

**HB**

**164**

<TARGET><BILL>HB 164</BILL><SUBJECT>HB  
164</SUBJECT><COMM>HFIN27</COMM></TARGET>

# HOUSE COMMITTEE REPORT

(11)

Date Referred to Committee: March 9, 2011

FURTHER REFERRALS:

Date of Committee Action: 4/6/11

The FINANCE Committee considered:

HB 164

**HOUSE BILL NO. 164**

"An Act relating to insurance; relating to health care insurance, exemption of certain insurers, reporting, notice, and record-keeping requirements for insurers, biographical affidavits, qualifications of alien insurers assuming ceded insurance, risk-based capital for insurers, insurance holding companies, licensing, federal requirements for nonadmitted insurers, surplus lines insurance, insurance fraud, life insurance policies and annuity contracts, rate filings by health care insurers, long-term care insurance, automobile service corporations, guaranty fund deposits of a title insurer, joint title plants, delinquency proceedings, fraternal benefit societies, multiple employer welfare arrangements, hospital and medical service corporations, and health maintenance organizations; and providing for an effective date."

**HB 164 INSURANCE: HEALTH CARE & OTHER**

Recommends it be replaced with [ ] HCS or [X] CS for HB 1104 (FIN)  
 For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR \_\_\_\_\_ [ ] Same Title [X] New Title

- [ ] attach amendments
- [ ] add new referral to \_\_\_\_\_ Committee
- [ ] Letter of Intent \_\_\_\_\_ Committee

List of Abbrev for Depts.:  
 ADM  
 CED  
 COR  
 CRT  
 EED  
 DEC  
 DFG  
 GOV  
 DHS  
 LWF  
 LAW  
 LEG  
 MVA  
 DNR  
 DPS  
 REV  
 DOT  
 UA

NEW FISCAL NOTES				
*FN# is assigned by Chief Clerk's Office				
*FN#	List by Dept(s):	Fiscal	Indet.	Zero

PREVIOUS FISCAL NOTES				
FN#	List by Dept(s):	Fiscal	Indet.	Zero
1	CED			✓

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	FAIRCLOUGH			X	
Jammie Wilson	T Wilson			X	
	Foulke				
	Crare				
	Hawken				
	COSTELLO				
Boye Edgmon	Edgmon				
Mike Doogan	DOOGAN				
Chair:					
Chair:	Stoltz			X	

# FISCAL NOTE

STATE OF ALASKA  
2011 LEGISLATIVE SESSION

Fiscal Note Number 1  
 Bill Version CSHB 164(L&C)  
 (H) Publish Date 3/9/11

Identifier (file name) HB164-CCED-INS-02-17-11 Dept. Affected DCCED  
 Title Insurance Appropriation Insurance Operations  
 Allocation Insurance Operations  
 Sponsor House Labor & Commerce  
 Requester House Labor & Commerce OMB Component Number 354

**Expenditures/Revenues** (Thousands of Dollars)

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

	Appropriation Required	Information						
		FY 2012	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
<b>OPERATING EXPENDITURES</b>								
Personal Services								
Travel								
Services								
Commodities								
Capital Outlay								
Grants								
Miscellaneous								
<b>TOTAL OPERATING</b>		<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

<b>CAPITAL EXPENDITURES</b>								
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<b>CHANGE IN REVENUES</b>								
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**FUND SOURCE** (Thousands of Dollars)

1002 Federal Receipts								
1003 GF Match								
1004 GF								
1005 GF/Program Receipts								
1037 GF/Mental Health								
1178 Micro-Loan Fund (RLF)								
Other (please identify)								
<b>TOTAL</b>		<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>	<b>0.0</b>

Estimate of any current year (FY2011) cost 0.0

**POSITIONS**

Full-time								
Part-time								
Temporary								

Why this fiscal note differs from previous version (if initial version, please note as such)

Initial Version

Prepared by Linda Hall, Division Director  
 Division Division of Insurance  
 Approved by Susan Bell, Commissioner  
Commerce, Community, and Economic Development

Phone 465-2560  
 Date/Time 2/17/11 10:06 AM  
 Date 2/18/2011

FISCAL NOTE #1

STATE OF ALASKA  
2011 LEGISLATIVE SESSION

BILL NO. CSHB 164(L&C)

**Analysis**

This legislation addresses an amendment to federal law (the Nonadmitted and Reinsurance Reform Act of 2010) effective in June 2011 that changes how premium taxes on Surplus Lines insurance can be collected and allocated. This legislation will avoid loss of revenue from premium tax.

The bill addresses various financial changes such as risk based capital tests, one of which will be an accreditation standard on 1/1/2012, requirements for filing biographical affidavits for domestic insurance company officers and directors and changes in the collateralization of certain reinsurance obligations.

Two provisions of this bill address insolvencies of insurance companies. One adds provisions to receivership statutes to address large deductible policies and payment of deductibles to the guaranty fund. The other increases the coverage in Alaska Life and Health Insurance Guaranty Association to \$250,000 for annuity benefits.

Consumer protection provisions include amending the long term care statutes to conform to the NAIC long term care model act and to require filing and approval of premium rates, filing and approval of health insurance rates for all companies offering health insurance in Alaska and requiring notifications of lapse, cancellation or changes in premiums for health insurance policies. Also included is a provision to make forging of an insurance document a felony regardless of the intent to defraud.

This legislation would eliminate the requirement of "individual in a firm" license type which will allow individuals to change employers without additional filings, fees or notification requirements as well as eliminate most late notification penalties. This legislation will also allow for communication by electronic methods.

The agency does not predict a significant fiscal impact as a result of the proposed statute. Accordingly, the agency submits a zero fiscal note.

**CS FOR HOUSE BILL NO. 164(FIN)**

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SEVENTH LEGISLATURE - FIRST SESSION

**BY THE HOUSE FINANCE COMMITTEE**

**Offered:**

**Referred:**

**Sponsor(s): HOUSE LABOR AND COMMERCE COMMITTEE**

**A BILL**

**FOR AN ACT ENTITLED**

1 "An Act relating to health care insurance, exemption of certain insurers, reporting,  
2 notice, and record-keeping requirements for insurers, biographical affidavits,  
3 qualifications of alien insurers assuming ceded insurance, risk-based capital for  
4 insurers, insurance holding companies, licensing, federal requirements for nonadmitted  
5 insurers, surplus lines insurance, insurance fraud, life insurance policies and annuity  
6 contracts, rate filings by health care insurers, long-term care insurance, automobile  
7 service corporations, guaranty fund deposits of a title insurer, joint title plants, fraternal  
8 benefit societies, multiple employer welfare arrangements, hospital and medical service  
9 corporations, health maintenance organizations, and alternate forms of payment to  
10 policyholders; and providing for an effective date."

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

12 \* **Section 1.** AS 21.03.021 is amended by adding a new subsection to read:

1 (f) If an insurer is not required to obtain a certificate of authority in this state  
 2 under AS 21.09.020(5), the provisions of the title do not apply to policies or contracts  
 3 issued by the insurer.

4 \* **Sec. 2.** AS 21.07.010 is amended to read:

5 **Sec. 21.07.010. Patient and health care provider protection.** (a) A contract  
 6 between a participating health care provider and a health care insurer [MANAGED  
 7 CARE ENTITY THAT OFFERS A MANAGED CARE PLAN] must contain a  
 8 provision that

9 (1) provides for a reasonable mechanism to identify all medical care  
 10 services to be provided by the health care insurer [MANAGED CARE ENTITY];

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

13 (3) clearly states all ways in which the contract between the health care  
 14 provider and health care insurer [MANAGED CARE ENTITY] may be terminated;  
 15 a provision that provides for discretionary termination by either party must apply  
 16 equitably to both parties;

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

20 (A) for an initial meeting at which all parties are present or  
 21 represented by individuals with authority regarding the matters in dispute; the  
 22 meeting shall be held within 10 working days after the health care insurer  
 23 [PLAN] receives written notice of the dispute or gives written notice to the  
 24 provider, unless the parties otherwise agree in writing to a different schedule;

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

31 (C) that if, after a period of 60 days following commencement

1 of mediation, the parties are unable to resolve the dispute, either party may  
2 seek other relief allowed by law;

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

5 (5) states that a health care provider may not be penalized or the health  
6 care provider's contract terminated by the health care insurer [MANAGED CARE  
7 ENTITY] because the health care provider acts as an advocate for a covered person in  
8 seeking appropriate, medically necessary medical care services;

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

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

13 (b) A contract between a participating health care provider and a health care  
14 insurer [MANAGED CARE ENTITY] that offers a health care insurance policy  
15 [MANAGED CARE PLAN] may not contain a provision that

16 (1) has as its predominant purpose the creation of direct financial  
17 incentives to the health care provider for withholding covered medical care services  
18 that are medically necessary; nothing in this paragraph shall be construed to prohibit a  
19 contract between a participating health care provider and a health care insurer  
20 [MANAGED CARE ENTITY] from containing incentives for efficient management  
21 of the utilization and cost of covered medical care services;

22 (2) requires the provider to contract for all products that are currently  
23 offered or that may be offered in the future by the health care insurer [MANAGED  
24 CARE ENTITY]; or

25 (3) requires the health care provider to be compensated for medical  
26 care services performed at the same rate as the health care provider has contracted  
27 with another health care insurer [MANAGED CARE ENTITY].

28 (c) A health care insurer [MANAGED CARE ENTITY] may not enter into a  
29 contract with a health care provider that requires the provider to indemnify or hold  
30 harmless the health care insurer [MANAGED CARE ENTITY] for the acts or  
31 conduct of the health care insurer [MANAGED CARE ENTITY]. An

1 indemnification or hold harmless clause entered into in violation of this subsection is  
2 void.

3 \* **Sec. 3.** AS 21.07.020 is amended to read:

4 **Sec. 21.07.020. Required contract provisions for health care insurance**  
5 **policy [MANAGED CARE PLANS]. A health care insurance policy [MANAGED**  
6 **CARE PLAN] must contain**

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

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

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

17 (4) a provision that any utilization review decision

18 (A) must be made within 72 hours after receiving the request  
19 for preapproval for nonemergency situations; for emergency situations,  
20 utilization review decisions for care following emergency services must be  
21 made as soon as is practicable but in any event not later than 24 hours after  
22 receiving the request for preapproval or for coverage determination; and

23 (B) to deny, reduce, or terminate a health care benefit or to  
24 deny payment for a medical care service because that service is not medically  
25 necessary shall be made by an employee or agent of the health care insurer  
26 [MANAGED CARE ENTITY] who is a licensed health care provider;

27 (5) a provision that provides for an internal appeal mechanism for a  
28 covered person who disagrees with a utilization review decision made by a health  
29 care insurer [MANAGED CARE ENTITY]; except as provided under (6) of this  
30 section, this appeal mechanism must provide for a written decision

31 (A) from the health care insurer [MANAGED CARE

1 ENTITY] within 18 working days after the date written notice of an appeal is  
2 received; and

3 (B) on the appeal by an employee or agent of the health care  
4 insurer [MANAGED CARE ENTITY] who holds the same professional  
5 license as the health care provider who is treating the covered person;

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

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

14 (B) provide for a written decision on the appeal by an  
15 employee or agent of the health care insurer [MANAGED CARE ENTITY]  
16 who holds the same professional license as the health care provider who is  
17 treating the covered person;

18 (7) a provision that discloses the existence of the right to an external  
19 appeal of a utilization review decision made by a health care insurer [MANAGED  
20 CARE ENTITY]; the external appeal shall be [AS] conducted in accordance with  
21 AS 21.07.050;

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

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

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

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

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

1 including audiotape or braille information.

