SB 524

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

7th FLOOR FRONTIER BLDG.
3601 C STREET, SUITE 740
ANCHORAGE, ALASKA 99503-5934
PHONE: (907) 562-3626

January 4, 1990

Southern Region Emergency
Medical Services Council
6130 Tuttle Place, Suite 2
Anchorage, Alaska 99507-2041

Dear Mr. Scott:

Acting Director Jordan has asked me to respond to your letter of December 11, 1989 in which you requested this Division's opinion as to compliance with Title 21 of Alaska Statutes dealing with insurance of your proposed ambulance service membership program.

Based upon review of the information provided in your letter and follow up package, it is the opinion of the Division that your organization's ambulance service membership program would be required to comply with Chapter 87 of the Alaskan insurance statutes. Specifically, AS 21.87.010 requires any organization "...engaging... in the provision of all or a part of a health care service as defined in AS 21.87.330, for its subscribers in exchange for periodic prepayments in identifiable amount by or as to subscribers" to adhere to AS 21.87.

Accordingly, your attention is directed to the enclosures and in particular AS 21.87.070 to .090 for the procedures you should follow in applying for a certificate of authority. Our licensing officer, Jan Clemetson, who is located in Juneau can be contacted for the necessary forms and further information.

Very truly yours,

Eugene W. Furman, CPA
Insurance Financial Examiner

Enclosures

EF/sh
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DIV OF INSURANCE
(DEC) ltr to EMS 1/4/90

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Southern Region
EMERGENCY
Medical Services Council, Inc.

February 5, 1990

Honorable Pat Rodey
Alaska State Senate
P.O. Box V
Juneau, AK 99811

Dear Pat:

A problem has come up which we need the legislature's help on. I would like to get your advice about how best to solve the problem.

On January 1, 1990 Ninilchik Community Ambulance Association, the volunteer ambulance service in Ninilchik, raised their rates from $50 per call to $200 per call. At the same time they offered the residents of this unincorporated area the option of purchasing a membership for $50 per year. The membership covers the uninsured portion of the ambulance bill for the member and his family.

The Association started this membership program to help offset hard feelings in the community about such a dramatic rate increase. At the same time the rate increase is needed so that the association can continue to offer ambulance service. The annual Memorial Day Pancake Feed and $50 for 40 ambulance calls per year does not cover the cost of training, equipment, insurance, heated storage, gasoline and maintenance.

I assisted Ninilchik with formulating their program so that it would meet the insurance company requirements. I also asked the Division of Insurance to review the contract to assure that it complied with Alaska law. Unfortunately, the Division pointed out that the services provided by Ninilchik fall within the definition of prepaid health care services and therefore must comply with the requirements of AS 21.87.

In reading this statute it is clear that the intent of the Legislature was to regulate prepaid health care that is comprehensive in nature, e.g. health maintenance organizations and preferred provider organizations. The need to offer protection to the consumer is that these services are both expensive to the customer and represent a very large contingent liability for the provider. I think you will agree that these ambulance service membership programs bear little resemblance to these types of plans in terms of cost, contingent liability of the provider and even basic structure.

The following language is intended to exempt municipal and non-profit ambulance services which choose to provide any form of prepaid ambulance service from regulation under the state insurance statutes.

The assumption is that only Section 21.87 applies. It has not been determined if any other portion of the insurance statutes would apply to such schemes. If so, we would like to see language included that would exempt them from that as well.

Section 21.87.010 (b) is amended by adding the following:

(5) municipalities, fire service areas, emergency medical service areas and private non-profit corporations which provide emergency medical services certified by the Department of Health and Social Services under AS 27.08.080 that either individually or jointly accept prepayment from persons within their service areas for ambulance and emergency medical services, but not for other health services.

This statute would also allow two or more providers to join together to provide such services. This would be useful where adjacent service areas want to conduct a joint marketing campaign, so that if their members are hurt in the neighboring jurisdiction that they are covered.

This is modeled on the Oregon statute, which is attached.

OREGON

withstanding this subsection, an association of employes described in this subsection may elect to be subject to the Insurance Code by a majority vote of its members residing in Oregon.

(2) A doctor contracting to furnish health care services to an association of employes described in subsection (1) of this section.

(3) An association of grade schools, high schools, colleges or universities that:

(a) Provides health care services to students of member institutions; and

(b) Does not compensate anyone for procuring new members.

(4) A patrons of husbandry association, fraternal fire insurance association, fraternal life insurance association, or religious organization providing fire insurance for its members or churches, that was continuously active in this state for 15 years prior to January 1, 1957, and was not required to have a certificate of authority on that date.

(5) A fraternal benefit society that:

(a) Admits to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business; and

(b) Insures only its own members and their families, and its ladies' societies or ladies auxiliaries.

(6) An air ambulance service which is operated by a nonprofit corporation, if the majority of the group of persons vested with the management of the affairs of the corporation are not employes of the corporation.

(7) An association of the members of a workers' productive cooperative, which cooperative has been organized under ORS chapter 62 and is engaged primarily in reforestation, if the association insures only the members of the cooperative and their families for health insurance. [1967 c.359 §7; 1971 c.69 §1; 1971 c.536 §1; 1979 c.848 §1]

731.036 Persons completely exempt from application of Insurance Code. The Insurance Code does not apply to any of the following to the extent of the subject matter of the exemption:

(1) A bail bondsman, other than a corporate surety and its agents;

(2) A fraternal benefit society that has maintained lodges in this state and other states for 50 years prior to January 1, 1961, and for which a certificate of authority was not required on that date;

(3) A religious organization providing insurance benefits only to its employes, which organization is in existence and exempt from taxation under section 501 (c) (3) of the federal Internal Revenue Code on September 13, 1975;

(4) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance fund for tort liability in accordance with ORS 30.282;

(5) Public bodies, as defined in ORS 30.260, that either individually or jointly establish a self-insurance fund for property damage;

(6) Cities and counties that either individually or jointly insure for health insurance coverage, excluding disability insurance, their employes or retired employes, or their dependents, or combination of employes and dependents, with or without employe contributions, if all of the following conditions are met:

(a) The scope of the program meets the following minimum requirement:

(A) In the case of an individual public body program, the number of covered employes and retired employes aggregates at least 1,000 individuals; and

(B) In the case of a joint program of two or more public bodies, the number of covered employes and retired employes aggregates at least 1,000 individuals, or the annual contributions to the program aggregate at least $500,000;

(b) The health insurance includes all coverages and benefits required of group health insurance policies under ORS chapter 743;

(c) The public body, or the program administrator in the case of a joint insurance program of two or more public bodies, files with the Director of the Department of Insurance and Finance copies of all documents creating and governing the program, all forms used to communicate the coverage to beneficiaries, the schedule of payments established to support the program and, annually, a financial report showing the total incurred cost of the program for the preceding year. A copy of the annual audit required by ORS 297.425 may be used to satisfy the financial report filing requirement; and

(d) Each public body in a joint insurance program is liable only to its own employes and no others for benefits under the program in the event, and to the extent, that no further funds, including funds from insurance policies obtained by the pool, are available in the joint insurance pool; or

(7) Cities, rural fire protection districts and rural ambulance districts providing transport

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Southern Region
EMERGENCY
Medical Services Council, Inc.

