SB

289

SFIN

FILE

REPORTED OUT
MAR 2 9 2006
SENATE FINANCE COMMITTEE

SENATE FINANCE COMMITTEE REPORT

DATE: 2/27/06

FURTHER:

DATE TURNED IN TO OFFICE: 3/29/06

Finance Committee considered SENATE BILL NO. 289

SB 289 INSURANCE

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

and recommends:

[✓] be replaced with _____ CS SB 289 (FIN)

[ ] adopt previous _____ CS CS Forthcoming (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

CS Senate Bill:
[ ] Same Title
[✓] New Title

SCS House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Ind.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Ind.	Zero	FN#
DCED	2/16/06			✓	1

[ ] APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
	✓			
			✓	
			✓	
	✓			
	✓			
COCHAIR:	✓			
COCHAIR:	✓			

REPORTED OUT
MAR 2 9 2006
SENATE FINANCE COMMITTEE

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSSB 289(L&C)
(S) Publish Date: 2/27/06

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Insurance
RDU: Insurance (116)
Component: Insurance Operations
Sponsor: Labor & Commerce by Request
Requester: Labor & Commerce
Component No.: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This legislation contains numerous changes to Title 21 that are designed to ensure that state statutes are consistent with federal law, the National Association of Insurance Commissioners (NAIC) model acts, standards and guidelines, and to update procedures and transactions and to provide protections to consumers that purchase life, annuity and health insurance. This legislation does not have a fiscal impact on the operations of the division.

Prepared by: Linda S. Hall, Director
Phone 907-269-7900
Division: Insurance
Date/Time 2/16/06 9:42 AM
Approved by: William C. Noll, Commissioner
Date 2/16/2006
Agency: Commerce, Community and Economic Development

(Revised 9/7/2005 OMB)

COMMITTEE COPY

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
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Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 29, 2006

SUBJECT: Conforming change to title to reflect removal of section relating to suitability of life and health insurance policies. (CSSB 289(FIN)) (Work Order No. 24-LS1563\S)

TO: Senator Lyda Green
Senator Gary Wilken
Co-Chairs of the Senate Finance Committee
Attn: Robin Paul

FROM: Dennis C. Bailey
Legislative Counsel

Please note that I have made a conforming change to CSSB 289(FIN) correcting the title by deleting "to suitability of life and health insurance policies and annuity contracts." This change reflects the committee's amendment removing sec. 32, addressing "suitability," in order to more accurately describe the subject of the bill in the title.

If this is not acceptable please let me know.

DCB:ljw
06-165.ljw

Enclosure

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

ADOPTED

SENATE FINANCE COMMITTEE
Amendment # 1
To Bill Number: SB 289
Sponsor: Green
Date: 3/29/06 Logged by: Robin

AMENDMENT

OFFERED IN THE SENATE BY SENATOR GREEN

TO: CSSB 289(L&C)

Page 1, line 5 – 6, following "annuity contracts,"

Delete "to unfair discrimination under a health insurance policy,"

Page 25, line 13, through page 26, line 2:

Delete all material.

SENATE FINANCE COMMITTEE

3 /29/ 2006

COMMITTEE ACTION

Bill Number	SB 289			
Amendment	#1			
Motion	to adopt			
Motion by	Green			
Objection by	Green			
Removed	✓			
Second Objection by				
Committee Member	Y	**Vote**		N
Senator Stedman				
Senator Bunde				
Senator Dyson				
Senator Hoffman				
Senator Olson				
Co-Chair Wilken				
Co-Chair Green				
Tally				
Yea				
Nay				
Absent				
MOTION	ADOPTED			

Alaska State Senate

Senate Finance Committee

Official Business

Mail Stop 3000
State Capitol
Juneau, Alaska 99801-1182

FAX COVER SHEET

DATE: 3/29/06 TIME: 9:25am

TO: Legal

NUMBER OF PAGES, INCLUDING COVER SHEET: 2

FROM: ROBIN PAUL
SENATE FINANCE CMTE. ASST. SECRETARY
PHONE: 465-2618
FAX: 465-2187

NOTES: FINAL Pls. CS SB 289(FIN)
Version 24-LS1563\I
plus Amendment #1
Attached.