2 \* **Sec. 4.** AS 21.07.030(a) is amended to read:

3 (a) If a **health care insurer** [MANAGED CARE ENTITY] offers a **health**  
 4 **care insurance policy** [MANAGED CARE PLAN] that provides for coverage of  
 5 medical care services only if the services are furnished through a network of health  
 6 care providers that have entered into a contract with the **health care insurer**  
 7 [MANAGED CARE ENTITY], the **health care insurer** [MANAGED CARE  
 8 ENTITY] shall also offer a non-network option to covered persons at initial  
 9 enrollment, as provided under (c) of this section. The non-network option may require  
 10 that a covered person pay a higher deductible, copayment, or premium for the plan if  
 11 the higher deductible, copayment, or premium results from increased costs caused by  
 12 the use of a non-network provider. [THE MANAGED CARE ENTITY SHALL  
 13 PROVIDE AN ACTUARIAL DEMONSTRATION OF THE INCREASED COSTS  
 14 TO THE DIRECTOR AT THE DIRECTOR'S REQUEST. IF THE INCREASED  
 15 COSTS ARE NOT JUSTIFIED, THE DIRECTOR SHALL REQUIRE THE  
 16 MANAGED CARE ENTITY TO RECALCULATE THE APPROPRIATE COSTS  
 17 ALLOWED AND RESUBMIT THE APPROPRIATE DEDUCTIBLE,  
 18 COPAYMENT, OR PREMIUM TO THE DIRECTOR.] This subsection does not  
 19 apply to a covered person who is offered non-network coverage through another  
 20 **health care insurance policy** [MANAGED CARE PLAN] or through another **health**  
 21 **care insurer** [MANAGED CARE ENTITY].

22 \* **Sec. 5.** AS 21.07.030(b) is amended to read:

23 (b) The amount of any additional premium charged by the **health care**  
 24 **insurer** [MANAGED CARE ENTITY] for the additional cost of the creation and  
 25 maintenance of the option described in (a) of this section and the amount of any  
 26 additional cost sharing imposed under this option shall be paid by the covered person  
 27 unless it is paid by an employer or other person through agreement with the **health**  
 28 **care insurer** [MANAGED CARE ENTITY].

29 \* **Sec. 6.** AS 21.07.030(c) is amended to read:

30 (c) A covered person may make a change to the medical care coverage option  
 31 provided under this section only during a time period determined by the **health care**

1 insurer [MANAGED CARE ENTITY]. The time period described in this subsection  
2 must occur at least annually and last for at least 15 working days.

3 \* **Sec. 7.** AS 21.07.030(d) is amended to read:

4 (d) If a health care insurer [MANAGED CARE ENTITY] that offers a  
5 health care insurance policy [MANAGED CARE PLAN] requires or provides for a  
6 designation by a covered person of a participating primary care provider, the health  
7 care insurer [MANAGED CARE ENTITY] shall permit the covered person to  
8 designate any participating primary care provider that is available to accept the  
9 covered person.

10 \* **Sec. 8.** AS 21.07.030(e) is amended to read:

11 (e) Except as provided in this subsection, a health care insurer [MANAGED  
12 CARE ENTITY] that offers a health care insurance policy [MANAGED CARE  
13 PLAN] shall permit a covered person to receive medically necessary or appropriate  
14 specialty care, subject to appropriate referral procedures, from any qualified  
15 participating health care provider that is available to accept the individual for medical  
16 care. This subsection does not apply to specialty care if the health care insurer  
17 [MANAGED CARE ENTITY] clearly informs covered persons of the limitations on  
18 choice of participating health care providers with respect to medical care. In this  
19 subsection,

20 (1) "appropriate referral procedures" means procedures for referring  
21 patients to other health care providers as set out in the applicable member policy  
22 [CONTRACT] and as described under (a) of this section;

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

25 \* **Sec. 9.** AS 21.07.030(f) is amended to read:

26 (f) If a contract between a health care provider and a health care insurer  
27 [MANAGED CARE ENTITY] is terminated, a covered person may continue to be  
28 treated by that health care provider as provided in this subsection. If a covered person  
29 is pregnant or being actively treated by a provider on the date of the termination of the  
30 contract between that provider and the health care insurer [MANAGED CARE  
31 ENTITY], the covered person may continue to receive medical care services from that

1 provider as provided in this subsection, and the contract between the health care  
 2 insurer [MANAGED CARE ENTITY] and the provider shall remain in force with  
 3 respect to the continuing treatment. The covered person shall be treated for the  
 4 purposes of benefit determination or claim payment as if the provider were still under  
 5 contract with the health care insurer [MANAGED CARE ENTITY]. However,  
 6 treatment is required to continue only while the health care insurance policy  
 7 [MANAGED CARE PLAN] remains in effect and

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

9 (A) the end of the current policy or plan year;

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

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

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

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

19 (a) A health care insurer [MANAGED CARE ENTITY] offering a health  
 20 care insurance policy [MANAGED CARE PLAN] shall provide for an external  
 21 appeal process that meets the requirements of this section in the case of an externally  
 22 appealable decision for which a timely appeal is made in writing either by the health  
 23 care insurer [MANAGED CARE ENTITY] or by the covered person.

24 \* **Sec. 11.** AS 21.07.050(b) is amended to read:

25 (b) A health care insurer [MANAGED CARE ENTITY] may condition the  
 26 use of an external appeal process in the case of an externally appealable decision upon  
 27 a final decision in an internal appeal under AS 21.07.020, but only if the decision is  
 28 made in a timely basis consistent with the deadlines provided under this chapter.

29 \* **Sec. 12.** AS 21.07.050(c) is amended to read:

30 (c) Except as provided in this subsection, the external appeal process shall be  
 31 conducted under a contract between the health care insurer [MANAGED CARE

1 ENTITY] and one or more external appeal agencies that **are** [HAVE] qualified under  
2 AS 21.07.060. The **health care insurer** [MANAGED CARE ENTITY] shall provide

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

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

8 (3) that all costs of the process, except those incurred by the covered  
9 person or treating professional in support of the appeal, shall be paid by the **health**  
10 **care insurer** [MANAGED CARE ENTITY] and not by the covered person.

11 \* **Sec. 13.** AS 21.07.050(d) is amended to read:

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

13 (1) a fair, de novo determination based on coverage provided by the  
14 **policy** [PLAN] and by applying terms as defined by the **policy** [PLAN]; however,  
15 nothing in this paragraph may be construed as providing for coverage of items and  
16 services for which benefits are excluded under the **policy** [PLAN] or coverage;

17 (2) an external appeal agency shall determine whether the **health care**  
18 **insurer's** [MANAGED CARE ENTITY'S] decision is

19 (A) in accordance with the medical needs of the patient  
20 involved, as determined by the **health care insurer** [MANAGED CARE  
21 ENTITY], taking into account, as of the time of the **health care insurer's**  
22 [MANAGED CARE ENTITY'S] decision, the patient's medical needs and any  
23 relevant and reliable evidence the agency obtains under (3) of this subsection;  
24 [.] and

25 (B) in accordance with the scope of the covered benefits under  
26 the **policy** [PLAN]; if the agency determines the decision complies with this  
27 paragraph, the agency shall affirm the decision, and, to the extent that the  
28 agency determines the decision is not in accordance with this paragraph, the  
29 agency shall reverse or modify the decision;

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

1 (A) the decision made by the health care insurer  
 2 [MANAGED CARE ENTITY] upon internal appeal under AS 21.07.020 and  
 3 any guidelines or standards used by the health care insurer [MANAGED  
 4 CARE ENTITY] in reaching a decision;

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

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

9 (D) the health care insurance policy [MANAGED CARE  
 10 PLAN];

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

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

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

19 (C) practice and treatment guidelines prepared or financed in  
 20 whole or in part by government agencies;

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

22 (E) generally accepted principles of professional medical  
 23 practice;

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

28 (G) to the extent that the agency determines them [IT] to be  
 29 free of any conflict of interest, the results of peer reviews conducted by the  
 30 health care insurer [MANAGED CARE ENTITY] involved;

31 (H) the community standard of care; and

1 (I) anomalous utilization patterns;

2 (5) an external appeal agency shall determine

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

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

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

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

11 (7) the health care insurer [MANAGED CARE ENTITY] involved  
12 shall provide the external appeal agency with access to information and to provisions  
13 of the policy [PLAN OR HEALTH INSURANCE COVERAGE] relating to the  
14 matter of the externally appealable decision, as determined by the external appeal  
15 agency; and

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

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

19 (B) be made in accordance with the medical exigencies of the  
20 case involved, but in no event later than 21 working days after the appeal is  
21 filed, or, in the case of an expedited appeal, 72 hours after the time of  
22 requesting an external appeal of the health care insurer's [MANAGED  
23 CARE ENTITY'S] decision;

24 (C) state, in layperson's language, the basis for the  
25 determination, including, if relevant, any basis in the terms or conditions of the  
26 policy [PLAN OR COVERAGE]; and

27 (D) inform the covered person of the individual's rights,  
28 including any time limits, to seek further review by the courts of the external  
29 appeal determination.

30 \* **Sec. 14.** AS 21.07.050(e) is amended to read:

31 (e) If the external appeal agency reverses or modifies the denial of a claim for

benefits, the **health care insurer** [MANAGED CARE ENTITY] shall

(1) upon receipt of the determination, authorize benefits in accordance with that determination;

(2) take action as may be necessary to provide benefits, including items or services, in a timely manner consistent with the determination; and

(3) submit information to the external appeal agency documenting compliance with the agency's determination.

\* **Sec. 15.** 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 under the **policy** [PLAN OR COVERAGE].

\* **Sec. 16.** AS 21.07.060 is amended to read:

**Sec. 21.07.060. Qualifications of external appeal agencies.** (a) An external appeal agency qualifies to consider external appeals if, with respect to a **health care insurance policy** [MANAGED CARE 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.

(b) An external appeal agency is qualified to consider appeals of **health care insurance policy** [MANAGED CARE 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

1 two clinical peers, unless otherwise agreed to by both parties; and

2 (3) the agency has sufficient medical, legal, and other expertise and  
3 sufficient staffing to conduct external appeal activities for the **health care insurer**  
4 [MANAGED CARE ENTITY] on a timely basis consistent with this chapter.