December 11, 1989

Jim Jordan, Acting Director
Division of Insurance
3301 C Street, Suite 740
Anchorage, AK 99503-5990

Dear Mr. Jordan:

I would like to get the Division's opinion whether or not ambulance service membership programs are in compliance with the State's insurance laws and regulations. Specifically, I would like your opinion regarding the attached contract to be used by the Ninilchik Community Ambulance Association.

An ambulance service membership program, also known as a subscription program, has the following characteristics:

1. Member pays an annual fee, e.g. $50.00 per family.
2. Fee covers out-of-pocket expenses for medically necessary ambulance service.
3. The ambulance service bills all third party payors who provide coverage to member.
4. Contract clearly states that this is not an insurance contract.

These type programs are rapidly expanding throughout the lower 48. There is increasing interest in them here in Alaska. Ambulance services have been heavily subsidized by local and state government. With the decline in support from those quarters they now see the need to begin charging their patients the real cost of providing the service. They want to be able to offer an option to the members in the community that mitigates the impact of increasing fees.

For your information I have enclosed a Medicare letter ruling on membership programs and the section from the Medicare manual dealing with these programs. I have also enclosed an article on the programs by Jack Stout, a leading national consultant on implementing these programs.

Other states where these programs currently operate include Arizona, Oregon, Texas, Oklahoma, and Michigan.

The Ninilchik Community Ambulance Association intends to begin selling memberships on January 1, 1990. The contract is modeled on the contract used by Medstar in Fort Worth, Texas. They have agreed to refund all of the

EMS letter 12/11/89
to Div. of Insurance

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administrat

6325 Security Boulevard
Baltimore, MD 21207

JUN 3 1996

Mr. David M. Werfel
1320 Stony Brook Road
Suite 213
Stony Brook, New York 11790

Dear Mr. Werfel:

This is in reply to your recent letter asking whether an ambulance company commits a criminal violation of the bribe, kickback and rebate provisions of section 1877(b) of the Social Security Act if it furnishes services under an annual subscription agreement, accepts assignment for all Medicare covered services furnished to agreement subscribers, and routinely does not bill the subscribers for applicable deductible and coinsurance amounts.

Services furnished by an ambulance company under a subscription agreement calling for payment of an annual membership fee may be covered under Medicare only if the agreement explicitly or by clear implication authorizes the company to charge, except for applicable deductible and coinsurance, to the extent of the available Medicare or other coverage of the services. Under this type of agreement, the subscription fees for subscribers who have Medicare or other coverage become, in effect, premiums for coverage by the ambulance company of deductible and coinsurance amounts. Thus, the actual charge and customary charge reductions imposed under Medicare Carriers Manual section 5220 for routine waiver of deductible and coinsurance do not apply. There is no requirement, moreover, that subscription fees be uniform for all subscribers nor is there any requirement that fees be different for those subscribers who have Medicare or other insurance than for those subscribers who have no insurance.

In accepting Medicare assignments from subscribers and treating annual fees under subscription agreements as premiums for deductible and coinsurance coverage, ambulance companies function in a manner similar to group practice prepayment plans.

We have discussed above the Medicare reimbursement implications of ambulance company subscription agreements. These civil implications of the agreements under the Social Security Act are in the jurisdiction of the Health Care Financing Administration. The question of whether these agreements involve any criminal

Jack Stout

INTERFACE

Why Subscription Programs?

Several weeks ago I was discussing with my philosophical arch-rival, Dennis Murphy, author of *jems'* "Public Forum" column, the legal subtleties of ambulance subscription programs. At the end of our discussion, Dennis suggested that, because this issue is so deceptively complex and poorly understood, I should devote an "Interface" column to subscription programs. Here it is.

What Are They? Ambulance subscription programs fall into two major categories: those which involve the actual sale of ambulance services on a prepaid basis (i.e., for purposes of this discussion, Type I programs); and those which allow subscribers to fix-price and prepay the uninsured portions of ambulance bills (i.e., Type II programs). Legally and financially, these two types of programs are profoundly different.

If the subscription agreement (sometimes called a "membership agreement") entitles the subscriber to "free ambulance services" for a defined period of time in exchange for a subscription or membership fee, then the program involves the actual sale of ambulance services on a prepaid basis and is, therefore, a Type I program. But if the subscription agreement merely allows the subscriber to prepay at a fixed price set by the company the uninsured portions of ambulance bills, then the contract is *not* for the sale of ambulance services, but is instead an agreement between the customer and the provider to alter the method of payment of uninsured portions of ambulance bills—i.e., a Type II program.

The most important difference between Type I and Type II subscription programs is that, under a Type II program, the provider may (with certain restrictions) collect and retain third party reimbursements for services rendered to subscribers. Under a Type I program, monies collected from third party payors technically belong to the subscriber, and in some cases, it may be unlawful for third party bills to exceed the amount of annual subscription fee.

In practice, subscription agreements and promotional materials are often so poorly drafted that it is impossible to determine what is actually being sold—ambulance services versus an altered method of paying uninsured costs. That uncertainty carries great financial risk for the provider who bills third party payors, especially Medicare, for services received by subscribers.

Why Subscription Programs? For most providers, public and private, a subscription program is primarily a political safety value. If it didn't raise a dollar, the program would still be worth having for some providers.

Since about 1970 the ambulance industry has experienced tremendous clinical and technological progress. In about half of our communities, this progress has been heavily financed by local tax subsidies, with user fees remaining at token levels a fraction of production costs. But in other communities, progress has either been limited or financed through substantial increases in user fees. In addition, many local governments which were able to afford large ambulance subsidies in the easy-money fiscal years of the 1970s must now choose between higher user fees versus allowing a deterioration in quality of ambulance services.

For reasons detailed in depth in previous "Interface" articles, poor EMS at any price is false economy, and there are serious disadvantages to local tax financing of health care services, including EMS. Thus, assuming reasonable levels of efficiency, it is good public policy to finance quality ambulance services by raising ambulance fees to cover full production costs. It's good public policy, but it can also sting.

When ambulance rates go up dramatically, either to finance better service or to offset a subsidy reduction, the wisdom of the action may be less than widely recognized by the public at large. Here's why.

In some insurance policies, the level of maximum reimbursement for ambulance service was established back when teenaged ambulance jockeys roared through the streets in barely modified Cadillac hearses loosely called ambulances. Furthermore, Medicare's method of changing its "allowable charges" for ambulance services incorporates an 18-month delay from the time the rates are raised. And if your community is surrounded by heavily subsidized providers, your neighbor's token rates will, because of Medicare's method, forever depress your own reimbursement levels.

