

**CS FOR SENATE BILL NO. 289(FIN)**

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY THE SENATE FINANCE COMMITTEE

Offered: 3/29/06

Referred: Rules

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 prompt payment of health care  
5 insurance claims, to required notice by an insurer, to individual deferred annuities, to  
6 mental health benefits under a health care insurance plan, to the definitions of 'title  
7 insurance limited producer' and of other terms used in the title regulating the practice  
8 of the business of insurance, and to small employer health insurance; repealing the  
9 Small Employer Health Reinsurance Association; making conforming amendments; and  
10 providing for an effective date."

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

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

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

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

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

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

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

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

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

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

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

30 (A) for an initial meeting at which all parties are present or  
 31 represented by individuals with authority regarding the matters in dispute; the

1 meeting shall be held within 10 working days after the plan receives written  
 2 notice of the dispute or gives written notice to the provider, unless the parties  
 3 otherwise agree in writing to a different schedule;

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

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

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

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

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

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

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

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

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

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

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

6 \* **Sec. 5.** AS 21.07.020 is amended to read:

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

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

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

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

19 (4) a provision that any utilization review decision

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

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

29 (5) a provision that provides for an internal appeal mechanism for a  
30 covered person who disagrees with a utilization review decision made by a managed  
31 care entity; except as provided under (6) of this section, this appeal mechanism must

1 provide for a written decision

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

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

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

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

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

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

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

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

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

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

29 (12) a provision describing available translation or interpreter services,  
30 including audiotape or braille information.

31 \* **Sec. 6.** AS 21.07.030 is amended to read:

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

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

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

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

31           (e) Except as provided in this subsection, a managed care entity that offers a

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

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

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

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

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

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

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

29 (C) through completion of postpartum care, if the covered  
 30 person is pregnant on the date of termination; or

31 (2) until the end of the medically necessary treatment for the condition,

1 disease, illness, or injury if the person has a terminal condition, disease, illness, or  
 2 injury; in this paragraph, "terminal" means a life expectancy of less than one year.

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

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

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

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

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

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

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

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

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

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

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

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

31 (1) a fair, de novo determination based on coverage provided by the

1 plan and by applying terms as defined by the plan; however, nothing in this paragraph  
 2 may be construed as providing for coverage of items and services for which benefits  
 3 are excluded under the plan or coverage;

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

13 (3) the external appeal agency shall include among the evidence taken  
 14 into consideration

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

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

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

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

23 (4) the external appeal agency may also take into consideration the  
 24 following evidence:

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

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

31 (C) practice and treatment guidelines prepared or financed in

1 whole or in part by government agencies;

2 (D) government-issued coverage and treatment policies;

3 (E) generally accepted principles of professional medical  
4 practice;

5 (F) to the extent that the agency determines it to be free of any  
6 conflict of interest, the opinions of individuals who are qualified as experts in  
7 one or more fields of health care that are directly related to the matters under  
8 appeal;

9 (G) to the extent that the agency determines it to be free of any  
10 conflict of interest, the results of peer reviews conducted by the managed care  
11 entity involved;

12 (H) the community standard of care; and

13 (I) anomalous utilization patterns;

14 (5) an external appeal agency shall determine

15 (A) whether a denial of a claim for benefits is an externally  
16 appealable decision;

17 (B) whether an externally appealable decision involves an  
18 expedited appeal; and

19 (C) for purposes of initiating an external review, whether the  
20 internal appeal process has been completed;

21 (6) a party to an externally appealable decision may submit evidence  
22 related to the issues in dispute;

23 (7) the managed care entity involved shall provide the external appeal  
24 agency with access to information and to provisions of the plan or health insurance  
25 coverage relating to the matter of the externally appealable decision, as determined by  
26 the external appeal agency; and

27 (8) a determination by the external appeal agency on the decision must

28 (A) be made orally or in writing and, if it is made orally, shall  
29 be supplied to the parties in writing as soon as possible;

30 (B) be made in accordance with the medical exigencies of the  
31 case involved, but in no event later than 21 working days after the appeal is

1 filed, or, in the case of an expedited appeal, 72 hours after the time of  
2 requesting an external appeal of the managed care entity's decision;