5 (c) A clinical peer or other entity meets the independence requirements of this  
6 section if

7 (1) the peer or entity does not have a familial, financial, or professional  
8 relationship with a related party;

9 (2) compensation received by a peer or entity in connection with the  
10 external review is reasonable and not contingent on any decision rendered by the peer  
11 or entity;

12 (3) the **health care insurer has** [PLAN AND THE ISSUER HAVE]  
13 no recourse against the peer or entity in connection with the external review; and

14 (4) the peer or entity does not otherwise have a conflict of interest with  
15 a related party.

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

17 (1) **a health care insurer or, with respect to group health care**  
18 **insurance, a plan sponsor, including any officer, director, management employee,**  
19 **or fiduciary of the health care insurer or the plan sponsor** [WITH RESPECT TO

20 (A) A MANAGED CARE PLAN, THE PLAN OR THE  
21 INSURER OFFERING THE COVERAGE; OR

22 (B) INDIVIDUAL HEALTH INSURANCE COVERAGE,  
23 THE INSURER OFFERING THE COVERAGE, OR ANY PLAN SPONSOR,  
24 FIDUCIARY, OFFICER, DIRECTOR, OR MANAGEMENT EMPLOYEE  
25 OF THE PLAN OR ISSUER];

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

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

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

1 (5) the covered person; or

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

5 \* **Sec. 17.** AS 21.07.070 is amended to read:

6 **Sec. 21.07.070. Limitation on liability of reviewers.** An external appeal  
7 agency qualifying under AS 21.07.060 and having a contract with a **health care**  
8 **insurer** [MANAGED CARE ENTITY], and a person who is employed by the agency  
9 or who furnishes professional services to the agency, may not be held by reason of the  
10 performance of any duty, function, or activity required or authorized under this  
11 chapter to have violated any criminal law, or to be civilly liable if due care was  
12 exercised in the performance of the duty, function, or activity and there was no actual  
13 malice or gross misconduct in the performance of the duty, function, or activity.

14 \* **Sec. 18.** AS 21.07.080 is amended to read:

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

17 (1) restrict or limit the right of a **health care insurer** [MANAGED  
18 CARE ENTITY] to include services provided by a religious nonmedical provider as  
19 medical care services covered by the **health care insurance policy** [MANAGED  
20 CARE PLAN];

21 (2) require a **health care insurer** [MANAGED CARE ENTITY],  
22 when determining coverage for services provided by a religious nonmedical provider,  
23 to

24 (A) apply medically based eligibility standards;

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

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

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

31 (3) require a **health care insurance policy** [MANAGED CARE

1 PLAN] to exclude coverage for services provided by a religious nonmedical provider  
 2 because the religious nonmedical provider is not providing medical or other data  
 3 required from a health care provider if the medical or other data is inconsistent with  
 4 the religious nonmedical treatment or nursing care being provided.

5 \* **Sec. 19.** AS 21.07.250(12) is amended to read:

6 (12) "participating health care provider" means a health care provider  
 7 who has entered into an agreement with a **health care insurer** [MANAGED CARE  
 8 ENTITY] to provide services or supplies to a patient covered by a **health care**  
 9 **insurance policy** [MANAGED CARE PLAN];

10 \* **Sec. 20.** AS 21.07.250(16) is amended to read:

11 (16) "utilization review" means a system of reviewing the medical  
 12 necessity, appropriateness, or quality of medical care services and supplies provided  
 13 under a **health care insurance policy** [MANAGED CARE PLAN] using specified  
 14 guidelines, including preadmission certification, the application of practice guidelines,  
 15 continued stay review, discharge planning, preauthorization of ambulatory procedures,  
 16 and retrospective review.

17 \* **Sec. 21.** AS 21.07.250 is amended by adding a new paragraph to read:

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

19 \* **Sec. 22.** AS 21.09.020 is amended to read:

20 **Sec. 21.09.020. Exception from [EXCEPTIONS,] certificate of authority**  
 21 **requirement.** A certificate of authority is not required of an insurer, not otherwise  
 22 authorized in this state, **with** [IN] regard to

23 (1) transactions relative to its policies lawfully written in the state, or  
 24 liquidation of assets and liabilities of the insurer, [(] other than collection of new  
 25 premiums, [), ALL AS] resulting from its former authorized operations in the state;

26 (2) related transactions subsequent to issuance of a policy covering  
 27 only subjects of insurance not resident, located, or expressly to be performed in the  
 28 state at time of issuance, and which coverage was lawfully solicited, written, and  
 29 delivered outside the state;

30 (3) transactions under surplus lines coverages lawfully written under  
 31 AS 21.34; [OR]

1 (4) reinsurance, except as to domestic reinsurers; or

2 (5) transactions relative to policies issued in another state, but only

3 if

4 (A) the insurer does not market insurance in this state;

5 (B) the laws of the state of issue apply to this state's  
6 residents covered under the policies; and

7 (C) the insurer complies with other requirements the  
8 director adopts by regulation to qualify for an exception under this  
9 paragraph.

10 \* **Sec. 23.** AS 21.09.200(e) is amended to read:

11 (e) An insurer shall pay to the division \$100 for each day the insurer fails to  
12 file a [THE ANNUAL] statement or report in the form and location required and  
13 within the time established in [(a) OF] this section. The authority of the insurer to  
14 enter into new obligations or issue new or renewal policies of insurance in this state  
15 may be suspended by the director if a statement or report required by this section  
16 [THE ANNUAL STATEMENT] has not been filed by the due date [MARCH 1].

17 \* **Sec. 24.** AS 21.09.245(b) is amended to read:

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

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

23 **Sec. 21.09.247. Biographical affidavits.** A domestic insurer shall file with the  
24 director a complete affidavit of biographical information not later than 30 days after  
25 the appointment of an officer or director of the insurer. If requested by the director, a  
26 foreign insurer shall file with the director an affidavit of biographical information for  
27 the appointment of an officer or director of the insurer. A filing under this section  
28 must be on a form approved by the director. A filing is not required if a biographical  
29 affidavit of the officer or director has been submitted to the director within one year  
30 before the date of appointment. A biographical affidavit filed under this section is  
31 confidential and not subject to public inspection.

1 \* **Sec. 26.** AS 21.09.320 is amended to read:

2           **Sec. 21.09.320. Maintenance of records.** (a) A foreign [AN] insurer  
3 [DOMICILED IN A JURISDICTION OTHER THAN THIS STATE] shall keep at its  
4 principal place of business a complete record of its assets, transactions, and affairs in  
5 accordance with the methods and systems that are customary or suitable to the kind of  
6 business [INSURANCE] transacted.

7           (b) To meet the requirements of (a) of this section, the insurer shall keep the  
8 records as required [SPECIFIED] in AS 21.69.390(d) [FOR FIVE YEARS FROM  
9 THE DATE THE RECORD WAS CREATED] or as required by the record  
10 maintenance requirements of the insurer's domicile jurisdiction, whichever is longer.

11 \* **Sec. 27.** AS 21.12.020(a) is amended to read:

12           (a) Credit for reinsurance transactions shall be allowed a domestic ceding  
13 insurer as either an asset or a deduction from liability on account of reinsurance ceded  
14 only with respect to cessions of a kind or class of business that the assuming insurer is  
15 licensed or permitted to write or assume in its state of domicile or, in the case of a  
16 United States branch of an alien assuming insurer, in the state through which it is  
17 entered and licensed to transact insurance or reinsurance and only if the reinsurance is  
18 ceded to an

19                   (1) assuming insurer that is licensed to transact insurance or  
20 reinsurance in this state;

21                   (2) assuming insurer that is accredited as a reinsurer in this state; an  
22 accredited reinsurer is one that

23                           (A) files evidence of submission to this state's jurisdiction,  
24 submits to this state's authority to examine its books and records under  
25 AS 21.06.120, is licensed to transact insurance or reinsurance in at least one  
26 state that is accredited by the National Association of Insurance  
27 Commissioners, or, in the case of a United States branch of an alien admitted  
28 insurer, is entered through and licensed to transact insurance or reinsurance in  
29 at least one state that is accredited by the National Association of Insurance  
30 Commissioners;

31                           (B) maintains at least \$20,000,000 in policyholder surplus and

1 whose accreditation has not been denied by the director within 90 days after  
2 application to the director, or maintains less than \$20,000,000 in policyholder  
3 surplus and whose application for accreditation has been approved by the  
4 director; and

5 (C) files annually with the director a copy of the reinsurer's  
6 annual financial statement filed with the insurance department of the  
7 reinsurer's state of domicile or state of entry and a copy of the reinsurer's most  
8 recent audited financial statement;

9 (3) assuming insurer that is domiciled in a state, or, in the case of a  
10 United States branch of an alien assuming insurer, is entered through a state accredited  
11 by the National Association of Insurance Commissioners that employs standards  
12 regarding credit for reinsurance ceded substantially similar to those applicable under  
13 (1) and (2) of this subsection, the assuming insurer maintains a policyholder surplus of  
14 at least \$20,000,000, and the assuming insurer submits to the authority of this state to  
15 examine its books and records; the surplus requirements in this paragraph do not apply  
16 to reinsurance ceded and assumed under a pooling arrangement among insurers in the  
17 same holding company system;

18 (4) assuming alien insurer that

19 (A) maintains a trust fund in a qualified United States financial  
20 institution for the payment of the valid claims of its United States domiciled  
21 [POLICYHOLDERS AND] ceding insurers, and their assigns and successors  
22 in interest, that conforms to the following requirements:

23 (i) the trust and each amendment to the trust shall be  
24 established in a form approved by the insurance supervisory official of  
25 the state where the trust is domiciled or the insurance supervisory  
26 official of another state who, under the terms of the trust instrument,  
27 has accepted responsibility for regulatory oversight of the trust; the  
28 form of the trust and each trust amendment shall be filed with the  
29 insurance supervisory official of every state in which the beneficiaries  
30 of the trust are domiciled; the trust instrument must provide that  
31 contested claims are valid and enforceable upon the final order of any

1 court of competent jurisdiction in the United States; the trust shall vest  
 2 legal title to its assets in the trustees of the trust for its United States  
 3 domiciled [POLICYHOLDERS AND] ceding insurers, their assigns,  
 4 and successors in interest; the trust and the assuming insurer are subject  
 5 to examination as determined by the director, and the assuming insurer  
 6 shall submit to examination of its books and records by the director and  
 7 bear the expense of examination; the trust must remain in effect for so  
 8 long as the assuming insurer has outstanding liabilities due under the  
 9 reinsurance agreements subject to the trust;

10 (ii) on or before March 1 of each year, the trustees shall  
 11 report in writing to the director on the balance of the trust and list the  
 12 trust's investments at the end of the preceding year, and shall certify the  
 13 date of termination of the trust, if so planned, or certify that the trust  
 14 does not expire before the following December 31;

15 (iii) in the case of a single assuming insurer, the trust  
 16 shall consist of trust assets not less than [MONEY REPRESENTING]  
 17 the assuming insurer's liabilities attributable to reinsurance ceded by  
 18 [BUSINESS WRITTEN IN] the United States domiciled ceding  
 19 insurers and, in addition, include a trust surplus of not less than  
 20 \$20,000,000 for the benefit of the United States domiciled ceding  
 21 insurers as additional security for the liabilities covered by the  
 22 trust; the single assuming insurer shall make available to the director  
 23 an annual certification of the insurer's solvency by an independent  
 24 certified public accountant or an accountant holding a substantially  
 25 equivalent designation as determined by the director;