The bottom line: When you raise

Jack Stout has been at the forefront of innovations in the design and implementation of EMS systems for the past dozen years. If you have a question, a problem, or a solution related to the public/private interface in prehospital care, address your letter to "Interface" jems, P.O. Box 1026, Solana Beach, CA 92075.

subscriber because, under a Type I subscription plan, he has already paid you for services in advance.

The solution to this problem is simple: If you intend to collect money from third party payors for services rendered to subscribers, just be sure your subscription contract and promotional materials make it very clear that yours is a Type II subscription program.

Deductibles and Coinsurance. Even for Type II subscription programs, there have remained questions regarding whether the subscription fees can count toward the subscriber's deductible, and whether the provider is at risk for failing to attempt to collect "coinsurance" amounts as required by Medicare law.

Attorney David Werfel, consultant to the American Ambulance Association, recently succeeded in obtaining from the Health Care Financing Administration (HCFA) clarification of policy regarding these issues. Quoting from HCFA's June 3, 1986 response to Mr. Werfel's letter:

"Services furnished by an ambulance company under a subscription agreement calling for payment of an annual membership fee may be covered under Medicare only if the agreement explicitly or by clear implication authorizes the company to charge, except for applicable deductible and coinsurance, to the extent of the available Medicare or other coverages of the services. Under this type of agreement, the subscription fees for subscribers who have Medicare or other coverage become, in effect, premiums for coverage by the ambulance company of deductible and coinsurance amounts. Thus, the actual charge and customary charge reductions imposed under *Medicare Carriers Manual* section 5220 for routine waiver of deductible and coinsurance do not apply. There is no requirement, moreover, that subscription fees be uniform for all subscribers nor is there any requirement that fees be different for those subscribers who have Medicare or other insurance than for those subscribers who have no insurance."

That's about as clear-cut a statement of policy as you'll ever get out of HCFA, and what's more, it's a policy our industry and our customers can live with. This happy outcome is, I believe, partly the result of Mr. Werfel's careful drafting of the letter requesting the opinion. (How you ask a question can greatly affect the answer you get.) Mr. Werfel is clearly earning his fee.

The Plot Thickens. Mr. Werfel's letter also asked for an opinion on whether subscription programs might violate the anti-kickback provisions of the Social Security Act—i.e., Section 1877(b). He didn't get it.

HCFA's response: "The question of whether these (subscription) agreements involve any criminal conduct under section 1877(b) of the Social Security Act is in the jurisdiction of the Department's Office of Inspector General (OIG). . . . We understand that the OIG does not give advisory opinions on the effect of criminal statutes." Thus, we seem to be left, for the moment, in a sort of awkward situation.

Pricing Subscription Fees. Most subscription programs employ a uniform price per "household." However, you may wish to consider setting the subscription fee for Medicare subscribers separately. Here's why.

When you accept assignment, as you will do for all Medicare-eligible subscribers, you agree to accept Medicare's reimbursement as payment in full for the balance which would otherwise be owed by the customer. The subscription fee already paid by the subscriber satisfies the customer's obligation to pay any deductible and coinsurance which would otherwise be owed. Okay so far.

But what if, at the end of a fiscal year, it turns out that your revenues from subscription fees paid by Medicare-eligible subscribers, when added to the Medicare payments received for services rendered to those same patients, exceeds the combined "allowable charges" for all of those services? You *could* be found guilty of overcharging for services to Medicare patients on whom you have accepted assignment.

Readers already familiar with how Medicare works will immediately see the problem. For the rest of you (whose lives are obviously filled with more interesting stuff to think about), just understand that when you "accept assignment" on a Medicare patient, you are agreeing to charge Medicare no more than 80% of its "allowable charge" for that service (which may be far less than your standard rate), and you are agreeing to collect from the patient the remaining 20% and not one cent more. That's the law.

Steve Williamson, Executive Director of the Tulsa system, and manager of an unusually successful urban subscription program, has a solution to this problem that should satisfy the law. Every year, before setting the following year's subscription fees, Steve compiles

tion program may be risky. Two reasons: first, if you sell subscriptions limited to non-emergency services only, you may be inadvertently encouraging patients who should call 911 to call your number instead, and you may end up embroiled in a messy [illegible]

Second, [illegible] subscription [illegible] ambulance [illegible] was not the nearest ambulance to a subscriber's emergency, the subscriber will die and you will be trying to convince the court that there's nothing wrong with making a buck by luring customers away from the 911 system. (Don't call me as your expert witness on that one.)

Ingredients for Success. Today's most successful, big system subscription programs generally have several features in common. All are full service programs offered by the area's primary (and often exclusive) provider. Many are offered by all ALS, full-service, single provider systems. In nearly every case, quality of service is well above average, the local reputation of the provider is good, fees/user rates are set at or near full production costs, efforts to collect from non-subscribers are professional and aggressive. (Why buy a subscription when the provider always accepts assignment anyway, or when the user fees are heavily subsidized, or when nothing much happens when you don't pay your bill?)

Nearly every successful subscription program includes a serious marketing and advertising budget, a limited annual enrollment period, and employs easy access for signing up (e.g., area banks, senior citizen centers, pharmacies, etc.). In later years, most programs enjoy high rates of renewal by existing subscribers, and make active use of their billing/collection [illegible] to stimulate renewals and [illegible] new subscribers.

Conclusion. Ambulance subscription programs are [illegible] and useful result of [illegible] upgrade [illegible] the unequal [illegible] of third party reimbursement [illegible]. They are, however, [illegible] be appropriate [illegible] industry [illegible] that program [illegible] of our [illegible] providers.

NINILCHIK COMMUNITY AMBULANCE ASSOCIATION (NCAA)
MEMBERSHIP APPLICATION AND CONTRACT

Description of Membership and Fee: I understand the annual fee for my Ninilchik Community Ambulance Association, hereinafter known as NCAA, Membership limits my out-of-pocket expenses for the uninsured portion of bill(s) for ambulance services provided by NCAA for medically necessary ambulance transportation originating and terminating in NCAA's Primary Service Area and to or from a medical facility. This year's fee is $50 for NCAA Primary Service Area residents.

Who Is Eligible for NCAA Membership?: NCAA Membership is available to legal residents of NCAA's Primary Service Area, which includes: Mile 121 to mile 145 of the Sterling Highway and the roads which are connected to the Sterling Highway between those mile markers. NCAA does not solicit memberships from Medicaid eligible recipients and such membership constitutes a voluntary contribution only.

Who In My Home Is Covered by This Program?: The NCAA Membership covers a husband and wife, or single parent, and their children 18 years and younger living at the same address, or a single individual in a household.

Where am I Covered: The NCAA Membership is good throughout NCAA's Primary Service Area. The Membership does not cover ambulance service outside the Primary Service Area, or services provided by companies other than NCAA.

