at least as favorable to the contract holder, upon cessation of payment
30 of considerations under the contract: (1) that, upon cessation of payment of
31 considerations under a contract **or upon the written request of the contract holder,**

1 the company will grant a paid-up annuity benefit on a plan stipulated in the contract of
 2 **the** [SUCH] value [AS IS] specified in (d) - (g) and (i) of this section; (2) if a contract
 3 provides for a lump sum settlement at maturity, or at any other time, that, upon
 4 surrender of the contract at or before the commencement of any annuity payments, the
 5 company will pay, in lieu of any paid-up annuity benefit, a cash surrender benefit of
 6 **the** [SUCH] amount [AS IS] specified in (d), (e), (g) and (i) of this section; the
 7 company **may** [SHALL] reserve the right to defer the payment of that cash surrender
 8 benefit for a period **not to exceed** [OF] six months after demand for the payment with
 9 surrender of the contract **after making a written request that addresses the**
 10 **necessity and equitableness to all contract holders of the deferral and after**
 11 **receiving written approval by the director**; (3) a statement of the mortality table, if
 12 any, and interest rates used in calculating any minimum paid-up annuity, cash
 13 surrender, or death benefits that are guaranteed under the contract, together with
 14 sufficient information to determine the amounts of those benefits; (4) a statement that
 15 any paid-up annuity, cash surrender, or death benefits that may be available under the
 16 contract are not less than the minimum benefits required by any statute of the state in
 17 which the contract is delivered and an explanation of the manner in which those
 18 benefits are altered by the existence of any additional amounts credited by the
 19 company to the contract, any indebtedness to the company on the contract, or any
 20 prior withdrawals from or partial surrenders of the contract. Notwithstanding the
 21 requirements of this subsection, any deferred annuity contract may provide that, if no
 22 considerations have been received under a contract for a period of two full years and
 23 the portion of the paid-up annuity benefit at maturity on the plan stipulated in the
 24 contract arising from considerations paid before that period would be less than \$20
 25 monthly, the company may, at its option, terminate the contract by payment in cash of
 26 the then present value of **the** [SUCH] portion of the paid-up annuity benefit,
 27 calculated on the basis of the mortality table, if any, and interest rate specified in the
 28 contract for determining the paid-up annuity benefit, and by that payment shall be
 29 relieved of any further obligation under the contract.

30 * **Sec. 37.** AS 21.45.305(e) is amended to read:

31 (e) For contracts **that** [WHICH] provide cash surrender benefits, **the** [SUCH]

1 cash surrender benefits available before maturity may not be less than the present
 2 value as of the date of surrender of that portion of the maturity value of the paid-up
 3 annuity benefit that [WHICH] would be provided under the contract at maturity
 4 arising from considerations paid before the time of cash surrender reduced by the
 5 amount appropriate to reflect any prior withdrawals from or partial surrenders of the
 6 contract. The present value shall be calculated on the basis of an interest rate not more
 7 than one percent higher than the interest rate specified in the contract for accumulating
 8 [THE NET] considerations to determine the maturity value, **unless a higher rate is**
 9 **approved by the director under AS 21.42.120,** decreased by the amount of any
 10 indebtedness to the company on the contract, including interest due and accrued, and
 11 increased by any existing additional amounts credited by the company to the contract.
 12 In no event may any cash surrender benefit be less than the minimum nonforfeiture
 13 amount at that time. The death benefit under those [SUCH] contracts shall be at least
 14 equal to the cash surrender benefit.

15 * **Sec. 38.** AS 21.45.305(g) is repealed and reenacted to read:

16 (g) For the purpose of determining the benefits calculated under (e) and (f) of
 17 this section,

18 (1) the maturity date shall be the latest date for which election is
 19 permitted by the contract, but not later than the anniversary of the contract next
 20 following the annuitant's 70th birthday or the 10th anniversary of the contract,
 21 whichever is later;

22 (2) a surrender charge may not be imposed on or past the maturity date
 23 of the contract, except that, for annuity contracts with one or more renewable
 24 guaranteed periods, a new surrender charge schedule may be imposed for each new
 25 guaranteed period if

26 (A) the surrender charge is zero at the end of each guaranteed
 27 period and remains zero for at least 30 days;

28 (B) the contract provides for continuation of the contract
 29 without surrender charges, unless the contract holder specifically elects a new
 30 guaranteed period with a new surrender charge schedule; and

31 (C) the renewal period does not exceed 10 years and the

1 maturity date complies with (1) of this subsection;

2 (3) a contract that provides for flexible considerations may have
3 separate surrender charge schedules associated with each consideration; for purposes
4 of determining the maturity date, the 10th anniversary of the contract is determined
5 separately for each consideration.