26 (iv) in the case of a group, including incorporated and  
 27 individual unincorporated insurers, the trust shall consist of trust assets  
 28 [MONEY] representing the group's liabilities attributable to business  
 29 ceded by [THE] United States domiciled ceding insurers and, in  
 30 addition, include a trust surplus not less than \$100,000,000 held jointly  
 31 for the benefit of the United States domiciled ceding insurers of [OR]

1 any member of the group for all years of account as additional  
2 security for the group's liabilities covered by the trust; the  
3 incorporated members of the group may not be engaged in any business  
4 other than underwriting as a member of the group and are subject to the  
5 same level of solvency regulation and control by the group's  
6 domiciliary regulator as are the unincorporated members; within 90  
7 days after its financial statements are due to be filed with the group's  
8 domiciliary regulator, the group shall make available to the director an  
9 annual certification of the solvency of each insurer by the group's  
10 domiciliary regulator or, if the certification is unavailable, financial  
11 statements, prepared by an independent certified public accountant, or  
12 an accountant holding a substantially equivalent designation as  
13 determined by the director, for each underwriter member of the group;

14 (v) in the case of a group of incorporated insurers under  
15 common administration that complies with the reporting requirements  
16 contained in (ii) of this subparagraph, that has continuously transacted  
17 an insurance business outside the United States for at least three years  
18 immediately before making application for accreditation, that submits  
19 to this state's authority to examine its books and records and bears the  
20 expense of the examination, and that has aggregate policyholders'  
21 surplus of \$10,000,000,000, the trust shall consist of trust assets [BE]  
22 in an amount not less than [EQUAL TO] the group's several liabilities  
23 attributable to business ceded by United States domiciled ceding  
24 insurers to a member of the group under reinsurance contracts issued in  
25 the name of the group, and the group shall maintain a joint trustee  
26 surplus, of which \$100,000,000 shall be held jointly for the benefit of  
27 United States domiciled ceding insurers of a member of the group as  
28 additional security for the group's liabilities covered by the trust, and,  
29 within 90 days after its financial statements are due to be filed with the  
30 group's domiciliary regulator, each member of the group shall make  
31 available to the director an annual certification of the underwriter

1 member's solvency by the member's domiciliary regulator and financial  
 2 statement of each underwriter member prepared by its independent  
 3 certified public accountant, or an accountant holding a substantially  
 4 equivalent designation as determined by the director; and

5 (B) reports annually to the director information substantially  
 6 the same as that required to be reported on the National Association of  
 7 Insurance Commissioners' annual statement form by licensed insurers to  
 8 enable the director to determine the sufficiency of the trust fund;

9 (5) assuming insurer that does not meet the requirements of (1) - (4) of  
 10 this subsection, but only with respect to the insurance of risks located in jurisdictions  
 11 where the reinsurance is required by applicable law or regulation of that jurisdiction.

12 \* Sec. 28. AS 21.12.050(b) is amended to read:

13 (b) Health care insurance means that part of health insurance that provides,  
 14 delivers, arranges for, pays for, or reimburses any of the costs of [BENEFITS  
 15 FOR] medical care [WHETHER PROVIDED DIRECTLY, THROUGH  
 16 REIMBURSEMENT, OR OTHER METHOD].

17 \* Sec. 29. AS 21.14.200(4) is amended to read:

18 (4) "company action level event" means a report, an adjusted report  
 19 that has not been challenged, or an adjusted report for which a challenge has been  
 20 rejected [,] that is filed under AS 21.14.010 and that indicates that

21 (A) an insurer's total adjusted capital is greater than or equal to  
 22 its regulatory action level risk based capital but is less than its company action  
 23 level risk based capital; [OR]

24 (B) if a life and health insurer, the insurer has total adjusted  
 25 capital that is greater than or equal to the insurer's company action level risk  
 26 based capital but is less than 250 percent of the insurer's authorized control  
 27 level risk based capital and that has a negative trend; or

28 (C) if a property and casualty insurer or health  
 29 organization, the insurer or organization has total adjusted capital that is  
 30 greater than or equal to the company action level risk based capital but is  
 31 less than 300 percent of its authorized control level risk based capital and

1                   **that has a negative trend:**

2       \* **Sec. 30.** AS 21.14.200(9) is amended to read:

3                   (9) "life and health insurer"

4                   (A) means an insurer who transacts life insurance as defined in  
5 AS 21.12.040 or health insurance as defined in AS 21.12.050 **and who filed**  
6 **with the director the National Association of Insurance Commissioners**  
7 **Life Risk-Based Capital Report:**

8                   (B) does not include a benevolent association under AS 21.72,  
9 a fraternal benefit society under AS 21.84, a health maintenance organization  
10 under AS 21.86, or a hospital or medical service corporation under AS 21.87;

11       \* **Sec. 31.** AS 21.14.200(12) is amended to read:

12                   (12) "negative trend" for a life and health insurer, **a property and**  
13 **casualty insurer, and a health organization** means a negative trend over a period of  
14 time, as determined by the "trend test calculation" in the risk based capital  
15 instructions;

16       \* **Sec. 32.** AS 21.14.200(13) is amended to read:

17                   (13) "property and casualty insurer" means an insurer who transacts  
18 health insurance as defined in AS 21.12.050, property insurance as defined in  
19 AS 21.12.060, casualty insurance as defined in AS 21.12.070, surety insurance as  
20 defined in AS 21.12.080, marine or wet marine and transportation insurance as defined  
21 in AS 21.12.090, or mortgage guaranty insurance as defined in AS 21.12.110 **and who**  
22 **filed with the director the National Association of Insurance Commissioners**  
23 **Property and Casualty Risk-Based Capital Report:**

24       \* **Sec. 33.** AS 21.14.200 is amended by adding a new paragraph to read:

25                   (21) "health organization" means a health maintenance organization,  
26 limited health service organization, dental or vision plan, hospital, medical and dental  
27 indemnity or service corporation, or other managed care organization holding a  
28 certificate of authority under AS 21.86 or AS 21.87, or a company that writes  
29 primarily health insurance as defined in AS 21.12.050 and filed with the director the  
30 National Association of Insurance Commissioners Health Risk-Based Capital Report.

31       \* **Sec. 34.** AS 21.22.060(k) is amended to read:

1 (k) An insurer subject to registration under (a) of this section shall register  
 2 annually by May 1 [APRIL 1] of each year for the previous calendar year unless, for  
 3 good cause shown, the director extends the time for registration. The director may  
 4 require an insurer that is allowed to register as provided under (c) of this section [,] to  
 5 furnish a copy of

6 (1) the registration statement;

7 (2) the summary specified in (l) of this section; or

8 (3) other information filed by the insurer with the insurance regulatory  
 9 authority of the insurer's state of domicile.

10 \* **Sec. 35.** AS 21.27.020(b) is amended to read:

11 (b) To qualify for issuance or renewal of an individual [OR INDIVIDUAL IN  
 12 THE FIRM] license, an applicant or licensee shall comply with this title and  
 13 regulations adopted under AS 21.06.090 and

14 (1) shall be 18 years of age or older;

15 (2) if for a resident license, shall be a bona fide resident before  
 16 issuance of the license and actually reside in the state;

17 (3) shall successfully pass an examination required under  
 18 AS 21.27.060;

19 (4) shall be a trustworthy person;

20 (5) may not use or intend to use the license for the purpose principally  
 21 of writing controlled business, as defined in AS 21.27.030;

22 (6) may not have committed an act that is a cause for denial,  
 23 nonrenewal, suspension, or revocation of a license in this state or another jurisdiction.

24 \* **Sec. 36.** AS 21.27.020(c) is amended to read:

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

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

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

1 (3) designate one or more compliance officers for the firm;

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

4 (5) notify the director, in writing, within 30 days of a change in the  
5 firm's compliance officer [OR OF THE TERMINATION OF EMPLOYMENT OF  
6 AN INDIVIDUAL IN THE FIRM LICENSEE].

7 \* **Sec. 37.** AS 21.27.025 is repealed and reenacted to read:

8 **Sec. 21.27.025. Required notice of licensee.** (a) A licensee shall notify the  
9 director in writing within 30 days after a change in residence, place of business, legal  
10 name, fictitious name or alias, mailing address, electronic mailing address, or  
11 telephone number. A licensee shall report to the director in writing any administrative  
12 action taken against the licensee by a governmental agency of another state or by a  
13 governmental agency of another jurisdiction within 30 days after the final disposition  
14 of the action. A licensee shall submit to the director the final order and other relevant  
15 legal documents in the action. A licensee shall report to the director any criminal  
16 prosecution of the licensee in this or another state or jurisdiction within 30 days after  
17 the date of filing of the criminal complaint, indictment, information, or citation in the  
18 prosecution. The licensee shall submit to the director a copy of the criminal complaint,  
19 calendaring order, and other relevant legal documents in the prosecution.

20 (b) In addition to any other penalty provided by law, a failure to notify the  
21 director as required by this section is cause for denial, nonrenewal, suspension, or  
22 revocation of a license.

23 \* **Sec. 38.** AS 21.27.040(e) is amended to read:

24 (e) As part of the application required by (a) of this section, a resident [AN]  
25 applicant shall furnish to the director a full set of fingerprints and the fees required by  
26 the Department of Public Safety under AS 12.62.160 for criminal justice information  
27 and a national criminal history record check so that the director may obtain criminal  
28 justice information as provided under AS 12.62 about the applicant. The director shall  
29 submit the completed fingerprint card and fees to the Department of Public Safety for  
30 a report of criminal justice information under AS 12.62 and a national criminal history  
31 record check under AS 12.62.400.

1 \* **Sec. 39.** AS 21.27.100(c) is amended to read:

2 (c) An individual who has entered into an employment contract with a  
3 licensed [IN A FIRM WHO ACTS SOLELY ON BEHALF OF A] firm that is  
4 appointed as an agent or a managing general agent on behalf of an admitted insurer  
5 under this section may not be required to also have an appointment under this section  
6 if the individual has entered into an employment contract [IN THE FIRM IS  
7 LICENSED] with that firm for a specific class of authority.

8 \* **Sec. 40.** AS 21.27.140(b) is amended to read:

9 (b) A firm may not be licensed as an insurance producer, managing general  
10 agent, reinsurance intermediary broker, reinsurance intermediary manager, surplus  
11 lines broker, or independent adjuster, or transact insurance unless each individual  
12 employed by the firm as an insurance producer, managing general agent, surplus lines  
13 broker, trainee independent adjuster, or independent adjuster [BY THE FIRM] is  
14 licensed and has entered into an employment contract with the firm [AS AN  
15 INDIVIDUAL IN THE FIRM].