What Is Medically Necessary?: I understand that NCAA Membership ambulance services are restricted to the "medically necessary", defined as the specific need for ambulance service transportation to or from a health care facility (hospital, nursing home, etc.) where use of alternative forms of transportation (private car, taxi, etc.) would be medically inappropriate given the patient's condition. NCAA reserves the right to require physician certification of medical necessity in cases of suspected abuse. If abuse is found to exist, then I understand my membership can be terminated. If my insurance company denies my NCAA claim on grounds that my transport by ambulance was not medically necessary, I will be responsible to NCAA for the full amount of the bill.

If I Have Insurance*, Who Receives Claim Payments?: I understand that my NCAA Membership is not insurance and that NCAA will receive payments from my insurer or third party agency (e.g. Medicare, Blue Cross, etc.). To help process authorized claims, I authorize release of any medical information necessary to process a claim to both my insurer and to NCAA, and I further authorize such payment to be made directly to NCAA. I further agree to forward to NCAA any payments made by my insurer to me for services provided by NCAA.

*Note: I understand that if it is the policy of my insurance company that my NCAA Membership voids its responsibility for payment of claims, this contract may be cancelled and full amount of my membership fee refunded to me.

Effective Dates: I understand that my membership is effective upon receipt of full payment and signed membership application and contract, through December 31, 1990.

Signature _____ Date _____

Spouse's Signature _____ Date _____

Membership contract must be signed by the Insurance Policy Holder or Authorized Person if uninsured.
Membership is non-transferable and non-refundable except as described above.

If you have questions or have trouble understanding this contract, please call 567-3342.

When you have completed the Member Information and signed the Contract, please mail it to:

NCAA Membership Program
P.O. Box 39351
Ninilchik, AK 99639

If you are paying by check or money order, please make it payable to:
Ninilchik Community Ambulance Association

Revisor's notes. — Reorganized in 1986 to alphabetize the defined terms.

Effect of amendments. — The 1982 amendment added paragraph (2).

Editor's notes. — "Health systems agencies," referred to in (10) of this section, are further described in 42 U.S.C. 300*l*-1.

NOTES TO DECISIONS

Health care facility. — Federal law defines a skilled nursing facility in a manner which includes such facilities when they are contained in larger institutions such as pioneer homes (42 C.F.R. § 100.102(e)(4) (1979)). Alaska state law was meant to be no less comprehensive. South Cent. Health Planning & Dev., Inc. v. Commissioner of Dep't of Admin., Sup. Ct. Op. No. 2359 (File No. 5633), 628 P.2d 551 (1981).

Chapter 08. Emergency Medical Services.

Collateral references. — 39 Am. Jur. 2d, Health, §§ 9-18.

39A C.J.S., Health and Environment, §§ 3-17.

Sec. 18.08.010. Administration. The department is responsible for the development, implementation and maintenance of a statewide comprehensive emergency medical services system and, accordingly, shall

(1) coordinate public and private agencies engaged in the planning and delivery of emergency medical services to plan an emergency medical services system;

(2) assist public and private agencies to deliver emergency medical services through the award of grants in aid. (§ 1 ch 100 SLA 1977)

Sec. 18.08.020. Advisory Council on Emergency Medical Services. There is established in the department an Advisory Council on Emergency Medical Services. The council shall

(1) advise the commissioner with regard to the planning and implementation of a statewide emergency medical services system;

(2) assist the Statewide Health Coordinating Council in performing its duties under AS 18.07.011 relating to emergency medical services. (§ 1 ch 100 SLA 1977)

Sec. 18.08.030. Composition. The council consists of 11 members appointed by the governor. Four of the members must be consumers of emergency medical services, and one from each judicial district in the state. (§ 1 ch 100 SLA 1977)

Sec. 18.08.040. Term of office. (a) Members of the council shall be appointed for staggered terms of four years.

(b) Each year the governor shall appoint a consumer to one of the staggered terms on the council that expire during that year.

(c) A vacancy occurring in the membership of the council shall be filled by appointment by the governor in the same manner as original appointments, and when a seat is vacated before expiration of a term, the vacancy shall be filled for the unexpired portion of the vacated term. (§ 1 ch 100 SLA 1977; am §§ 25, 26 ch 37 SLA 1986)

Effect of amendments. — The 1986 amendment substituted "staggered" for "overlapping" in subsection (a) and rewrote subsection (b).

Sec. 18.08.050. Compensation and per diem. Members of the council receive no salary, but are entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions. (§ 1 ch 100 SLA 1977)

Cross references. — For provisions relating to per diem, travel and other expenses for members of boards and commissions, see AS 39.20.180.

Sec. 18.08.060. Meetings. The council shall meet at the call of the chairman not less frequently than twice a year. A majority of members constitutes a quorum. (§ 1 ch 100 SLA 1977)

Sec. 18.08.070. Special committees. The council may create special committees or task forces outside its membership and may appoint persons who are not members of the council to serve as advisors or consultants to any committee created to carry out the purposes of the council. (§ 1 ch 100 SLA 1977)

Sec. 18.08.080. Regulations. The department shall adopt, with the concurrence of the Department of Public Safety, regulations establishing standards and procedures for the issuance, renewal, reissuance, revocation, and suspension of certificates required under AS 18.08.084, as well as other regulations necessary to carry out the purposes of this chapter. (§ 1 ch 100 SLA 1977; am § 1 ch 78 SLA 1978)

Sec. 18.08.082. Issuance of certificates. (a) The department shall prescribe by regulation a course of training or other requirements prerequisite to the issuance of certificates that provide for the following:

(1) certifies that a person meets the training and other requirements as an emergency medical technician;

(2) authorizes an emergency medical technician certified under this chapter to provide under the written or oral direction of a physician the advanced life support services enumerated on the certificate;

(3) certifies that a person, organization, or government agency that provides an emergency medical service meets the minimum operating standards prescribed by the department; and

(4) authorizes an emergency medical service certified under this chapter to provide under the written or oral direction of a physician the advanced life support services enumerated on the certificate.

(b) The department is the central certifying agency for personnel certified under (a)(1) and (2) of this section and under regulations adopted under AS 18.08.080. (§ 2 ch 78 SLA 1978)

Sec. 18.08.084. Certificate required. (a) One may not represent oneself, nor may an agency or business represent an agent or employee of that agency or business, as an emergency medical technician certified by the state unless the person represented is certified as an emergency medical technician under AS 18.08.082.

(b) A person, organization, or government agency may not represent itself as an emergency medical service or ambulance service certified by the state unless the person, organization, or government agency is certified as an emergency medical service under AS 18.08.082.

(c) A person may not provide, offer, or advertise to provide advanced life support services outside a hospital unless authorized by law.