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

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

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

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

11 (1) means

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

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

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

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

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

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

29 (b) An external appeal agency is qualified to consider appeals of **managed**  
30 **care** [GROUP HEALTH] plan health care decisions if the agency meets the following  
31 requirements:

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

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

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

9 (1) with respect to

10 (A) a **managed care** [GROUP HEALTH] plan [OR HEALTH

11 INSURANCE COVERAGE OFFERED IN CONNECTION WITH A PLAN],

12 the plan or the insurer offering the coverage; or

13 (B) individual health insurance coverage, the insurer offering

14 the coverage, or any plan sponsor, fiduciary, officer, director, or management

15 employee of the plan or issuer;

16 (2) the health care professional that provided the health care involved

17 in the coverage decision;

18 (3) the institution at which the health care involved in the coverage

19 decision is provided;

20 (4) the manufacturer of any drug or other item that was included in the

21 health care involved in the coverage decision;

22 (5) the covered person; or

23 (6) any other party that, under the regulations that the director may

24 prescribe, is determined by the director to have a substantial interest in the coverage

25 decision.

26 \* **Sec. 15.** AS 21.07.080 is amended to read:

27 **Sec. 21.07.080. Religious nonmedical providers.** This chapter may not be

28 construed to

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

30 [HEALTH CARE] services provided by a religious nonmedical provider as **medical**

31 [HEALTH] care services covered by the managed care plan;

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

3 (A) apply medically based eligibility standards;

4 (B) use health care providers to determine access by a covered  
5 person;

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

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

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

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

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

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

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

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

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

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

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

31 (5) "health care provider" means a person licensed in this state or

1 another state of the United States to provide medical [HEALTH] care services;

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

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

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

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

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

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

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

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

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

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

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

29 (18) "managed care plan" or "plan" means an individual or group  
30 health insurance plan operated by a managed care entity;

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

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

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

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

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

12                           (3) be supplemented with additional information as may be required by  
 13 the director.

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

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

1 report or work papers.

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

12 (e) In this section,

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

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

17 (A) Casualty Actuarial Society; or

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

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

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

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

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

29 (3) ~~[DISCLOSE TO THE DIRECTOR ALL OWNERS, OFFICERS,  
 30 DIRECTORS, OR PARTNERS OF THE FIRM;~~

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

1                   (4) [(5)] provide to the director documents necessary to verify the  
2 information contained in or made in connection with the application; and

3                   (5) [(6)] notify the director, in writing, within 30 days of a change in  
4 the firm's compliance officer or of the termination of employment of an individual in  
5 the firm licensee.

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

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

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

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

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

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

1 particular function, and specifies the division of responsibilities;

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

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

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

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

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

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

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

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

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

28 (i) the managing general agent's maximum annual  
29 premium volume;

30 (ii) the rating system and basis of the rates to be  
31 charged;

- 1 (iii) the types of risks that may be written;  
2 (iv) maximum limits of liability;  
3 (v) applicable exclusions;  
4 (vi) territorial limitations;  
5 (vii) policy cancellation provisions;  
6 (viii) the maximum policy term; and  
7 (ix) that the insurer shall have the right to cancel or not  
8 renew a policy of insurance subject to applicable state law;

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

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

16 (ii) claims shall be reported to the insurer within 30  
17 days;

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

26 (iv) each party shall comply with unfair claims  
27 settlement statutes and regulations;

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

30 (vi) claim files shall be the property of both the insurer  
31 and managing general agent; upon an order of liquidation of the

1 insurer, the files shall become the sole property of the insurer or the  
 2 insurer's estate; the managing general agent shall have reasonable  
 3 access to and the right to copy the files on a timely basis;

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

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

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

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

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

1 BY THE NATIONAL ASSOCIATION OF INSURANCE  
2 COMMISSIONERS]; and

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

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

13 (a) An insurer may not transact business with a third-party administrator  
14 unless

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

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

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

27 (A) a list of **persons who supervise or have responsibility**  
28 **over personnel performing administrative functions, including claims**  
29 **administration and payment, marketing administrative functions,**  
30 **premium accounting, premium billing, coverage verification,**  
31 **underwriting, or certificate issuance** [CURRENT EMPLOYEES,

1 IDENTIFYING THOSE TRANSACTING BUSINESS IN THIS STATE OR]  
 2 upon a subject resident, located, or to be performed in this state;