16 \* **Sec. 41.** AS 21.27 is amended by adding a new section to read:

17 **Sec. 21.27.215. Employment contracts.** (a) A firm may enter into an  
18 employment contract with a licensed individual to conduct business under the  
19 supervision of and in the name of the firm. The employment contract must be in  
20 writing and must specify the lines and classes of authorities of the individual and the  
21 firm. The individual and the firm shall retain a copy of the contract and shall reply in  
22 writing within three working days to an inquiry of the director regarding any business  
23 transacted by the individual and the firm.

24 (b) The firm shall examine the credentials of the individual to determine that  
25 the individual is licensed to conduct the kinds of business described in the contract.

26 (c) A licensed individual may, if authorized by the firm and an insurer for  
27 which the firm is an agent, issue on the firm's behalf contracts of insurance in  
28 accordance with a written agency employment contract.

29 (d) A firm shall be responsible for the actions of an individual transacting  
30 insurance under the firm's employment contracts. In any disciplinary proceeding under  
31 this title, the existence of the employment contract shall be prima facie evidence that

1 the firm knew of the activities of the individual.

2 (e) The individual and the firm shall maintain a current list of all of their  
3 respective contracts that identifies, for each contract, the parties to the contract, the  
4 parties' mailing addresses, electronic mailing addresses, and telephone numbers, and  
5 the parties' license numbers, and the effective and termination dates of employment.

6 (f) A licensee shall retain the records of an employment contract and make the  
7 records available for examination and inspection by the director, at any business time  
8 during the five years immediately following the date of the termination of the  
9 employment contract unless the director orders a longer period of retention. If the  
10 licensee assumes the business of another licensee or former licensee by merger,  
11 purchase, or otherwise, the requirements of AS 21.27.350(c) apply.

12 \* **Sec. 42.** AS 21.27.350(e) is amended to read:

13 (e) A licensee shall reply in writing within 10 working days to a records  
14 inquiry of the director. The director may inspect or request summary or detailed copies  
15 of records for examination by the division. Accounting and financial records inspected  
16 or examined under this section are confidential when in the possession of the division,  
17 but may be used by the director in a proceeding against the licensee. For purposes of  
18 this section, the records of a firm shall include and be considered the records of an  
19 individual licensee who has entered into an employment contract with the firm  
20 [ACTING ON BEHALF OF THE FIRM].

21 \* **Sec. 43.** AS 21.27.360(f) is amended to read:

22 (f) This section does not apply to an individual licensee who has entered into  
23 an employment contract with a [IN THE] firm and who acts solely on behalf of a  
24 firm that maintains compliance with this section.

25 \* **Sec. 44.** AS 21.27.790 is amended to read:

26 **Sec. 21.27.790. Surplus lines broker qualifications.** In addition to the general  
27 qualifications under AS 21.27.020, to qualify for issuance or for renewal of a resident  
28 surplus lines broker license, an applicant or licensee shall

29 (1) be licensed as either an insurance producer or managing general  
30 agent for property and casualty lines of authority;

31 (2) if required by the director by regulation, maintain a bond as

1 described in AS 21.27.190 in an amount acceptable to the director that requires the  
 2 surplus lines broker to conduct business under this title, promptly remit the taxes and  
 3 fees required by law, return premiums promptly when due, and pay proper losses  
 4 promptly;

5 (3) if the director requires, maintain an errors and omissions insurance  
 6 policy acceptable to the director.

7 \* **Sec. 45.** AS 21.27.900(22) is amended to read:

8 (22) "resident" means

9 (A) for an individual [OR AN INDIVIDUAL IN THE FIRM],  
 10 a natural person who is domiciled in this state, whose principal place of  
 11 business is in this state, who has a present intent to remain in this state while  
 12 licensed, and who manifests that intent by establishing an ongoing physical  
 13 presence in this state;

14 (B) for a firm, a person whose principal place of business is in  
 15 this state;

16 \* **Sec. 46.** AS 21.33.055(a) is repealed and reenacted to read:

17 (a) Except as to premiums on lawfully procured surplus lines insurance  
 18 exported under AS 21.34 and premiums on independently procured insurance on  
 19 which a tax has been paid under AS 21.33.061, every nonadmitted insurer shall pay to  
 20 the director, on or before March 1 following the calendar year in which the insurance  
 21 was procured, continued, or renewed, a premium-receipts tax of 3.7 percent of gross  
 22 premiums written for the insurance other than wet marine and transportation insurance  
 23 and a premium-receipts tax of three-fourths of one percent of gross premiums charged  
 24 for the wet marine and transportation insurance if the insured's home state is this state.  
 25 If the insurance covers properties, risks, or exposures located or to be performed both  
 26 in and out of this state, the tax payable shall be computed based on an amount equal to  
 27 that portion of the gross premiums allocated under (b) of this section to this state, plus  
 28 an amount equal to the portion of the premiums allocated under (b) of this section to  
 29 other properties, risks, or exposures located or to be performed outside of this state.  
 30 The insurance on subjects resident, located, or to be performed in this state procured  
 31 through negotiations or an application, in whole or in part occurring or made in or

1 from in or out of this state, or for which premiums in whole or in part are remitted  
 2 directly or indirectly from in or out of this state, shall be considered to be insurance  
 3 procured or continued or renewed in this state. The tax paid by the insurer under this  
 4 section is in lieu of all insurer taxes and fire department dues. In this subsection,  
 5 "premium" includes all premiums, membership fees, assessments, dues, and any other  
 6 consideration for insurance.

7 \* **Sec. 47.** AS 21.33.055 is amended by adding a new subsection to read:

8 (d) On default of a nonadmitted insurer in the payment of the tax, the insured  
 9 shall pay the tax within 30 days after written notice from the director of the default by  
 10 the nonadmitted insurer. If the tax prescribed by this section is not paid by the  
 11 nonadmitted insurer within the time stated or by the insured within the time stated  
 12 after notice of default by the nonadmitted insurer, the tax may be increased by

13 (1) a late payment fee of \$1,000 or 10 percent of the tax due,  
 14 whichever is greater;

15 (2) interest at the rate of one percent a month or part of a month from  
 16 the date the payment was originally due to the date paid; and

17 (3) a penalty not to exceed \$100 a day or 25 percent of the tax due,  
 18 whichever is greater, from the date the payment was due to the date paid.

19 \* **Sec. 48.** AS 21.33.061(c) is repealed and reenacted to read:

20 (c) If the insured's home state is this state, the insured shall pay to the director,  
 21 on or before March 1 following the calendar year in which the insurance was  
 22 procured, continued, or renewed, a tax of 3.7 percent of the gross premiums paid for  
 23 the insurance other than wet marine and transportation insurance, less any return  
 24 premiums. For wet marine and transportation insurance, if the insured's home state is  
 25 this state, the insured shall pay to the director a tax of three-fourths of one percent of  
 26 the gross premiums paid for the wet marine and transportation insurance. If the  
 27 insurance covers properties, risks, or exposures located or to be performed both in and  
 28 out of this state, the tax payable shall be computed based on an amount equal to that  
 29 portion of the gross premiums allocated under (d) of this section to this state, plus an  
 30 amount equal to the portion of the premiums allocated under (d) of this section to  
 31 other properties, risks, or exposures located or to be performed outside of this state. In

1 the event of cancellation and rewriting of the insurance contract, the additional  
 2 premium for tax purposes is the premium in excess of the unearned premium of the  
 3 cancelled insurance contract. In this subsection, "premium" includes all premiums,  
 4 membership fees, assessments, dues, and any other consideration for insurance.

5 \* **Sec. 49.** AS 21.33.061 is amended by adding a new subsection to read:

6 (j) If the tax payable under (c) of this section is not paid within the time stated,  
 7 the tax may be increased by

8 (1) a late payment fee of \$1,000 or 10 percent of the tax due,  
 9 whichever is greater;

10 (2) interest at the rate of one percent a month or part of a month from  
 11 the date the payment was due to the date paid; and

12 (3) a penalty not to exceed \$100 a day or 25 percent of the tax due,  
 13 whichever is greater, from the date the payment was due to the date paid.

14 \* **Sec. 50.** AS 21.33 is amended by adding a new section to read:

15 **Sec. 21.33.063. Agreements with other states.** The director is authorized to  
 16 participate in an agreement with another state for the purposes of collecting and  
 17 disbursing to the other state any premium tax collected under this chapter and payable  
 18 to the other state and for receiving from the other state premium tax it has collected  
 19 and is owed to this state. To the extent that another state where a portion of the  
 20 properties, risks, or exposures reside has failed to enter into an agreement with this  
 21 state, the director shall retain all of the net premium tax collected by this state.

22 \* **Sec. 51.** AS 21.34.020(b) is repealed and reenacted to read:

23 (b) If a policyholder meets the standards of an exempt commercial purchaser  
 24 under this title and regulations adopted by the director, insurance may be procured  
 25 from a surplus lines broker without complying with (a)(2), (3), and (4) of this section  
 26 if

27 (1) the broker procuring or placing the surplus lines insurance has  
 28 disclosed to the exempt commercial purchaser that the insurance may or may not be  
 29 available from the admitted market that may provide greater protection with more  
 30 regulatory oversight; and

31 (2) the exempt commercial purchaser has subsequently requested in

1 writing that the broker procure or place the insurance from a nonadmitted insurer.

2 \* **Sec. 52.** AS 21.34.040(c) is amended to read:

3 (c) A nonadmitted insurer may be eligible to provide coverage in this state if it  
4 qualifies under one of the following:

5 (1) a foreign but nonalien stock insurer may qualify under this  
6 subsection if it has the minimum unimpaired basic capital and additional surplus equal  
7 to that required in its domiciliary jurisdiction, or maintains [\$10,000,000 AS OF  
8 DECEMBER 31, 1991, \$12,500,000 AS OF DECEMBER 31, 1992, AND]  
9 \$15,000,000 [AS OF DECEMBER 31, 1993], whichever is greater;

10 (2) a foreign but nonalien mutual insurer, a reciprocal insurer, or a  
11 mutual protection and indemnity association may qualify under this subsection if it has  
12 the minimum unimpaired basic surplus and additional surplus equal to that required in  
13 its domiciliary jurisdiction or maintains [\$10,000,000 AS OF DECEMBER 31, 1991,  
14 \$12,500,000 AS OF DECEMBER 31, 1992, AND] \$15,000,000 [AS OF  
15 DECEMBER 31, 1993], whichever is greater;

16 (3) an alien insurer other than an alien mutual protection and  
17 indemnity association may qualify under this subsection if it meets the minimum  
18 requirements in (1) or (2) of this subsection and maintains in the United States an  
19 irrevocable trust fund in an amount not less than \$2,500,000 in a solvent federally  
20 insured bank acceptable to the director, as security to the full amount, for the  
21 protection of all its policyholders and creditors of each member of the mutual insurer,  
22 reciprocal insurer, or mutual protection and indemnity association in the United States;  
23 the trust fund must consist of instruments of substantially the same character and  
24 quality as those that are eligible investments for the capital and statutory reserves of  
25 admitted insurers authorized to write like kinds of insurance in this state or of  
26 irrevocable, clean, and unconditional letters of credit; the trust fund must have an  
27 expiration date that at no time is less than five years;

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

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

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

19 (6) an alien mutual protection and indemnity association may qualify  
20 under this subsection if it has the minimum unimpaired basic capital and additional  
21 surplus equal to that required in its domiciliary jurisdiction or \$10,000,000, whichever  
22 is greater, and maintains in the United States an irrevocable trust fund in an amount  
23 not less than \$1,000,000 in a federally insured bank acceptable to the director, as  
24 security to the full amount, for the protection of all its policyholders and creditors or  
25 each member of the mutual protection and indemnity association in the United States;  
26 the trust fund must consist of instruments of substantially the same character and  
27 quality as those that are eligible investments for the capital and statutory reserves of  
28 admitted insurers authorized to write wet marine and transportation insurance in this  
29 state or of irrevocable, clean, and unconditional letters of credit; the trust fund must  
30 have an expiration date that at no time is less than five years;

31 **(7) an insurer not domiciled in the United States or its territories**

1 qualifies under this subsection if it is listed on the Quarterly Listing of Alien  
 2 Insurers maintained by the National Association of Insurance Commissioners  
 3 International Insurers Department.