Thank you!
Robin

Our Proof

24-LS1563\S

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:
Referred:

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

A BILL

FOR AN ACT ENTITLED

"An Act relating to the payment of insurer examination expenses, to the regulation of managed care insurance plans, to actuarial opinions and supporting documentation for an insurer, to insurance firms, managing general agents, and third-party administrators, to eligibility of surplus lines insurers, to prompt payment of health care insurance claims, to required notice by an insurer, to individual deferred annuities, to mental health benefits under a health care insurance plan, to the definitions of 'title insurance limited producer' and of other terms used in the title regulating the practice of the business of insurance, and to small employer health insurance; repealing the Small Employer Health Reinsurance Association; making conforming amendments; and providing for an effective date."

language deleted per Amend #1 and Legal

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) a provision that any utilization review decision

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

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

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

provide for a written decision

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) the end of the current plan year;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) the [GROUP] managed care plan;

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

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

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

(C) practice and treatment guidelines prepared or financed in

whole or in part by government agencies;

(D) government-issued coverage and treatment policies;

(E) generally accepted principles of professional medical practice;

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

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

(H) the community standard of care; and

(I) anomalous utilization patterns;

(5) an external appeal agency shall determine

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) means

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

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

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

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

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

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

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

(1) the agency meets the independence requirements of this section;

(2) the agency conducts external appeal activities through a panel of two clinical peers, unless otherwise agreed to by both parties; and

(3) the agency has sufficient medical, legal, and other expertise and sufficient staffing to conduct external appeal activities for the managed care entity on a timely basis consistent with this chapter.

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

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

(1) with respect to

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

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

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

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

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

(5) the covered person; or

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

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

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

(1) restrict or limit the right of a managed care entity to include [HEALTH CARE] services provided by a religious nonmedical provider as **medical** [HEALTH] care services covered by the managed care plan;

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

(A) apply medically based eligibility standards;

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

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

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

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

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

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

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

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

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

(B) a serious impairment to bodily functions; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

report or work papers.

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

(e) In this section,

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

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

(A) Casualty Actuarial Society; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) An insurer may not transact business with a managing general agent unless

(1) the insurer holds a certificate of authority in this state;

(2) the managing general agent is licensed under this chapter or **has filed a certification with the director certifying that** [, WHEN] the managing general agent is operating only for a foreign insurer **and** [,] is licensed by its resident insurance regulator in a state that the director has determined has enacted provisions substantially similar to those contained in this chapter and the state is accredited by the National Association of Insurance Commissioners;

(3) a written contract is in effect between the parties that establishes the responsibilities of each party, indicates both party's share of responsibility for a

particular function, and specifies the division of responsibilities;

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

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

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

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

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

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

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

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

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

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

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

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

(iv) maximum limits of liability;

(v) applicable exclusions;

(vi) territorial limitations;

(vii) policy cancellation provisions;

(viii) the maximum policy term; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS]; and

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

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

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

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

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

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

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

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

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

(C) other information the director may require;

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

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

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

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

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

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

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

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

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

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

(H) if the contract permits th hird-party administrator to do underwriting, the contract must include the following:

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

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

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

(iv) maximum limits of liability;

(v) applicable exclusions;

(vi) territorial limitations;

(vii) policy cancellation provisions;

(viii) the maximum policy term; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Amend #1 Language deleted

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

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

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

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

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

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

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

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

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

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

(i) In this section,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

health benefits;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) a small employer insurer shall

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Alaska State Legislature

Senator Con Bunde
Senate District P

Vice Chair: Senate Finance Committee
Chair: Senate Labor & Commerce Committee

Sponsor Statement
Senate Bill 289 Insurance

Senate Bill 289 could be referred to as an *insurance omnibus bill* because it contains numerous changes to Title 21 that are designed to ensure that state statutes are consistent with federal law, the National Association of Insurance Commissioners (NAIC) model acts, standards and guidelines, and to update procedures and transactions and to provide protections to consumers that purchase life, annuity and health insurance. Many of the changes are technical in nature and others are to make terminology more consistent throughout Title 21.