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

4 (C) other information the director may require;

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

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

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

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

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

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

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

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

1 trade secrets contained in books and records reviewed by the director,  
2 including the identity and addresses of policyholders and certificate holders,  
3 shall be kept confidential, except that the director may use the information in a  
4 proceeding instituted against the third-party administrator or the insurer;

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

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

9 (i) the third-party administrator's maximum annual  
10 premium volume;

11 (ii) the rating system and basis of the rates to be  
12 charged;

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

14 (iv) maximum limits of liability;

15 (v) applicable exclusions;

16 (vi) territorial limitations;

17 (vii) policy cancellation provisions;

18 (viii) the maximum policy term; and

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

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

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

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

31 (iii) a copy of the claim file shall be sent to the insurer

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

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

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

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

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

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

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

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

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

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

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

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

8 (2) the nonadmitted insurer has remedied the reason for removal from  
 9 the list; and

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

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

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

17 (b) If a health care insurer does not pay or denies a health care insurance  
 18 claim, the insurer shall give notice to the covered person, or to the provider of the  
 19 medical care services or supplies if the claim was assigned or if the covered person  
 20 elected direct payment under AS 21.51.120(a)(2) or AS 21.54.020(a), of the basis for  
 21 denial or the specific information that is needed for the insurer to adjudicate the claim.  
 22 The health care insurer shall provide the notice required under this subsection within  
 23 30 calendar days after the insurer or third-party administrator under contract with the  
 24 insurer receives the claim.

25 (c) If a health care insurer does not provide the notice as required under (b) of  
 26 this section, the claim is presumed a clean claim, and interest shall accrue at a rate of  
 27 15 percent annually beginning on the day following the day that the notice was due  
 28 and continues to accrue until the date that the claim is paid.

29 (d) If a health care insurer provides the notice required under (b) of this  
 30 section and requests specific information that is needed to adjudicate the claim, the  
 31 insurer shall pay the claim not later than 15 calendar days after receipt of the

1 information specified in the notice or within 30 days after receipt of the claim. If a  
 2 health care insurer does not pay the claim within the time period required under this  
 3 subsection, the claim is presumed to be a clean claim, interest at a rate of 15 percent  
 4 accrues, and interest continues to accrue until the date the claim is paid.

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

8 (f) For the purposes of this section, a claim is considered paid on the day  
 9 payment is mailed or transmitted electronically.

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

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

16 (i) In this section,

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

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

22 \* **Sec. 33.** AS 21.36.260 is amended to read:

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

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

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

29 (2) transmit the notice by electronic means, to the last known  
 30 electronic address of the intended recipient, if the insurer can obtain an  
 31 electronic confirmation of receipt by the intended recipient.

1 \* **Sec. 34.** AS 21.45.305(b) is amended to read:

2 (b) In the case of contracts issued on or after the operative date of this section  
 3 as defined in (k) of this section, no contract of annuity, except as stated in (a) of this  
 4 section, may be delivered or issued for delivery in this state unless it contains in  
 5 substance the following provisions, or corresponding provisions that, in the opinion of  
 6 the director, are at least as favorable to the contract holder, upon cessation of payment  
 7 of considerations under the contract: (1) that, upon cessation of payment of  
 8 considerations under a contract **or upon the written request of the contract holder,**  
 9 the company will grant a paid-up annuity benefit on a plan stipulated in the contract of  
 10 **the** [SUCH] value [AS IS] specified in (d) - (g) and (i) of this section; (2) if a contract  
 11 provides for a lump sum settlement at maturity, or at any other time, that, upon  
 12 surrender of the contract at or before the commencement of any annuity payments, the  
 13 company will pay, in lieu of any paid-up annuity benefit, a cash surrender benefit of  
 14 **the** [SUCH] amount [AS IS] specified in (d), (e), (g) and (i) of this section; the  
 15 company **may** [SHALL] reserve the right to defer the payment of that cash surrender  
 16 benefit for a period **not to exceed** [OF] six months after demand for the payment with  
 17 surrender of the contract **after making a written request that addresses the**  
 18 **necessity and equitableness to all contract holders of the deferral and after**  
 19 **receiving written approval by the director;** (3) a statement of the mortality table, if  
 20 any, and interest rates used in calculating any minimum paid-up annuity, cash  
 21 surrender, or death benefits that are guaranteed under the contract, together with  
 22 sufficient information to determine the amounts of those benefits; (4) a statement that  
 23 any paid-up annuity, cash surrender, or death benefits that may be available under the  
 24 contract are not less than the minimum benefits required by any statute of the state in  
 25 which the contract is delivered and an explanation of the manner in which those  
 26 benefits are altered by the existence of any additional amounts credited by the  
 27 company to the contract, any indebtedness to the company on the contract, or any  
 28 prior withdrawals from or partial surrenders of the contract. Notwithstanding the  
 29 requirements of this subsection, any deferred annuity contract may provide that, if no  
 30 considerations have been received under a contract for a period of two full years and  
 31 the portion of the paid-up annuity benefit at maturity on the plan stipulated in the