4 \* **Sec. 53.** AS 21.34.040 is amended by adding new subsections to read:

5 (f) If an insurer has less than the minimum capital and surplus required in (c)  
 6 of this section, the insurer may satisfy the requirements of this section upon an  
 7 affirmative finding of acceptability by the director. The director's finding must be  
 8 based on factors including quality of management, capital and surplus of any parent  
 9 company, company underwriting profit and investment income trends, market  
 10 availability, and company record and reputation within the industry. The director may  
 11 not make an affirmative finding of acceptability when the nonadmitted insurer's  
 12 capital and surplus is less than \$4,500,000.

13 (g) The director may participate in interstate agreements formed for the  
 14 purpose of developing additional and alternative nationwide uniform eligibility  
 15 requirements that are applicable to nonadmitted insurers domiciled in another state or  
 16 territory of the United States.

17 \* **Sec. 54.** AS 21.34.080(a) is amended to read:

18 (a) A surplus lines broker shall execute and file with the [MONTHLY] report  
 19 required by AS 21.34.170 a written report, which shall be kept confidential, regarding  
 20 each surplus lines insurance transaction occurring in the preceding period  
 21 [CALENDAR MONTH]. The report must include

22 (1) the name and address of the insured;

23 (2) the identity of each insurer including the National Association of  
 24 Insurance Commissioners company number and the percentage of coverage provided  
 25 by each;

26 (3) a complete description of the subject and location of the risk;

27 (4) the amount of gross premium written for the insurance; and

28 (5) other information required by the director.

29 \* **Sec. 55.** AS 21.34.170(a) is amended to read:

30 (a) A surplus lines broker shall file with the director [ON OR BEFORE THE  
 31 END OF EACH MONTH], on forms prescribed by the director, a report of all surplus

1 lines insurance, by type of insurance as required to be reported in the annual statement  
 2 that must be filed with the director by admitted insurers. The report must include all  
 3 surplus lines insurance transactions during the preceding period [CALENDAR  
 4 MONTH] showing the aggregate gross premiums written, the aggregate return  
 5 premiums, the amount of aggregate tax remitted to this state, and the amount of  
 6 aggregate tax remitted to each other state for which an allocation is made under  
 7 AS 21.34.180. The forms shall be filed quarterly on March 1, June 1,  
 8 September 1, and December 1 of each year.

9 \* **Sec. 56.** AS 21.34.180 is repealed and reenacted to read:

10 **Sec. 21.34.180. Surplus lines tax.** (a) In addition to collecting the full amount  
 11 of gross premiums written by an insurer for surplus lines insurance, the surplus lines  
 12 broker shall collect and pay to the director a tax of 2.7 percent on the net premium,  
 13 which is the total gross premiums written, less any return premiums, for the insurance.  
 14 Where the insurance covers properties, risks, or exposures located or to be performed  
 15 both in and out of this state, the tax payable shall be computed based on an amount  
 16 equal to 2.7 percent on that portion of the net premiums allocated under (f) of this  
 17 section to this state, plus an amount equal to the portion of the premiums allocated  
 18 under (f) of this section to other states or territories based on the tax rates and fees  
 19 applicable to other properties, risks, or exposures located or to be performed outside of  
 20 this state.

21 (b) The surplus lines broker may not absorb the tax or any part of it and may  
 22 not rebate, for any reason, any part of the tax.

23 (c) If, under AS 21.09.210, an admitted insurer is required to collect and pay  
 24 premium tax on a portion of a subscription policy, the surplus lines broker is not  
 25 required to collect any amount that would constitute double taxation of that portion of  
 26 the insurance.

27 (d) The director may participate in an agreement with another state formed for  
 28 the purpose of collecting and disbursing to a remitting state any funds collected under  
 29 (a) of this section applicable to other properties, risks, or exposures located or to be  
 30 performed outside of this state. To the extent that another state where a portion of the  
 31 properties, risks, or exposures resides has failed to enter into an agreement with this

1 state, the director shall retain all of the net premium tax collected by this state.

2 (e) At the time of filing the quarterly report as set out in AS 21.34.170, each  
3 surplus lines broker shall pay the premium tax due for transactions occurring during  
4 the period covered by the report. The tax must be paid by electronic or other means as  
5 specified by the director.

6 (f) In determining the amount of premiums taxable in this state, all premiums  
7 written, procured, or received in this state shall be considered written on properties,  
8 risks, or exposures located or to be performed in this state except premiums that are  
9 properly allocated or apportioned and reported as taxable premiums of a remitting  
10 state. Allocation of the amount of premiums taxable for surplus lines insurance  
11 covering properties, risks, or exposures only partially located or to be performed in  
12 this state shall be determined by reference to an allocation schedule established by  
13 regulation adopted by the director subject to the following:

14 (1) if a policy covers more than one classification, the following apply:

15 (A) for any portion of the coverage identified by a  
16 classification on the allocation schedule, the tax shall be computed by using the  
17 allocation schedule for the corresponding portion of the premium;

18 (B) for any portion of the coverage not identified by a  
19 classification on the allocation schedule, the tax shall be computed by using an  
20 alternative equitable method of allocation for the property or risk;

21 (C) for any portion of the coverage where the premium is  
22 indivisible, the tax shall be computed by using the method of allocation that  
23 pertains to the classification describing the predominant coverage;

24 (2) if the information provided by the surplus lines broker is  
25 insufficient to substantiate the method of allocation used by the surplus lines broker,  
26 or if the director determines that the broker's method is incorrect, the director shall  
27 determine the equitable and appropriate amount of tax due to this state as follows:

28 (A) by use of the allocation schedule if the risk is appropriately  
29 identified in the schedule;

30 (B) if the allocation schedule does not identify a classification  
31 appropriate to the coverage, the director may give significant weight to

1 documented evidence of the underwriting bases and other rating criteria used  
 2 by the insurer; the director may also consider other available information to the  
 3 extent sufficient and relevant, including the percentage of the insured's  
 4 physical assets in this state, the percentage of the insured's sales in this state,  
 5 the percentage of income or resources derived from this state, and the amount  
 6 of premium tax paid to another jurisdiction for the policy.

7 (g) If the amount of tax due under (a) of this section is less than \$50 in any  
 8 jurisdiction, the tax must be paid in the jurisdiction in which the reports and summary  
 9 of exported business are filed.

10 (h) The director shall, at least annually, furnish to the commissioner of a  
 11 remitting state a copy of all filings reporting an allocation of taxes required by this  
 12 section.

13 (i) This section does not apply to insurance of risks of state government or its  
 14 political subdivisions, to an agency of state government or its political subdivisions, or  
 15 to insurance of aircraft primarily engaged in interstate or foreign commerce.

16 (j) A surplus lines broker shall pay to the division a late payment fee of \$50 a  
 17 month plus five percent of the tax due each calendar month or part of a month during  
 18 which the broker fails to pay the full amount of the tax or a portion of the tax and  
 19 interest at the rate of one percent of the tax due each calendar month or part of a  
 20 month for the period the broker fails to pay the tax. The late payment fee, not  
 21 including interest, may not exceed \$250 plus 25 percent of the tax due. The tax  
 22 payment shall be made in the form required by the director, or a penalty shall be added  
 23 to the tax equal to 25 percent of the tax due, not to exceed \$2,000, with a minimum  
 24 penalty of \$100. In addition to any other penalty provided by law, if the provisions of  
 25 this section are wilfully violated, a civil penalty may be assessed of not more than  
 26 \$10,000. The director may suspend or revoke the license of a broker that fails to pay  
 27 its taxes, a penalty, or a late payment fee required under this section.

28 \* **Sec. 57.** AS 21.34.190(a) is amended to read:

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

1 filing of the statement.

2 \* **Sec. 58.** AS 21.34.900 is amended by adding new paragraphs to read:

3 (10) "affiliate" or "affiliated" means, with respect to an insured, any  
4 entity that controls, is controlled by, or is under common control with the insured;

5 (11) "affiliated group" means any group of entities that are all  
6 affiliated;

7 (12) "control" means for purposes of an entity having "control" over  
8 another entity

9 (A) the entity directly or indirectly or acting through 1 or more  
10 other persons owns, controls, or has the power to vote 25 percent or more of  
11 any class of voting securities of the other entity; or

12 (B) the entity controls in any manner the election of a majority  
13 of the directors or trustees of the other entity;

14 (13) "exempt commercial purchaser" has the meaning given under 15  
15 U.S.C. 8206 (Nonadmitted and Reinsurance Reform Act of 2010);

16 (14) "home state" means, for purposes of determining the home state  
17 of an insured in a multistate placement of nonadmitted insurance,

18 (A) except as provided in (B) of this paragraph, "home state"  
19 means, with respect to an insured:

20 (i) the state in which an insured maintains its principal  
21 place of business or, in the case of an individual, the individual's  
22 principal residence; or

23 (ii) if 100 percent of the insured risk is located out of  
24 the state referred to in (i) of this subparagraph, the state to which the  
25 greatest percentage of the insured's taxable premium for that insurance  
26 contract is allocated;

27 (B) if two or more insureds from an affiliated group are named  
28 insureds on a single policy, "home state" under (A) of this paragraph is based  
29 on the member of the affiliated group that has the largest percentage of  
30 premium attributed to it under the insurance contract;

31 (C) for purposes of (A) of this paragraph, the principal place of

1 business of an insured is the state where the insured maintains its headquarters  
 2 and where the insured's high-level officers direct control and coordinate the  
 3 business activities of the insured;

4 (15) "remitting state" means a state that has entered into an agreement  
 5 with this state for remitting to this state any premium tax collected by the other state  
 6 on premiums allocated to properties, risks, or exposures located in this state.

7 \* **Sec. 59.** AS 21.36 is amended by adding a new section to read:

8 **Sec. 21.36.225. Notice of health insurance coverage cancellation, coverage**  
 9 **change, or premium change.** (a) Except for a health care insurance policy subject to  
 10 AS 21.51.400 or AS 21.54.130, an insurer may not cancel a health insurance policy  
 11 unless the insurer provides written notice to a covered individual at least 45 days  
 12 before the effective date of the cancellation.