(d) A person, organization, or government agency that provides, offers, or advertises to provide an emergency medical service may not provide advanced life support services unless authorized under AS 18.08.082. (§ 2 ch 78 SLA 1978)

Sec. 18.08.086. Immunity from liability. (a) A person certified under AS 18.08.082, or a person or public agency that employs, sponsors or controls the activities of persons certified under AS 18.08.082, who administers emergency medical services to an injured or sick person is not liable for civil damages as a result of an act or omission in administering those services, if done in good faith and if the injured or sick person is in immediate danger of serious harm or death. This

subsection does not preclude liability for civil damages that are the proximate result of gross negligence or intentional misconduct, nor preclude imposition of liability on a person or public agency that employs, sponsors, or controls the activities of persons certified under AS 18.08.082 if the act or omission is a proximate result of a breach of duty to act created under this chapter. For the purposes of this subsection, "gross negligence" means reckless, wilful, or wanton misconduct.

(b) A physician who in good faith arranges for, requests, recommends, or initiates the transfer of a patient from a hospital to another hospital is not liable for civil damages as a result of arranging, requesting, recommending, or initiating the transfer if

(1) in the exercise of that degree of knowledge or skill possessed, or that degree of care ordinarily exercised by physicians practicing the same specialty in the same or similar communities to that in which the physician is practicing, the physician determines that treatment of the patient's medical condition is beyond the capability of the transferring hospital or the medical community in which the hospital is located;

(2) the physician has confirmed that the receiving facility is more capable of treating the patient; and

(3) the physician has secured a prior agreement from the receiving facility to accept and render the necessary treatment to the patient.

(c) A registered nurse or licensed practical nurse who escorts a patient in a means of conveyance not equipped as an ambulance is not liable for civil damages as a result of an act or omission in administering patient care services, if done in good faith and if the life of the injured or sick person is in danger. This subsection does not preclude liability for civil damages that are the result of gross negligence or intentional misconduct. (§ 2 ch 78 SLA 1978; am § 2 ch 122 SLA 1986)

Cross references. — For liability for services rendered by a physician-trained mobile intensive care paramedic, see AS 08.64.366.

For civil liability for emergency aid, see AS 09.65.090.

Effect of amendments. — The 1986 amendment substituted "if done in good faith and if the injured or sick person is in immediate danger of serious harm or death" for "if done in good faith and if the life of the injured or sick person is in danger" at the end of the first sentence in subsection (a) and made minor grammatical changes.

Collateral references. — Liability of hospital operating ambulance for personal injuries to person being transported. 21 ALR2d 915.

Hospital's liability as to diagnosis and care of patients brought to emergency ward. 72 ALR2d 396.

Application of rule of strict liability in tort to person or entity rendering medical services. 100 ALR3d 1205.

Sec. 18.08.088. Penalty. A person who violates a provision of this chapter is guilty of a misdemeanor and upon conviction is punishable by a fine of not more than $1,000, or by imprisonment for not more than 90 days, or by both. Each violation is a separate offense. (§ 2 ch 78 SLA 1978)

Cross references. — For sentences for misdemeanors, see AS 12.55.135.

Sec. 18.08.090. Definitions. In this chapter,

(1) "advanced life support" means emergency care techniques provided under the written or oral orders of a physician that include, but are not limited to, electric cardiac defibrillation, administration of antiarrhythmic agents, intravenous therapy, intramuscular therapy, or use of endotracheal intubation devices;

(2) "ambulance" means any publicly or privately owned means of conveyance intended to be used and maintained or operated for the transportation of persons who are sick, injured, wounded, or otherwise helpless;

(3) "commissioner" means the commissioner of health and social services;

(4) "consumer of emergency medical services" means a person who is not a provider of emergency medical services as defined in this section;

(5) "department" means the Department of Health and Social Services;

(6) "emergency medical care" means the services utilized in responding to the perceived individual needs for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury;

(7) "emergency medical service" means the provision of emergency medical care and transportation of the sick and injured;

(8) "emergency medical services system" means a system that provides for the arrangement of personnel, facilities and equipment for the effective and coordinated delivery of health care services under emergency conditions, occurring either as a result of the patient's condition or of natural disasters or similar situations, and that is administered by a statewide network that has the authority and resources to provide effective administration of the system;

(9) "emergency medical technician" means a person trained in emegency medical care and certified in accordance with the regulations prescribed under AS 18.08.080;

(10) "provider of emergency medical services" means a person whose occupation or profession is, or has been, the delivery or administration of emergency medical services; a person who has a fiduciary position with, or has a fiduciary interest in, a health activity, facility

or other health agency, or a legal or financial interest in the rendering of any component of emergency medical services;

(11) "Statewide Health Coordinating Council" means the council created under AS 18.07.011. (§ 1 ch 100 SLA 1977; am § 3 ch 78 SLA 1978)

Revisor's notes. — Reorganized in 1986 to alphabetize the defined terms.

Chapter 10. Health Units and Districts.

Collateral references. — 39 Am. Jur. 2d, Health, §§ 4-7.

39A C.J.S., Health and Environment, §§ 7-15.

Delegation to board or officer of police power to require vacation, destruction, or repair of individual building deemed by such officer or board unsafe or unsanitary, apart from noncompliance with specific regulations. 114 A.L.R. 446.

Extension of police power of municipal corporation beyond territorial limits. 14 ALR2d 103.

Validity and construction of statute requiring establishment of "need" as precondition to operation of hospital or other facilities for the care of sick people. 61 ALR3d 278.

Sec. 18.10.010. Local health unit and health board. Each community or settlement outside an incorporated city is a health unit. In each health unit there shall be a board of health composed of the president of the school board and two citizens of the unit selected by the school board. At least one of the members of the health board must, where practicable, be a licensed physician. In a health unit where there is no school board, the commissioner of the department shall appoint three residents of the unit to the local board of health, at least one member of which must, where practicable, be a licensed physician. (§ 1 ch 118 SLA 1949)

Cross references. — For transitional measures as to local governments, see Alaska Const., art. XV, § 3.

Sec. 18.10.020. Health unit in incorporated city. AS 18.10.010 applies to an incorporated city unless the city otherwise provides for the establishment and maintenance of a local board of health or a health officer. (§ 1 ch 118 SLA 1949)

former paragraphs (7) and (8) into present paragraph (7), added "and" at the end of paragraph (7), redesignated former paragraphs (9) and (10) as present paragraphs (8) and (9), respectively, and made internal reference changes in paragraphs (5) and (6).

Chapter 87. Hospital and Medical Service Corporations.

Collateral references. — 44 Am. Jur. 2d, Insurance, § 1842 et seq.; 61 Am. Jur. 2d, Physicians, Surgeons, and Other Healers, §§ 153, 156.

44 C.J.S., Insurance, § 15.

Validity and nature of group medical and hospital service plans, 167 ALR 322.

Sec. 21.87.010. Applicability. (a) This chapter applies to every individual, person, firm, corporation, association, or organization of any kind hereafter engaging or purporting to engage in the provision of all or part of a health care service as defined in AS 21.87.330, for its subscribers in exchange for periodic prepayments in identifiable amount by or as to the subscribers.