1 contract arising from considerations paid before that period would be less than \$20  
 2 monthly, the company may, at its option, terminate the contract by payment in cash of  
 3 the then present value of **the** [SUCH] portion of the paid-up annuity benefit,  
 4 calculated on the basis of the mortality table, if any, and interest rate specified in the  
 5 contract for determining the paid-up annuity benefit, and by that payment shall be  
 6 relieved of any further obligation under the contract.

7 \* **Sec. 35.** AS 21.45.305(e) is amended to read:

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

23 \* **Sec. 36.** AS 21.45.305(g) is repealed and reenacted to read:

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

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

30 (2) a surrender charge may not be imposed on or past the maturity date  
 31 of the contract, except that, for annuity contracts with one or more renewable

1 guaranteed periods, a new surrender charge schedule may be imposed for each new  
2 guaranteed period if

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

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

8 (C) the renewal period does not exceed 10 years and the  
9 maturity date complies with (1) of this subsection;

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

14 \* **Sec. 37.** AS 21.51.120(a) is amended to read:

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

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

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

31 (3) a covered person may revoke an election of direct payment of

1 indemnities made under this subsection by giving written notice of the revocation to  
 2 the insurer and to the provider of the services; the written notice of revocation given to  
 3 the insurer must certify that the covered person has given written notice of revocation  
 4 to the provider of the services; revocation of an election of direct payment is not  
 5 effective until the notice of revocation is received by the insurer and the provider of  
 6 the services;

7 (4) the right of the insured to request payment of indemnities for  
 8 hospital, nursing, medical, dental, or surgical services directly to the provider of the  
 9 services or to another person may be transferred to a person who is not the insured by  
 10 a qualified domestic relations order; rights under the qualified domestic relations order  
 11 do not take effect until the order is received by the insurer; in this paragraph,  
 12 "qualified domestic relations order" means an order or judgment in a divorce or  
 13 dissolution action under AS 25.24 that designates a person to determine to whom  
 14 indemnities for a named beneficiary should be paid under a health insurance policy.

15 \* **Sec. 38.** AS 21.54.020 is repealed and reenacted to read:

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

25 (b) A covered person may revoke an election of direct claim payment made  
 26 under (a) of this section by giving written notice of the revocation to the health care  
 27 insurer and to the provider of the service. The written notice of revocation to the  
 28 health care insurer must certify that the covered person has given written notice of  
 29 revocation to the provider of the service. Revocation of direct claim payment is not  
 30 effective until the later of the date the health care insurer received the notice of  
 31 revocation or the date the provider of the service received the revocation.

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

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

11 \* **Sec. 39.** AS 21.54 is amended by adding a new section to read:

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

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

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

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

24 (B) provide an aggregate lifetime limit for mental health  
 25 benefits that is not less than the aggregate lifetime limit for medical and  
 26 surgical benefits;

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

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

1 health benefits;

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

4 (A) include the mental health benefits with the annual limit and  
5 may not distinguish in the application of the limit between medical and  
6 surgical benefits and mental health benefits; or

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

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

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

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

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

21 \* **Sec. 40.** AS 21.56.120(a) is amended to read:

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

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

28 (2) regarding a health care insurance plan issued before July 1, 1993, if  
29 premium rates charged or offered for the same or similar coverage under a health care  
30 insurance plan covering a small employer with similar case characteristics as  
31 determined by the insurer exceeds the applicable index rate by more than 35 percent,