13 (b) An insurer shall provide written notice to a covered individual of changes  
 14 in coverage or premium at least 45 days before the effective date of the change in  
 15 coverage or premium.

16 \* **Sec. 60.** AS 21.36.360(q) is amended to read:

17 (q) A fraudulent or criminal insurance act described in

18 (1) (b) of this section that is committed to obtain \$10,000 or more is a  
 19 class B felony;

20 (2) (c), (d), or (p)(4) [(c) OR (d)] of this section is a class B felony;

21 (3) (b) of this section that is committed to obtain \$500 or more but less  
 22 than \$10,000 is a class C felony;

23 (4) (e), (f), (g), or (h), of this section is a class C felony;

24 (5) (b) of this section that is committed to obtain less than \$500 is a  
 25 class A misdemeanor;

26 (6) (i), (j), (k), (l), (m), or (n) of this section is a class A misdemeanor;

27 (7) (o) of this section is a class B misdemeanor;

28 (8) (p)(1) of this section is a class B misdemeanor unless another  
 29 specific penalty is provided for the violation of the provision; and

30 (9) (p)(2) and (3) [(p)(2) - (4)] of this section may be prosecuted under  
 31 AS 11.46.

1 \* **Sec. 61.** AS 21.45.020 is amended by adding new subsections to read:

2 (c) A life insurance policy or annuity contract delivered or issued for delivery  
3 in this state and each life insurance policy or annuity contract application must contain  
4 a notice prominently printed on or attached to the first page stating

5 (1) on written request, an insurer is required to provide, within a  
6 reasonable time, reasonable factual information regarding the benefits and provisions  
7 of the policy or contract to the policy or contract holder; and

8 (2) if, for any reason, the policy or contract holder is not satisfied with  
9 the policy or contract, the policy or contract holder may return the policy or contract  
10 within 10 days after the policy or contract is delivered and, except as provided in (d)  
11 of this section, receive a refund of all money paid.

12 (d) For a variable life insurance policy or variable annuity contract, the refund  
13 under (c) of this section must equal the sum of

14 (1) the difference between the premiums paid, including any policy or  
15 contract fees or other charges; and

16 (2) the amounts allocated to any separate accounts under the policy or  
17 contract on the date the returned policy is received by the insurer or its insurance  
18 producer.

19 \* **Sec. 62.** AS 21.51.405 is amended by adding new subsections to read:

20 (b) An insurer shall file with the director the premium rates charged for an  
21 individual health care insurance plan before using them. A premium rate or premium  
22 rate change must be on file with the director for a waiting period of at least 45 days  
23 before the effective date of the premium rate. That period may be extended by the  
24 director or the insurer for an additional 15 days if, during the initial 45-day waiting  
25 period, notice is given stating that additional time for consideration of the filing is  
26 needed. A filing may become effective at the end of the waiting period unless  
27 disapproved by the director during the waiting period. If an insurer fails to provide  
28 information requested by the director during the waiting period, the filing is  
29 considered withdrawn by the insurer, and the premium rate does not become effective.

30 (c) The director shall adopt regulations

31 (1) establishing procedures for filing and use of rates; and

1 (2) specifying information that must be submitted in a filing required  
2 under (b) of this section.

3 \* **Sec. 63.** AS 21.53.020 is amended to read:

4 **Sec. 21.53.020. Disclosure and performance standards.** An insurer, hospital  
5 or medical service corporation, or [A] fraternal benefit society that delivers or issues  
6 for delivery a long-term care insurance policy may not

7 (1) cancel, fail to renew, or otherwise terminate the policy on the  
8 grounds of age or deterioration of the mental or physical health of the insured [OR  
9 CERTIFICATE HOLDER];

10 (2) include a provision requiring a new waiting period in the event  
11 existing coverage is converted to or replaced by a new or another form of health  
12 insurance within the same company, unless there is an increase in benefits voluntarily  
13 selected by the insured or group policyholder; or

14 (3) provide coverage only for skilled nursing care [,] or provide  
15 significantly more coverage for skilled care in a facility than is provided for coverage  
16 for lower levels of care [; EVALUATION OF THE COVERAGE PROVIDED  
17 UNDER THIS PARAGRAPH MUST BE BASED ON THE NUMBER OF DAYS OF  
18 COVERAGE PROVIDED FOR LOWER LEVELS OF CARE, WHEN COMPARED  
19 TO THE NUMBER OF DAYS OF COVERAGE PROVIDED FOR SKILLED  
20 CARE].

21 \* **Sec. 64.** AS 21.53.030(a) is amended to read:

22 (a) An insurer, hospital or medical service corporation, or [A] fraternal benefit  
23 society may not include, in a long-term care insurance policy or certificate, a  
24 definition of "preexisting condition" that is more restrictive than the following:  
25 preexisting condition means [THE EXISTENCE OF SYMPTOMS THAT WOULD  
26 CAUSE AN ORDINARILY PRUDENT PERSON TO SEEK DIAGNOSIS, CARE,  
27 OR TREATMENT, OR] a condition for which medical advice or treatment was  
28 recommended by, or received from, a provider of health care services [,] within six  
29 months preceding the effective date of coverage of an insured person.

30 \* **Sec. 65.** AS 21.53.030(b) is amended to read:

31 (b) In a long-term care insurance policy, [OR CERTIFICATE] an insurer,

1 hospital or medical service corporation, or [A] fraternal benefit society may not  
 2 exclude coverage for a loss or confinement that is the result of a preexisting condition,  
 3 unless the loss or confinement begins within six months following the effective date of  
 4 coverage of an insured person.

5 \* **Sec. 66.** AS 21.53.030(d) is amended to read:

6 (d) This section does not prohibit an insurer, hospital or medical service  
 7 corporation, or [A] fraternal benefit society from using an application form designed  
 8 to elicit the complete health history of an applicant, and, on the basis of the answers on  
 9 the application, from applying that insurer's, hospital or medical service corporation's,  
 10 or fraternal benefit society's established underwriting standards. Unless otherwise  
 11 provided in the policy [OR CERTIFICATE], a preexisting condition, regardless of  
 12 whether it is disclosed on the application, need not be covered until the waiting period  
 13 described in (b) of this section expires. A long-term care insurance policy [OR  
 14 CERTIFICATE] may not exclude, limit, or reduce, or use waivers or riders of any  
 15 kind to exclude, limit, or reduce coverage or benefits for specifically named or  
 16 described preexisting diseases or physical conditions after the waiting period  
 17 described in (b) of this section, unless the waiver or rider has been specifically  
 18 approved by the director.

19 \* **Sec. 67.** AS 21.53.040 is amended to read:

20 **Sec. 21.53.040. Prior hospital or institutional care conditions prohibited.**

21 (a) A long-term care insurance policy may not be delivered or issued for delivery in  
 22 this state if the policy conditions eligibility

23 (1) on a prior hospitalization requirement;

24 (2) on the receipt of a higher level of institutional care, when care is  
 25 provided in an institutional setting;

26 (3) for noninstitutional benefits on a prior institutional stay of more  
 27 than 30 days for which benefits are paid; [OR]

28 (4) on admission to an institutional care facility for the same or a  
 29 related condition within a period of less than 30 days after discharge from the  
 30 institution, if the policy provides benefits only following institutionalization; or

31 (5) for a benefit, other than a waiver of premium,

1 postconfinement, postacute care, or recuperative benefit, on a prior  
 2 institutionalization.

3 (b) A long-term care insurance policy containing a postconfinement,  
 4 postacute care, or recuperative benefit must clearly label the limitations or  
 5 conditions, including any required number of days of confinement, "Limitations  
 6 or Conditions on Eligibility for Benefits" [MAY CONTAIN A LIMITATION OR  
 7 CONDITION ON ELIGIBILITY FOR BENEFITS, NOT PROHIBITED IN (a) OF  
 8 THIS SECTION, IF THE LIMITATION OR CONDITION IS CLEARLY SET OUT]  
 9 in a separate paragraph of the policy [OR CERTIFICATE].

10 \* **Sec. 68.** AS 21.53.050(a) is amended to read:

11 (a) A long-term care insurance applicant may return a policy within 30 days  
 12 after delivery and have the premium refunded if, after examination of the policy, the  
 13 applicant is not satisfied with the policy. A long-term care insurance policy must have  
 14 a notice prominently printed on the first page of the policy or separately attached  
 15 stating that the applicant has the right to return the policy within 30 days of its  
 16 delivery and to have the premium refunded if, after examination of the policy, the  
 17 applicant is not satisfied with the policy for any reason. This subsection also applies  
 18 to application denials, and any refund must be made within 30 days after return  
 19 or denial.

20 \* **Sec. 69.** AS 21.53.050(b) is amended to read:

21 (b) An insurer, hospital or medical service corporation, or [A] fraternal benefit  
 22 society shall deliver an outline of coverage to a prospective applicant for long-term  
 23 care insurance at the time of initial solicitation by a means that prominently directs the  
 24 attention of the recipient to the document and its purpose. In the case of agent  
 25 solicitations, an agent shall deliver the outline of coverage before the presentation of  
 26 an application or enrollment form. In the case of direct response solicitations, the  
 27 outline of coverage must be presented in conjunction with an application or enrollment  
 28 form. The outline of coverage must include

29 (1) a description of the principal benefits and coverage provided in the  
 30 policy;

31 (2) a statement of the principal exclusions, reductions, and limitations

1 contained in the policy;

2 (3) a statement of the terms under which the policy [OR  
3 CERTIFICATE, OR BOTH,] may be continued in force or discontinued, including a  
4 reservation in the policy of a right to change the premium; continuation or conversion  
5 provisions of group coverage must be specifically described;

6 (4) a statement that the outline of coverage is a summary only, not a  
7 contract of insurance, and that the policy or group master policy contains governing  
8 contractual provisions;

9 (5) a description of the terms under which the policy [OR  
10 CERTIFICATE] may be returned and premium refunded; [AND]

11 (6) a brief description of the relationship between the cost of care and  
12 benefits; and

13 (7) a statement that discloses to the policyholder whether the  
14 policy is intended to be a federal qualified long-term care insurance contract  
15 under 26 U.S.C. 7702B(b) (Internal Revenue Code).

16 \* **Sec. 70.** AS 21.53.050 is amended by adding new subsections to read:

17 (d) For a policy issued to a group defined in AS 21.53.200(3)(A), an insurer,  
18 hospital or medical service corporation, or fraternal benefit society is not required to  
19 provide an outline of coverage if the information required on the outline of coverage  
20 under (b) of this section is contained in other enrollment materials. An insurer,  
21 hospital or medical service corporation, and fraternal benefit society shall provide the  
22 enrollment materials to the director on request.

23 (e) If an application for a long-term care insurance policy is approved, the  
24 insurer shall deliver the policy to the applicant not later than 30 days after the date of  
25 approval.