6 * **Sec. 39.** AS 21.51.120(a) is amended to read:

7 (a) A health insurance policy delivered or issued for delivery must contain the
8 following provisions:

9 (1) indemnity for loss of life shall be paid according to the beneficiary
10 designation and payment provisions contained in the policy that are effective at the
11 time of payment; if a beneficiary has not been designated, indemnity shall be paid to
12 the estate of the insured; accrued indemnities unpaid at the insured's death shall be
13 paid to either the beneficiary or the estate, at the option of the insurer; all other
14 indemnities shall be paid to the insured;

15 (2) the insurer may, and upon written request of the insured shall,
16 [WITHIN 30 WORKING DAYS AFTER RECEIVING A PROOF OF LOSS
17 STATEMENT,] pay indemnities for hospital, nursing, medical, dental, or surgical
18 services directly to the provider of the services; an insurer who pays indemnities to an
19 insured, after the insured has given the insurer written notice in the proof of loss
20 statement of an election of direct payment of indemnities to the provider of the
21 services, shall also pay indemnities to the provider of the services; this paragraph does
22 not require that services be provided by a particular hospital or person;

23 (3) a covered person may revoke an election of direct payment of
24 indemnities made under this subsection by giving written notice of the revocation to
25 the insurer and to the provider of the services; the written notice of revocation given to
26 the insurer must certify that the covered person has given written notice of revocation
27 to the provider of the services; revocation of an election of direct payment is not
28 effective until the notice of revocation is received by the insurer and the provider of
29 the services;

30 (4) the right of the insured to request payment of indemnities for
31 hospital, nursing, medical, dental, or surgical services directly to the provider of the

1 services or to another person may be transferred to a person who is not the insured by
2 a qualified domestic relations order; rights under the qualified domestic relations order
3 do not take effect until the order is received by the insurer; in this paragraph,
4 "qualified domestic relations order" means an order or judgment in a divorce or
5 dissolution action under AS 25.24 that designates a person to determine to whom
6 indemnities for a named beneficiary should be paid under a health insurance policy.

7 * **Sec. 40.** AS 21.54.020 is repealed and reenacted to read:

8 **Sec. 21.54.020. Direct payment to providers.** (a) On the written request of a
9 covered person, a health care insurer shall pay amounts due under a health insurance
10 policy directly to the provider of medical care services. A health insurance policy may
11 not contain a provision that requires services be provided by a particular hospital or
12 person, except as applicable to a managed care plan under AS 21.07 or a health
13 maintenance organization under AS 21.86. If a health care insurer makes a claim
14 payment to the covered person after the covered person has given written notice
15 electing direct payment to the provider of the service, the health care insurer shall also
16 pay that amount to the provider of the service.

17 (b) A covered person may revoke an election of direct claim payment made
18 under (a) of this section by giving written notice of the revocation to the health care
19 insurer and to the provider of the service. The written notice of revocation to the
20 health care insurer must certify that the covered person has given written notice of
21 revocation to the provider of the service. Revocation of direct claim payment is not
22 effective until the later of the date the health care insurer received the notice of
23 revocation or the date the provider of the service received the revocation.

24 (c) The right of the covered person to request payment of indemnities under a
25 blanket health insurance policy directly to the provider of the services or to another
26 person may be transferred by a qualified domestic relations order to a person who is
27 not the covered person. Rights under the qualified domestic relations order do not take
28 effect until the order is received by the health care insurer. In this subsection,
29 "qualified domestic relations order" means an order or judgment in a divorce or
30 dissolution action under AS 25.24 that designates a person to determine to whom
31 indemnities for a covered person should be paid under a health insurance policy.

1 (d) This section does not prohibit a health care insurer from recovering an
2 amount mistakenly paid to a provider or a covered person.