A summary of the general changes made by SB 289:

1. Provisions to extend "patient bill of rights" which was enacted in 2000 and applied only to group health care insurance plans will be made effective to individual health insurance plans
2. Provisions to make technical changes including substituting the phrase "medical care services" for "health care services" to make the terminology consistent with other parts of AS 21 relating to health insurance.
3. Provisions that require insurers providing individual health care insurance to comply with provider non-discrimination and prompt payment provisions
4. Provisions to enact the model law of the NAIC relating to actuarial opinion summary for property and casualty insurers
5. Licensing revisions relating to managing general agents to conform to the NAIC model law and to make license regulation in Alaska consistent with national standards
6. Repeals the small employers Health Reinsurance Association as insurers are not using the mechanism
7. Provisions for mental health parity to be consistent with federal HIPAA law
8. Provisions for changes in the standard non-forfeiture law for individual annuities aimed at limiting unfair practices relating to surrender charges
9. Provisions allowing the director to adopt regulations related to suitability of life, health and annuity policies
10. Provisions for technical changes to licensing to achieve national uniformity in producer licensing and improving division efficiency in processing license applications and providing for electronic notices

These changes to Title 21 will promote consistency between Alaska and other states, promote more efficient operations and provide better public protection.

Section Analysis of Insurance Bill - CSSB 289(L&C)

Sec.	Statute	Change	Purpose or Effect
1.	21.06.110(8)	Amended	Modifies the reference consistent with the change in Sec. 39
2.	21.06.160(a)	Amended	Requires examination fees to be paid by an electronic payment method specified by the director.
3.	21.07.010(a)	Amended	AS 21.07 is amended to expand applicability of the provisions to individual health insurance plans. Changes to this subsection: ➢ remove reference to "group" since applicability will extend to individual health insurance plans ➢ changes the term "health care services" to "medical care services" since medical care is a defined term used in the federal and state HIPAA laws to refer to health care services
4.	21.07.010(b)	Amended	same as Sec. 3.
5.	21.07.020	Amended	same as Sec. 3.
6.	21.07.030	Amended	same as Sec. 3. and in addition changes ➢ the term "enrollee" to "covered person" so that consistent terms are used throughout the chapter; and ➢ "group health plan" to managed care plan" which is the term redefined to include individual health insurance plans.
7.	21.07.040(c)	Amended	As in Sec. 6. changes the term "health care services" to "medical care services" since medical care is a defined term used in the federal and state HIPAA laws to refer to health care services
8.	21.07.050(a)	Amended	As in Sec. 6. changes the term "group health plan" to managed care plan" which is the term redefined to include individual health insurance plans
9.	21.07.050(c)	Amended	As in Sec. 6. changes the term "enrollee" to "covered person" so that consistent terms are used throughout the chapter
10.	21.07.050(d)	Amended	➢ Removes reference to "group managed care plan" since the term is redefined to "managed care plan" and includes individual health insurance plans ➢ As in prior sections changes the term "enrollee" to "covered person"
11.	21.07.050(h)	Amended	As in prior sections changes the term "enrollee" to "covered person"
12.	21.07.060(a)	Amended	Same as Sec. 8.
13.	21.07.060(b)	Amended	Same as Sec. 8.
14.	21.07.060(d)	Amended	Same as Sec. 8.
15.	21.07.080	Amended	As in Sec. 3. changes the term "health care services" to "medical care services" since medical care is a defined term used in the federal and state HIPAA laws to refer to health

			care services
16.	21.07.250(1)	Amended	Same as Sec. 15.
17.	21.07.250(3)	Amended	Same as Sec. 15.
18.	21.07.250(5)	Amended	Same as Sec. 15.
19.	21.07.250(10)	Amended	➢ Removes reference to "group managed care plan" since the term is redefined to "managed care plan" and includes individual health insurance plans ➢ As in Sec. 3. changes the term "health care services" to "medical care services" since medical care is a defined term used in the federal and state HIPAA laws to refer to health care services
20.	21.07.250(12)	Amended	As in prior sections removes reference to "group managed care plan" since the term is redefined to "managed care plan" and includes individual health insurance plans
21.	21.07.250(13)	Amended	As in Sec. 3. changes the term "health care services" to "medical care services" since medical care is a defined term used in the federal and state HIPAA laws to refer to health care services
22.	21.07.250 (15)	Amended	Modifies definition of "religious nonmedical provider"
23.	21.07.250(16)	Amended	➢ As in Sec. 3. changes the term "health care services" to "medical care services" since medical care is a defined term used in the federal and state HIPAA laws to refer to health care services ➢ As in prior sections removes reference to "group managed care plan" since the term is redefined to "managed care plan" and includes individual health insurance plans
24.	21.07.250(18)	Amended	Modifies definition to include individual health insurance plans
25.	21.09.207	New	This section provides an additional tool that the division can use to more quickly identify an insurer that may be in a troubled financial situation by giving the division information on how the insurer's reserves, as shown in the financial statement, compare to the estimates developed by the actuary. A domestic insurer who is required to file a statement of actuarial opinion with the director must now also file an actuarial opinion summary. The actuarial opinion summary is a confidential document that includes the actuary's estimate or range of reasonable estimates of reserves, explains adverse development and any difference between the actuary's estimate and management's reserves as stated in the insurer's annual statement. Confidentiality of the document is necessary as the actuary's indicated reserves presented in the summary are not otherwise published and can be taken out of context by the public when evaluating an insurer's financial situation without looking at the full