(b) This chapter does not apply to

(1) insurers or fraternal benefit societies authorized to transact the kind of insurance involved under other chapters of this title;

(2) fraternal and other organizations exempted from AS 21.24;

(3) health care services provided by an employer to employees and their dependents, with or without contribution to the costs thereof by the employees, through health care service facilities owned, employed, or controlled by the employer;

(4) infrequent instances of prepayment by or for the patient direct to the physician or hospital for specific services thereafter rendered to the patient by the physician or hospital. (§ 1 ch 120 SLA 1966)

Sec. 21.87.020. Purpose and interpretation. (a) It is the purpose of this chapter to regulate in the public interest the formation and operation of prepaid health care service organizations, in order that the services may be made available upon a basis of fair and equitable contracts through state-licensed nonprofit organizations meeting reasonable standards as to administration, reserves, and financial soundness.

(b) This chapter shall be liberally interpreted to effectuate the purpose declared in (a) of this section. (§ 1 ch 120 SLA 1966)

Sec. 21.87.030. Provisions exclusive. A provision of this title does not apply to a health care service corporation unless contained or referred to in this chapter. (§ 1 ch 120 SLA 1966)

Sec. 21.87.040. Incorporation and certificate of authority required. A person otherwise subject to this chapter may not engage or purport to engage in the provision of any part or all of a health care service for its subscribers in exchange for periodic prepayments in identifiable amount unless it is a service corporation incorporated under the laws of Alaska, and currently authorized as such a service corporation under a certificate of authority issued by the director under this chapter. (§ 1 ch 120 SLA 1966)

Sec. 21.87.050. Incorporation, approval of articles and amendments. (a) A service corporation shall be formed as a nonprofit, nonstock medical service corporation, or hospital service corporation, or a combination medical and hospital service corporation, consistent with the applicable requirements of this chapter under the statutes of Alaska governing the formation of nonprofit, nonstock corporations in general.

(b) Before the articles of incorporation of the proposed corporation formed after July 1, 1966, are filed with the commissioner of commerce and economic development, they shall be submitted to the director, and the commissioner may not file the articles unless the director's approval is endorsed thereon. The director shall approve the articles unless the director finds that they do not comply with law. If not approved, the director shall return the proposed articles of incorporation to the incorporators together with a written statement of particulars of the reasons for nonapproval.

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Sec. 21.87.07(
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amount unless it is a service corporation incorporated under the laws of Alaska, and currently authorized as such a service corporation under a certificate of authority issued by the director under this chapter.

History.—§ 1, ch. 120, SLA 1966.

§ 21.87.050 Applicability of nonprofit corporation statutes; filing and approval of articles of incorporation

(a) A service corporation shall be formed as a nonprofit, nonstock medical service corporation, or hospital service corporation, or a combination medical and hospital service corporation, consistent with the applicable requirements of this chapter under the statutes of Alaska governing the formation of nonprofit, nonstock corporations in general.

(b) Before the articles of incorporation of the proposed corporation formed after July 1, 1966, are filed with the commissioner of commerce and economic development, they shall be submitted to the director, and the commissioner may not file the articles unless the director's approval is endorsed thereon. The director shall approve the articles unless the director finds that they do not comply with law. If not approved, the director shall return the proposed articles of incorporation to the incorporators together with a written statement of particulars of the reasons for nonapproval.

(c) An amendment of the articles of incorporation of a service corporation may not be filed with the commissioner unless it is first submitted to and approved by the director, and bears the director's approval endorsed on it. The director shall approve the amendment unless the director finds that it was not lawfully adopted or that the articles of incorporation as amended would be unlawful. If not approved, the director shall return the proposed amendment to the corporation together with a written statement of the particulars of the reasons for nonapproval.

History.—§ 1, ch. 120, SLA 1966.

§ 21.87.060 Corporate name

A service corporation may not have or use a corporate or business name which includes the words "insurance," "casualty," "surety," "health and accident," "mutual," or other terms descriptive of an insurer or insurance business. A service corporation may not have or use a name so similar to that of another corporation transacting business in

this state when the service corporation was formed that it would tend to confuse or mislead the public.

History.—§ 1, ch. 120, SLA 1966.

§ 21.87.070 Qualifications for certificate of authority

The director may not issue or permit to exist a certificate of authority to be or act as a service corporation to a corporation which does not fulfill the following qualifications:

(1) it must be incorporated as provided in AS 21.87.050, as either a medical service corporation, or as a hospital service corporation, or as a combined medical and hospital service corporation;

(2) it must intend to and actually conduct its business in good faith as a nonprofit corporation;

(3) if a hospital service corporation, it must have in force at all times while so authorized, service agreements with participant hospitals located in the areas of the subscribers' residences, convenient as to location and sufficient as to capacity and facilities reasonably to furnish the hospital services provided or proposed to be provided by the corporation to its subscribers;

(4) if a medical service corporation, it must have in force service agreements with participant providers located in the areas of the subscribers' residences convenient as to location and sufficient in numbers and facilities reasonably to furnish the medical and surgical services provided or proposed to be provided by the corporation to its subscribers;

(5) If a newly formed corporation, it must possess sufficient available working funds to pay all reasonably anticipated cost of acquisition of new business and operating expenses, other than payment for hospital or medical services, for a period of not less than the six months following the date of issuance of the certificate of authority, if issued, or $100,000, whichever amount is greater;

(6) it must fulfill all other applicable requirements of this chapter.

History.—§ 1, ch. 120, SLA 1966; § 3, ch. 40, SLA 1981.

§ 21.87.080 Application for certificate

(a) Application for a certificate of authority to transact business as a

service corporation shall be made to the director, on forms as prepared and furnished by the director and requiring the information relative to the applicant, its directors, officers, and affairs as the director may reasonably require consistent with this chapter.

(b) The application shall be accompanied by the following documents which are not already on file with the director:

(1) one copy of the applicant's articles of incorporation and of all amendments, certified by the commissioner;

(2) one copy of the applicant's bylaws, certified by its corporate secretary;

(3) if a medical service corporation, a copy of each form of service agreement entered into or proposed to be entered into with participant providers, together with a list showing the name, residence and office addresses, and date of execution of the service agreement by each participant provider;

(4) if a hospital service corporation, a copy of each service agreement entered into with participant hospitals certified by the applicant's corporate secretary;

(5) a copy of each form of subscribers' contract proposed to be offered;

(6) a schedule of the rates proposed to be charged subscribers;

(7) a financial statement of the applicant as of a date not more than 30 days before the filing of the application, showing among other things the amount of working funds available to the applicant, the source of the funds, and accompanied by a copy of the agreement under which the funds were contributed to or provided for the applicant;

(8) a copy of any other relevant document reasonably requested by the director.

(c) At the time of filing the application the applicant shall pay to the director the application fee and the fee for issuance of the certificate of authority set under AS 21.06.250.