3 * **Sec. 41.** AS 21.54 is amended by adding a new section to read:

4 **Sec. 21.54.151. Mental health benefits.** (a) Except as provided in (d) of this
5 section, a health care insurance plan sold in the large employer group market that
6 provides both medical and surgical benefits and mental health benefits shall meet the
7 following requirements:

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

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

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

16 (B) provide an aggregate lifetime limit for mental health
17 benefits that is not less than the aggregate lifetime limit for medical and
18 surgical benefits;

19 (3) if the plan includes different aggregate lifetime limits or none on
20 different categories of medical and surgical benefits, the plan must provide for
21 aggregate lifetime limits on mental health benefits consistent with federal law;

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

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

27 (A) include the mental health benefits with the annual limit and
28 may not distinguish in the application of the limit between medical and
29 surgical benefits and mental health benefits; or

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

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

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

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

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

13 * **Sec. 42.** AS 21.56.120(a) is amended to read:

14 (a) A premium rate for a health care insurance plan subject to this chapter is
 15 subject to the following provisions:

16 (1) the premium rate charged or offered during a rating period to small
 17 employers with similar case characteristics as determined by the insurer for the same
 18 or similar coverage may not vary from the applicable index rate by more than 35
 19 percent of the applicable index rate;

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

25 (A) a percentage change in the base premium rate measured
 26 from the first day of the prior rating period to the first day of the new rating
 27 period; plus

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

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

1 (A) the percentage change in the new business premium rate
2 measured from the first day of the prior rating period to the first day of the new
3 rating period; in the case of a health benefit plan into which the small employer
4 insurer is no longer enrolling new small employers, the small employer insurer
5 shall use the percentage change in the base premium rate, provided that the
6 change does not exceed, on a percentage basis, the change in the new business
7 premium rate for the most similar health care insurance plan into which the
8 small employer insurer is actively enrolling new small employers;

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

14 (C) any adjustment due to change in coverage or change in the
15 case characteristics of the small employer, as determined from the small
16 employer insurer's rate manual;

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

21 (5) a premium rate for a health care insurance plan shall comply with
22 the requirements of this section [NOTWITHSTANDING AN ASSESSMENT PAID
23 OR PAYABLE BY SMALL EMPLOYER INSURERS UNDER AS 21.56.050(d)];

24 (6) a small employer insurer may use industry as a case characteristic
25 in establishing premium rates, provided that the rate factor associated with an industry
26 classification may not vary by more than 15 percent from the arithmetic average of the
27 highest and lowest rate factors associated with all industry classifications;

28 (7) a small employer insurer shall

29 (A) apply rating factors, including case characteristics,
30 consistently with respect to all small employers; rating factors must produce
31 premiums for identical groups that differ only by amounts attributable to plan

1 design and do not reflect differences due to the nature of the groups assumed to
2 select particular health care insurance plans; and

3 (B) treat all health care insurance plans issued or renewed in
4 the same calendar month as having the same rating period;

5 (8) for the purposes of this subsection, a health care insurance plan that
6 contains a restricted provider network may not be considered similar coverage to a
7 health care insurance plan that does not use a restricted provider network if the
8 restriction of benefits to network providers results in substantial differences in claim
9 costs;

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

13 * **Sec. 43.** AS 21.56.140(a) is amended to read:

14 (a) Except as provided under AS 21.56.160, a small employer insurer shall, as
15 a condition of transacting business in this state with small employers, offer to small
16 employers all health care insurance plans the small employer insurer actively markets
17 to small employers in this state, including a basic health care insurance plan and a
18 standard health care insurance plan **approved by the director.**

19 * **Sec. 44.** AS 21.56.140 is amended by adding a new subsection to read:

20 (i) The director may, by order, establish benefits, cost sharing levels,
21 exclusions, and limitations for the basic and standard health care insurance plans
22 offered under (a) of this section.

23 * **Sec. 45.** AS 21.66.480(8) is amended to read:

24 (8) "title insurance limited producer" means a person, firm,
25 association, trust, corporation, cooperative, joint-stock company, or other legal entity
26 authorized in writing by a title insurance company to solicit title insurance, collect
27 premiums, determine insurability in accordance with the underwriting rules and
28 standards prescribed by the title insurance company that the licensee represents, and
29 issue policies in its behalf [~~; HOWEVER, THE TERM "TITLE INSURANCE
30 LIMITED PRODUCER" DOES NOT INCLUDE OFFICERS AND SALARIED
31 EMPLOYEES OF A TITLE INSURANCE COMPANY~~].