			actuarial report, which for some insurer's may be volumes of data and calculations.
26.	21.27.020(c)	Amended	Removes the requirement for corporations to disclose its officers and directors, consistent with national uniformity license requirements.
27.	21.27.020(g)	Amended	Removes reference that one of the continuing education advisory committee representatives be from the limited lines area since the national standards for continuing education do not require continuing education for limited lines licensees.
28.	21.27.040	New	Provides a time period as to when an applicant must act on an incomplete filing; otherwise, the filing will be considered withdrawn.
29.	21.27.620(a)	Amended	Adds a requirement for a managing general agent (MGA) who qualifies for exemption to file a certification with the director; clarifies when the contract and termination must be filed with the director and eliminates additional approval requirements for resident MGAs.
30.	21.27.650(a)	Amended	Streamlines the notification requirement of the third party administrator's employees to key personnel instead of all employees.
31.	21.34.050	Amended	Allows division to publish the white list by posting it on the web site [instead of mailing it]; clarifies that failure to pay the continuation fee or file the required financial statement is grounds for removal from the list; and provides authority that the director may reinstate a company to the list under specific conditions, including the payment of a late fee.
32.	21.36.052	New	Provides public protection standards applicable to life, health and annuity products and gives authority to director to adopt regulations.
33.	21.36.090(d)	Amended	Expands provision to include individual health insurance policies.
34.	21.36.128	New	Consistent with Sec. 39 contains the prompt pay requirements moved from 21.54.020 and in addition applies the requirements to both individual and group policies.
35.	21.36.260	Amended	Expands authority to allow for electronic communications if electronic confirmation can be obtained.
36.	21.45.305(b)	Amended	Clean-up to make consistent with NAIC Standard Nonforfeiture Law
37.	21.45.305(e)	Amended	Allows director discretion to give an insurer approval to use a higher discount rate for complying with 21.45.305(g)
38.	21.45.305(g)	Amended	Changes to this section will have the effect of limiting surrender charges on an annuity to about 10% and in addition will not allow surrender charges after maturity. Under current law an insurer may set the maturity age at, for example, 115, in order to increase surrender charges. Most annuities are in fact surrendered and do not reach maturity.

39.	21.51.120(a)	Amended	Since the prompt payment provisions in Sec.33. will apply to individual health insurance plans, these sections are amended to remove an inconsistency with those provisions.
40.	21.54.020	Amended	Removed the prompt payment provisions and moved to 21.36.128 in Sec. 33.
41.	21.54.151	New	Adds HIPAA mental health parity provisions. These provisions were originally adopted in 1997 but sunset. Congress continues to extend the parity act and therefore these provisions need to be readopted. No sunset is proposed.
42.	21.56.120(a)	Amended	Removes reference to assessments consistent with the repeal of the Small Employer Health Reinsurance Association.
43.	21.56.140(a)	Amended	This amendment requires the director to approve the basic and standard health plans.
44.	21.56.140	New	Since the Small Employer Health Reinsurance Association is repealed in Sec. 49 and the Association determines the benefits offered in the basic and standard health care insurance plans that insurers are required to offer to small employers, this amendment allows the director to determine the benefits.
45.	21.66.480(8)	Amended	Modifies the definition to require licensure for any officer or salaried employees of a title insurance company that transacts insurance business, consistent with other license classes.
46.	21.90.900(17)	Amended	Modifies the definition, in conformance with national uniform licensing standards.
47.	21.90.900(29)	Amended	Modifies the definition, in conformance with national uniform licensing standards.
48.	25.24.160(b)	Amended	21.54 was amended which required this section to be updated to reflect the new section.
49.	25.24.230(h)	Amended	21.54 was amended which required this section to be updated to reflect the new section.
50.	21.07.250(4); 21.07.250(6); 21.27.900(9); 21.51.110; 21.56.010; 21.56.020; 21.56.030; 21.56.040; 21.56.050 21.56.060 21.56.070; 21.56.075; 21.56.080; 21.56.090;	Repealed	21.07.250(4) repeals "group managed care plan" which is replaced with "managed care plan" in Sec. 21 and includes individual health insurance plans; 21.27.900(9) is also defined in 21.90.900; 21.07.250(6) repeals "health care services" since that term is replaced with "medical care" services which is already defined in 21.90.900 21.56.010-250 repeals the Small Employer Health Reinsurance Association and references to the association throughout chapter 56.