History.—§ 1, ch. 120, SLA 1966; § 4, ch. 40, SLA 1981; § 26, ch. 26, SLA 1985.

§ 21.87.090 Issuance or refusal of certificate

(a) If, after the application for certificate of authority is completed,

the director finds that the applicant is fully qualified for a certificate of authority in accordance with this chapter, and that the service agreements, subscribers contracts, schedule of rates are in compliance with the applicable provisions of this chapter, the director shall issue to the applicant a certificate of authority as a medical service corporation or as a hospital service corporation, or as a combined medical and hospital service corporation, as the case may be.

(b) If the director does not so find, the director shall refuse to issue a certificate of authority and shall give the applicant written notice setting out the particulars of the reasons for the refusal, accompanied by return of the fee tendered for issuance of the certificate of authority.

(c) The director shall either issue or refuse to issue the certificate of authority within a reasonable time after the filing and completion of application.

History.—§ 1, ch. 120, SLA 1966.

§ 21.87.100 Continuance or expiration of certificate

(a) A certificate of authority issued to a service corporation shall continue in force as long as the corporation is entitled to it under this chapter, and until suspended or revoked by the director or terminated at the request of the corporation; subject, however, to continuance of the certificate by the corporation each year by

(1) payment, before June 30, of the continuation fee set under AS 21.06.250;

(2) filing by the insurer of its annual statement for the preceding calendar year as required under AS 21.87.240.

(b) If not continued by the service corporation, its certificate of authority shall expire at midnight on the June 30 following the failure of the insurer to continue it in force. The director shall promptly notify the insurer of the occurrence of a failure resulting in impending expiration of its certificate of authority.

History.—§ 1, ch. 120, SLA 1966; § 27, ch. 26, SLA 1985.

§ 21.87.110 Suspension or revocation of certificate

(a) The director shall suspend or revoke the certificate of authority of a service corporation that the director finds, after a hearing, is no longer qualified under this chapter.

MEMORANDUM State of Alaska

TO: Parties interested in starting a new domestic insurer

DATE: Updated July 31, 1989

FILE NO:

TELEPHONE NO:

THRU:

SUBJECT: Relevant Laws

FROM: Eugene W. Furman CPA
Insurance Financial Examiner

From time to time the Department of Commerce and Economic Development, Division of Insurance, is approached by parties interested in starting a new domestic insurer. This memorandum is a non-exhaustive outline of the more important laws dealing with the start up of a domestic insurer.

This memorandum is not intended to substitute for competent legal advice or feasibility studies and economic research normal to the start up of any new business endeavor. There are risk elements in any new business, many of which are magnified for a new domestic insurer due to the size of Alaska's population, lack of a domestically available insurer management pool, lack of a pool of trained insurer employees and many other factors. Perceived high cost of current insurance, tightness in one or more lines of available insurance coverage or enthusiasm by independent promoters and/or insurance sales people should not be considered to represent an available economic opportunity.

As a newly organized entity a new domestic insurer has no operating history. It is likely that there will be no secondary market for its shares or other securities. Accordingly, the securities of a newly formed domestic insurer are likely to be illiquid. Certain provisions of Alaskan law will operate to impair the newly formed domestic insurer's ability to realize the full value of its assets in the event of a voluntary or involuntary liquidation of its assets. An investment in a newly formed domestic insurer is not appropriate for all investors and no assurances can be given that the objectives of the newly formed domestic insurer can be achieved.

This memorandum is intended for the personal use of the organizers of domestic insurers for their informational purposes only. There are other requirements of Alaskan law not contained in the statutes dealing with insurance such as the anti-fraud and disclosure rules of the securities laws which organizers need to consider.

THERE CAN BE NO ASSURANCES BY THE STATE OF ALASKA, ITS EMPLOYEES OR ITS AGENTS AS TO THE ACHIEVEMENT OF THE OBJECTIVES OF THE ORGANIZERS OF A DOMESTIC INSURER. THERE IS NO APPROVAL OR DISAPPROVAL OF ANY PROSPECTUS OR OFFERING CIRCULAR PREPARED USING THIS MEMORANDUM AS A GUIDELINE. FURTHER, THERE IS NO APPROVAL OR DISAPPROVAL OF ANY SECURITIES OFFERED THRU USE OF THIS MEMORANDUM AS A GUIDELINE BY ORGANIZERS. ANY REPRESENTATION TO THE CONTRARY IS A CRIMINAL OFFENSE GOVERNED BY VARIOUS FEDERAL SECURITIES LAWS.

Scope of Insurance Laws

All persons transacting a business of insurance in Alaska, or relative to a subject resident, located or to be performed in Alaska, shall comply with the applicable provisions of Alaskan law, namely, Title 21 - Insurance. (AS 21.03.010) The activity performed by a domestic insurer is considered the transaction of the business of insurance in Alaska. Accordingly, Title 21 applies as do many of the provisions of Title 10, Chapter 05 Alaska Business Corporation Act dated July 1, 1989.

Specifically with respect to Title 21 a person may not act as an insurer and an insurer may not transact insurance in Alaska except as authorized by a valid certificate of authority issued by the director of the Division of Insurance. (AS 21.09.010) Domestic insurers may be incorporated stock insurers, incorporated mutual insurers or reciprocal insurers. (AS 21.09.040) Domestic stock insurers should refer to AS 21.09, while domestic mutual insurers and domestic reciprocal insurers should refer respectively to AS 21.69 and AS 21.75 in addition to AS 21.09.

Application Process

To apply for an original certificate of authority an insurer shall file with the director its application (accompanied by the applicable fees set under AS 21.06.250) showing the information and including the documents called for in AS 21.09.110. A forms packet is available from the Division's Licensing Supervisor in Juneau, (907) 465-2545. Additionally, it is the policy of the division to require complete biographical histories and a listing of business activities of organizers and proposed directors and investigate same under AS 21.09.100 and other provisions of Alaskan Insurance Laws.

Before organizers may advertize, solicit funds, make agreements or generally take any action with respect to organizing a domestic insurer a solicitation permit must be applied for and received form the director. The rules for this process are covered in AS 21.60.060 thru .260. There is a surety bond or cash deposit requirement of the organizers contained in AS 21.60.140. During the organization process and afterwards the director must be appointed as a domestic insurer's attorney to receive service of legal process issued against it in Alaska. (AS 21.09.180 and .190) It is strongly suggested that organizers be very familiar with AS 21.69 which covers organization, corporate procedures and the important concept of bulk reinsurance in sections .610 and .620. Further attention is directed to AS 21.36.360 (c), fraudulent insurance acts associated with forming an insurer and the requirement for pre-approval of insurance contract forms in AS 21.42.120.