1 * **Sec. 46.** AS 21.90.900(17) is repealed and reenacted to read:

2 (17) "firm" means a corporation, association, partnership, limited
3 liability company, limited liability partnership, or other legal entity;

4 * **Sec. 47.** AS 21.90.900(29) is repealed and reenacted to read:

5 (29) "managing general agent" means a person who

6 (A) manages all or part of the insurance business of an insurer,
7 including the managing of a separate division, department, or underwriting
8 office; and

9 (B) acts as an agent for an insurer, whether known as a
10 managing general agent, manager, or other similar term, who, with or without
11 the authority, separately or together with affiliates, produces, directly or
12 indirectly, and underwrites an amount of gross direct written premium equal to
13 or more than five percent of the policyholder surplus as reported in the last
14 annual statement of the insurer in any one quarter or year together with the
15 following activity related to the business produced, adjusts or pays claims over
16 \$10,000 a claim, or negotiates reinsurance on behalf of the insurer.

17 * **Sec. 48.** AS 25.24.160(b) is amended to read:

18 (b) If a judgment under this section distributes benefits to an alternate payee
19 under AS 14.25, AS 21.51.120(a), AS 21.54.020(c) [AS 21.54.020(g)], 21.54.050(c),
20 AS 22.25, AS 26.05.222 - 26.05.226, or AS 39.35, the judgment must meet the
21 requirements of a qualified domestic relations order under the definition of that phrase
22 that is applicable to those provisions.

23 * **Sec. 49.** AS 25.24.230(h) is amended to read:

24 (h) If a judgment under this section distributes benefits to an alternate payee
25 under AS 14.25, AS 21.51.120(a), AS 21.54.020(c) [AS 21.54.020(g)], 21.54.050(c),
26 AS 22.25, AS 26.05.222 - 26.05.226, or AS 39.35, the judgment must meet the
27 requirements of a qualified domestic relations order under the definition of that phrase
28 that is applicable to those provisions.

29 * **Sec. 50.** AS 21.07.250(4), 21.07.250(6); AS 21.27.900(10); AS 21.51.110; AS 21.56.010,
30 21.56.020, 21.56.030, 21.56.040, 21.56.050, 21.56.060, 21.56.070, 21.56.075, 21.56.080,
31 21.56.090, 21.56.100, 21.56.250(6), 21.56.250(9), 21.56.250(17), 21.56.250(19),

1 21.56.250(22), 21.56.250(24), and 21.56.250(25) are repealed.

2 * **Sec. 51.** The uncodified law of the State of Alaska is amended by adding a new section to
3 read:

4 APPLICABILITY. AS 21.45.305(g), as repealed and reenacted by sec. 38 of this Act,
5 applies to annuity contracts issued on or after January 1, 2007.

6 * **Sec. 52.** The uncodified law of the State of Alaska is amended by adding a new section to
7 read:

8 TRANSITION: SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

9 Notwithstanding the repeal of AS 21.56.010 - 21.56.100 by sec. 50 of this Act, the Small
10 Employer Health Reinsurance Association shall continue to exist and operate for purposes of
11 winding up the affairs of the association. The association shall be governed by the board of
12 directors as it existed on June 30, 2006, and shall operate according to former AS 21.56.010 -
13 21.56.100, as they read on June 30, 2006, except that, beginning July 1, 2006, the association

14 (1) may not assume reinsurance on any new small employer groups or eligible
15 employees or dependents of small employers;

16 (2) shall terminate reinsurance on each small employer group and each
17 eligible employee or dependent of a small employer covered by the association on the first
18 plan anniversary following July 1, 2006;

19 (3) shall continue to perform and carry out the provisions of former
20 AS 21.56.010 - 21.56.100 as they read on June 30, 2006, with respect to each small employer
21 group and eligible employee and dependent reinsured by the association until all
22 administrative expenses and losses are paid;

23 (4) shall refund to small employer insurers any money remaining after all
24 administrative expenses and losses are paid in the same proportion as the last assessment
25 imposed by the association on member insurers;

26 (5) shall submit a final accounting to the director of the division of insurance
27 for review and approval; and

28 (6) shall cease to operate on order of the director of the division of insurance
29 finding that the affairs of the association have been concluded.

30 * **Sec. 53.** Sections 26 - 31 of this Act take effect immediately under AS 01.10.070(c).

31 * **Sec. 54.** Sections 25, 38, and 50 of this Act take effect January 1, 2007.

1 * **Sec. 55.** Except as provided in secs. 53 and 54 of this Act, this Act takes effect July 1,
2 2006.