	21.56.100; 21.56.250(6); 21.56.250(9); 21.56.250(22); 21.56.250(24); and 21.56.250(25)		
51.	Uncodified Law	Amended	Makes the changes to Sec. 36 apply only to contracts issued after January 1, 2007 and therefore these provisions would not apply to any contracts that were issued before that date.
52.	Uncodified Law	Amended	Allows transition to allow the Small Employer Health Reinsurance Association to wind up the affairs of the association and provides guidelines for closure.
53.	Effective Date		Makes certain sections effective immediately.
54.	Effective Date		Makes some sections effective January 1, 2007.
55.	Effective Date		Makes other sections effective July 1, 2006.

DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT
Division of Insurance

Frank H. Murkowski, Governor
William C. Noll, Commissioner
Linda S. Hall, Director

February 14, 2006

The Honorable Con Bunde
Senate Labor & Commerce
State Capital

RE: Senate Bill 289

Senator Bunde,

The Division of Insurance strongly supports SB 289. The insurance bill proposes statutory changes that will promote consistency between Alaska and other states, provide increasing public protection, and improve the efficiency of Division operations.

Among the proposed modifications are changes in terminology to conform to terms used in federal and state laws, provisions for additional electronic payments and provisions for electronic notices. Other changes involve continuing reforms to make license regulation in Alaska consistent with national standards, modifications in the annuity nonforfeiture law in order to limit excessive surrender charges, extending certain provisions regulating group health insurance to individual policies and adoption of the National Association of Insurance Commissioners model law for actuarial opinion summary for property and casualty insurers. The bill would also provide for a minimum standard for suitability of life, health and annuity insurance policies and authorize the director to adopt regulations relating to suitability.

I would appreciate support for the measures contained in SB 289.

Thank you.

Sincerely,

Linda S. Hall

Linda S. Hall
Director

LB/pal102
021406

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
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Juneau, Alaska 99801-1182
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MEMORANDUM February 25, 2006

SUBJECT: Definition section in CSSB 289(L&C)
(Work Order No. 24-LS1563\I)

TO: Senator Con Bunde
Chair of Senate Labor and Commerce Committee
Attn: Jane Alberts

FROM: Dennis C. Bailey DCB
Legislative Counsel

This memo accompanies the final CSSB 289(L&C) including amendments per your request.

Please note that sec. 24 (AS 21.07.250(19)) adds a definition for "medical care" by reference to AS 21.90.900. AS 21.90.900 contains definitions applicable for all of Title 21, so the definition is already effective. Its inclusion in sec. 24 is therefore unnecessary and redundant. If you wish to remove the reference, it can be done in the next committee of referral.

The terms "group health plan" and "group health insurance" have generally been removed from Title 21 with the exception of a reference to "group health insurance plan" on page 14, line 31 and page 15, line 1. If this reference will cause confusion, you may want to revise it in a future version of the bill.

If I may be of further assistance, please advise.

DCB:lmb
06-078.lmb

Enclosure

COMMITTEE COPY

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/13/06

FURTHER: Finance

Date of 5-Day Notice: 2/9/06
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/27/06

Labor and Commerce Committee considered SENATE BILL NO. 289

SB 289 INSURANCE

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

and recommends:

[✓] be **replaced** with _____ **CS** SB 289 (L & C)

[ ] adopt **previous** _____ CS _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

CS Senate Bill:
[✓] Same Title
[ ] New Title

SCS House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
DCED	2/15/06			✓	1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
B. Stevens — Ben Stevens	✓			
Seekins — Ralph Seekins	✓			
Bunde — CHAIR: Tom Brice	✓			