If the director finds that the applicant has met the requirements for and is entitled to a certificate of authority under Alaskan Insurance Law, the director will issue a proper certificate specifying the kinds of insurance the

insurer is authorized to transact. This certificate remains at all times the property of the State. If the director does not find that the requirements have been met, the director will issue an order refusing the certificate. (AS 21.09.120)

It would also be important for the organizer to understand the concepts of continuation, amendment and termination of the certificate of authority. These concepts are covered in AS 21.09.130 to .180.

Required Capital

A domestic corporate insurer issuing capital stock applying for its original certificate of authority is required to possess the basic minimum paid-in-capital stock and additional funds in surplus as outlined in AS 21.09.070. In addition to the rules in AS 21.09.070, the required initial minimum surplus for a domestic mutual insurer is governed by AS 21.09, primarily section .220, while the required initial minimum surplus for a domestic reciprocal insurer is governed by AS 21.75, primarily AS 21.75.050 and .055. The amount of surplus is controlled by the types of insurance to be written. Generally, $1,000,000 of basic capital or surplus and additional surplus for a total of $2,000,000 is required for a life and disability insurer with $1,500,000 of basic capital or surplus and additional surplus for a total of $3,000,000 being required for a property and casualty insurer. Higher initial amounts of additional surplus is a subject which organizers should be prepared to discuss. Generally, organizers should concern themselves with capital in addition to the minimum requirements whenever their business plan filed with the application calls for the new domestic insurer to accept the risk of loss on any single occurrence in excess of $50,000 to $100,000.

Organizers should note that a business plan is an item of additional information that the director requires under AS 21.09.110. Domestic insurers desiring to assume reinsurance liabilities should be thinking in terms of $20,000,000 or greater total initial surplus. Finally, on the subject of initial minimum surplus, there is an important prohibition in AS 21.12.110 requiring any insurer to not retain a risk on any one subject of insurance in an amount exceeding 10% of its surplus to policyholders.

Trust Deposits

All insurers other than title insurers are generally required to have a trust deposit of at least $300,000 deposited with the director under AS 21.24.030.

Additional Items

The following additional items are a partial list of the concepts with which organizers should become familiar before committing to a decision concerning organizing a domestic insurer:

Additional Items (Cont.)

SUBJECT	REFERENCE
Reports - Annual Statement	AS 21.09.200
- Premium Tax Report	AS 21.09.210
Records	AS 21.69.390 and .400
Limit of Risk	AS 21.12.010
Reinsurance	AS 21.12.020
Definitions of Coverages	AS 21.12.040 to .110
Assets and Liabilities	AS 21.18, particularly Sections .010 and .030
Investments	AS 21.20, particularly Sections .020, .050, .250, .300 and .321
Holding Companies	AS 21.22, particularly Sections .010, .020 and .060
Insider Trading	AS 21.40
Dividends	AS 21.22.100, AS 21.09.080 (b) AS 21.69.480 to .510 and AS 21.75.240 and.250
Trade Practices	AS 21.36 Particularly Sections .090, .100, .120, .130, .190 and .360
Rates	AS 21.39
Insurance Contracts	AS 21.42 and AS 21.09.110 (9)
Unauthorized Business	AS 21.09.250
Stock of Subsidiaries	AS 21.21.180
Investments Prohibitions	AS 21.21.250 and .321

Addresses and Phone numbers

Juneau - State of Alaska
Department of Commerce and Economic Development
Division of Insurance
P. O. Box D
Juneau, Alaska 99811

(907) 465-2515
(907) 465-3041 (fax)

Delivery address: 333 Willoughby Street
Juneau, Alaska 99801

Anchorage - State of Alaska
Department of Commerce and Economic Development
Division of Insurance
3601 C Street, Room 740
Anchorage, Alaska 99503

(907) 562-3626
(907) 562-0048 (fax)

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: SB 524
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to ambulance and emergency medical services provided by municipalities . . . .
Sponsor: Labor & Commerce Committee
Requestor: Senate Judiciary Committee

Agency Affected: Commerce & Economic Dev.
BRU: Insurance
Components: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

No impact in FY 90

Prepared by: Joan Brown, Administrative Officer
Phone: 465-2597
Division: Insurance
Date: 3/27/90

Approved by Commissioner: Larry Merculieff (Jim Baltar)
Date: 3/27/90
Agency: Department of Commerce & Economic Development

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

JB/dg16598D
32790a

working capital to the corporation, the payment to be prorated on a uniform basis among all the outstanding contributions; or

(3) to reduce the rates thereafter to be charged subscribers, or to expand the services or benefits thereafter to be provided under subscription contracts.

History.—§ 1, ch. 120, SLA 1966; §§ 18, 19, ch. 40, SLA 1981.

§ 21.87.310 Fidelity bonds

Each service corporation shall procure and maintain in force a fidelity bond or bonds, with authorized corporate surety, covering every officer or employee entrusted with the handling of its funds, in an amount, but not less than $5,000, which may be fixed by its board of directors.

History.—§ 1, ch. 120, SLA 1966.

§ 21.87.320 Repealed. § 30, ch. 26, SLA 1985

§ 21.87.330 Definitions

In this chapter

(1) "health care service" means a service rendered to an individual for diagnosis, relief, or treatment of an injury, ailment or bodily condition;

(2) "hospital service corporation" means a service corporation that principally provides hospital services;

(3) "medical service corporation" means a service corporation that principally provides medical or surgical services;

(4) "nurse midwife" means a registered professional nurse who is certified as an advanced nurse practitioner under AS 08.68.410(1) and authorized to practice as a nurse midwife under regulations adopted in accordance with AS 08.68;

(5) "participant hospital" is one which has entered into a service agreement with a service corporation;

(6) "participant provider" means a provider who has entered into a service agreement with a service corporation;

(7) "physician" includes also "surgeon";

(8) "provider" means a physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, or other licensed health care practitioner;

(9) "service agreement" is a contract between a service corporation and a provider or hospital under which the provider or hospital agrees to render all or part of one or more health care services to subscribers of the service corporation;

(10) "service corporation" means a corporation providing all or part of one or more health care services for subscribers in exchange for periodic prepayments in identifiable amount by or as to the subscribers;

(11) "subscriber's contract" is that between the service corporation and its subscriber under which all or part of one or more health care services is to be rendered to or on behalf of the subscriber by a participant provider or hospital that has entered into a service agreement with the corporation covering the services.

History.—§ 1, ch. 120, SLA 1966; §§ 20—23, ch. 40, SLA 1981.

§ 21.87.340 Applicability of other provisions

In addition to the provisions contained or referred to previously in this chapter the following chapters and provisions of this title also apply with respect to service corporations to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of the express provisions, and for the purposes of the application the corporations shall be considered to be mutual "insurers":

(1) AS 21.03

(2) AS 21.06

(3) AS 21.09, except AS 21.09.090

(4) AS 21.18.010

(5) AS 21.18.030

(6) AS 21.18.040

(7) AS 21.18.120

(8) AS 21.21.321

(9) AS 21.36

(10) AS 21.69.400