1 an increase in premium rates for a new rating period may not exceed the sum of

2 (A) a percentage change in the base premium rate measured  
3 from the first day of the prior rating period to the first day of the new rating  
4 period; plus

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

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

9 (A) the percentage change in the new business premium rate  
10 measured from the first day of the prior rating period to the first day of the new  
11 rating period; in the case of a health benefit plan into which the small employer  
12 insurer is no longer enrolling new small employers, the small employer insurer  
13 shall use the percentage change in the base premium rate, provided that the  
14 change does not exceed, on a percentage basis, the change in the new business  
15 premium rate for the most similar health care insurance plan into which the  
16 small employer insurer is actively enrolling new small employers;

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

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

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

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

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

5 (7) a small employer insurer shall

6 (A) apply rating factors, including case characteristics,  
 7 consistently with respect to all small employers; rating factors must produce  
 8 premiums for identical groups that differ only by amounts attributable to plan  
 9 design and do not reflect differences due to the nature of the groups assumed to  
 10 select particular health care insurance plans; and

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

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

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

21 \* **Sec. 41.** AS 21.56.140(a) is amended to read:

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

27 \* **Sec. 42.** AS 21.56.140 is amended by adding a new subsection to read:

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

31 \* **Sec. 43.** AS 21.66.480(8) is amended to read:

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

9 \* **Sec. 44.** AS 21.90.900(17) is repealed and reenacted to read:

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

12 \* **Sec. 45.** AS 21.90.900(29) is repealed and reenacted to read:

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

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

17 (B) acts as an agent for an insurer, whether known as a  
 18 managing general agent, manager, or other similar term, who, with or without  
 19 the authority, separately or together with affiliates, produces, directly or  
 20 indirectly, and underwrites an amount of gross direct written premium equal to  
 21 or more than five percent of the policyholder surplus as reported in the last  
 22 annual statement of the insurer in any one quarter or year together with the  
 23 following activity related to the business produced, adjusts or pays claims over  
 24 \$10,000 a claim, or negotiates reinsurance on behalf of the insurer.

25 \* **Sec. 46.** AS 25.24.160(b) is amended to read:

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

31 \* **Sec. 47.** AS 25.24.230(h) is amended to read:

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

6 \* **Sec. 48.** AS 21.07.250(4), 21.07.250(6); AS 21.27.900(10); AS 21.51.110; AS 21.56.010,  
 7 21.56.020, 21.56.030, 21.56.040, 21.56.050, 21.56.060, 21.56.070, 21.56.075, 21.56.080,  
 8 21.56.090, 21.56.100, 21.56.250(6), 21.56.250(9), 21.56.250(17), 21.56.250(19),  
 9 21.56.250(22), 21.56.250(24), and 21.56.250(25) are repealed.

10 \* **Sec. 49.** The uncodified law of the State of Alaska is amended by adding a new section to  
 11 read:

12 APPLICABILITY. AS 21.45.305(g), as repealed and reenacted by sec. 36 of this Act,  
 13 applies to annuity contracts issued on or after January 1, 2007.

14 \* **Sec. 50.** The uncodified law of the State of Alaska is amended by adding a new section to  
 15 read:

16 TRANSITION: SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.  
 17 Notwithstanding the repeal of AS 21.56.010 - 21.56.100 by sec. 48 of this Act, the Small  
 18 Employer Health Reinsurance Association shall continue to exist and operate for purposes of  
 19 winding up the affairs of the association. The association shall be governed by the board of  
 20 directors as it existed on June 30, 2006, and shall operate according to former AS 21.56.010 -  
 21 21.56.100, as they read on June 30, 2006, except that, beginning July 1, 2006, the association

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

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

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

31 (4) shall refund to small employer insurers any money remaining after all

1 administrative expenses and losses are paid in the same proportion as the last assessment  
2 imposed by the association on member insurers;

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

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

7 \* **Sec. 51.** Sections 26 - 31 of this Act take effect immediately under AS 01.10.070(c).

8 \* **Sec. 52.** Sections 25, 36, and 48 of this Act take effect January 1, 2007.

9 \* **Sec. 53.** Except as provided in secs. 51 and 52 of this Act, this Act takes effect July 1,  
10 2006.