26 \* **Sec. 71.** AS 21.53.060(a) is amended to read:

27 (a) In addition to the requirements of AS 21.45, at the time of policy delivery,  
28 a policy summary shall be included with an individual life insurance policy if the  
29 policy or policy rider provides long-term care benefits. In the case of direct response  
30 solicitations, the insurer shall deliver the policy summary upon the applicant's request  
31 [,] but, regardless of request, shall deliver a policy summary not later than the time of

1 policy delivery. The summary must include

2 (1) an explanation of how the long-term care benefits interact with  
3 other components of the policy, including deductions from death benefits;

4 (2) an illustration of the amount and length of benefits, and guaranteed  
5 lifetime benefits, if any, for each covered person;

6 (3) an explanation of each exclusion, reduction, and limitation on long-  
7 term care benefits; [AND]

8 (4) if applicable to the policy type,

9 (A) disclosure of the effects of exercising other rights under the  
10 policy;

11 (B) disclosure of guarantees related to the long-term care costs  
12 of insurance charges; and

13 (C) current and projected maximum lifetime benefits; and

14 (5) if the director adopts a regulation that permits but does not  
15 require inflation protection, and the policy does not provide for inflation  
16 protection, a statement that inflation protection is not available under the policy.

17 \* **Sec. 72.** AS 21.53.060 is amended by adding a new subsection to read:

18 (c) If a claim under a long-term care insurance policy is denied by an insurer,  
19 the insurer shall, within 60 days after the date of a written request by a policyholder or  
20 a representative of a policyholder,

21 (1) provide a written explanation of the reasons for the denial; and

22 (2) make available all information directly related to the denial.

23 \* **Sec. 73.** AS 21.53 is amended by adding new sections to read:

24 **Sec. 21.53.062. Incontestability period.** (a) If a long-term care insurance  
25 policy has been in force for less than six months, an insurer may rescind the policy or  
26 deny an otherwise valid long-term care claim under the policy on a showing of  
27 misrepresentation that is material to the acceptance for coverage.

28 (b) If a long-term care insurance policy has been in force for at least six  
29 months but less than two years, an insurer may rescind the policy or deny an otherwise  
30 valid long-term care claim under the policy on a showing of misrepresentation that is  
31 both material to the acceptance for coverage and pertains to the condition for which

1 benefits are sought.

2 (c) If a long-term care insurance policy has been in force for two years or  
3 more, the policy is not contestable on the grounds of misrepresentation alone and may  
4 only be contested on a showing that the insured knowingly and intentionally  
5 misrepresented relevant facts relating to the insured's health.

6 (d) If an insurer has paid benefits under a long-term care insurance policy, the  
7 insurer may not recover the benefit payments if the policy is rescinded.

8 (e) This section applies to a life insurance policy that accelerates benefits for  
9 long-term care. However, if an insured dies, this section does not apply to the  
10 remaining death benefit of a life insurance policy that accelerates benefits for long-  
11 term care, and the remaining death benefit under the policy is subject to AS 21.45.040.

12 **Sec. 21.53.064. Nonforfeiture benefits.** (a) Except as provided in (b) of this  
13 section, a long-term care insurance policy may not be delivered or issued for delivery  
14 in this state unless the policyholder has been offered the option of purchasing a policy  
15 including a nonforfeiture benefit. The insurer may offer a nonforfeiture benefit in the  
16 form of a rider to the policy. If a policyholder declines the nonforfeiture benefit, the  
17 insurer shall provide a contingent benefit upon lapse that is available for a specified  
18 period of time following a substantial increase in premium rates.

19 (b) With respect to group long-term care insurance, an insurer shall make the  
20 offer required in (a) of this section to the group policyholder. For a policy issued as  
21 group long-term care insurance, other than a continuing care retirement community or  
22 other similar entity, the insurer shall make the offer required in (a) of this section to  
23 each proposed certificate holder.

24 **Sec. 21.53.066. Producer training requirements.** (a) A person may not sell,  
25 solicit, or negotiate long-term care insurance unless the person is licensed as an  
26 insurance producer for health or life insurance lines of authority and has completed a  
27 one-time training course that meets the requirements in (d) of this section.

28 (b) A person currently licensed and selling, soliciting, or negotiating long-term  
29 care insurance may not continue to sell, solicit, or negotiate long-term care insurance  
30 unless the person has completed a one-time training course that meets the  
31 requirements in (d) of this section.

1 (c) A person who sells, solicits, or negotiates long-term care insurance shall  
2 complete ongoing training that meets the requirements in (e) of this section.

3 (d) The one-time training course required under this section

4 (1) must be at least eight credit hours;

5 (2) may not include training that is insurer or company product  
6 specific or that includes any sales or marketing information, materials, or training,  
7 other than those required by state or federal law;

8 (3) must consist of topics related to long-term care insurance, long-  
9 term care services, and, if applicable, qualified long-term care insurance partnership  
10 programs, including

11 (A) state and federal requirements and the relationship between  
12 qualified state long-term care insurance partnership programs and other public  
13 and private coverage of long-term care services;

14 (B) available long-term care services and providers;

15 (C) changes or improvements in long-term care services or  
16 providers;

17 (D) alternatives to the purchase of private long-term care  
18 insurance;

19 (E) the effect of inflation on benefits and the importance of  
20 inflation protections; and

21 (F) consumer suitability standards and guidelines.

22 (e) The ongoing training course required under (c) of this section must be at  
23 least four credit hours every 24 months and must comply with the requirements in  
24 (d)(2) and (3) of this section.

25 (f) The director may approve the training requirements in (d) and (e) of this  
26 section as continuing education courses under AS 21.27.020.

27 (g) An insurer shall

28 (1) obtain verification that a producer received the training required  
29 under this section before a producer is permitted to sell, solicit, or negotiate the  
30 insurer's long-term care insurance products;

31 (2) maintain records of required training subject to the state's record

1 retention requirements;

2 (3) make the verification required under (1) of this subsection available  
3 to the director on request.

4 (h) An insurer shall maintain

5 (1) records with respect to the training of its producers concerning the  
6 distribution of its partnership policies that allows the director to provide assurance to  
7 the medical assistance program under AS 47.07 that producers have received the  
8 training described in (d)(3) of this section and that producers have demonstrated an  
9 understanding of the partnership policies and their relationship to public and private  
10 coverage of long-term care in this state; and

11 (2) the records described under (1) of this subsection in accordance  
12 with the record requirements under AS 21.09.320 and shall make the records available  
13 to the director on request.

14 **Sec. 21.53.068. Limitations related to producers and third-party**  
15 **administrators.** An insurer that authorizes issuance of a long-term care insurance  
16 policy by a producer or a third-party administrator under the underwriting authority of  
17 the insurer granted to the producer or a third-party administrator using the insurer's  
18 underwriting guidelines may issue a long-term care insurance policy through the  
19 producer or a third-party administrator only if the insurer compensates the issuer based  
20 on the number of policies issued.

21 \* **Sec. 74.** AS 21.53.090 is amended to read:

22 **Sec. 21.53.090. Required regulations.** The director shall adopt regulations  
23 regarding

24 (1) the sale of long-term care insurance that provide minimum  
25 standards for

26 (A) terms of renewability;

27 (B) initial and subsequent conditions of eligibility;

28 (C) nonduplication of coverage provisions;

29 (D) coverage of dependents;

30 (E) benefit triggers;

31 (F) preexisting conditions and recurrent conditions;

1 (G) termination of insurance, including incontestability  
 2 periods;

3 (H) continuation or conversion;

4 (I) probationary periods, limitations, exceptions, reductions,  
 5 and elimination periods; [AND]

6 (J) requirements for replacement;

7 (K) producer training, education, compensation, and  
 8 testing;

9 (L) marketing practices;

10 (M) independent review of benefit determinations;

11 (N) penalties and reporting practices; and

12 (O) premium rates, including rate filing requirements;

13 (2) standard definitions of long-term care insurance terms;

14 (3) nonforfeiture or minimum value requirements; [AND]

15 (4) consumer protection standards, including standards for full and fair  
 16 disclosure setting out the manner and content of required disclosures; and

17 (5) the standard format and content of the outline of coverage  
 18 required under AS 21.53.050.

19 \* **Sec. 75.** AS 21.53.200(3) is amended to read:

20 (3) "group long-term care insurance" means a long-term care insurance  
 21 policy, subscriber's contract, or fraternal benefit society certificate that is delivered or  
 22 issued for delivery in this state and issued to

23 (A) one or more employers or labor organizations, or to a trust  
 24 or to the trustees of a fund established by one or more employers or labor  
 25 organizations, or a combination of them, for employees or former employees  
 26 or a combination of them, or for members or former members or a combination  
 27 of them, of the labor organization;

28 (B) a professional, trade, or occupational association for its  
 29 members or former or retired members, or combination of them, if the  
 30 association is composed of individuals all of whom are or were actively  
 31 engaged in the same profession, trade, or occupation, and has been maintained

1 in good faith for purposes other than obtaining insurance;

2 (C) an association or a trust or the trustee of a fund established,  
3 created, or maintained for the benefit of members of one or more associations  
4 **that meets the requirements in AS 21.53.080;**

5 (D) a group other than described in this paragraph if the  
6 director determines that the issuance of the group policy is not contrary to the  
7 best interest of the public, would result in economies of acquisition or  
8 administration, and the benefits are reasonable in relation to the premiums  
9 charged;

10 \* **Sec. 76.** AS 21.53.200(4) is amended to read:

11 (4) "long-term care insurance"

12 (A) means an individual or group insurance policy, including  
13 group and individual life insurance or annuities, a subscriber's contract,  
14 fraternal benefit society certificate, or rider advertised, marketed, offered, or  
15 designed to provide coverage for not less than 12 consecutive months for each  
16 covered person on an expense incurred, indemnity, prepaid, or other basis, for  
17 one or more necessary or medically necessary diagnostic, preventive,  
18 therapeutic, rehabilitative, maintenance, or personal care services that are  
19 provided in a setting other than an acute care unit of a hospital, and includes a  
20 policy or rider that provides for payment of benefits based on cognitive  
21 impairment or loss of functional capacity;

22 (B) ["LONG-TERM CARE INSURANCE"] does not include

23 (i) an insurance policy, subscriber's contract, or  
24 fraternal benefit society certificate that is offered primarily to provide  
25 basic Medicare supplement coverage, basic hospital expense coverage,  
26 basic medical-surgical expense coverage, hospital confinement  
27 indemnity coverage, major medical expense coverage, disability  
28 insurance and related asset protection coverage, catastrophic coverage,  
29 comprehensive coverage, accident only coverage, specified disease or  
30 specified accident coverage, or limited benefit health coverage; **or**

31 **(ii) a life insurance policy that accelerates the death**

1                   benefit specifically for one or more of the qualifying events of  
 2                   terminal illness, medical conditions requiring extraordinary  
 3                   medical intervention, or permanent institutional confinement and  
 4                   that provides the option of a lump-sum payment for that benefit if  
 5                   the benefit and the eligibility for the benefit under the life  
 6                   insurance policy are not conditioned on the receipt of long-term  
 7                   care;

8           \* **Sec. 77.** AS 21.54.015 is amended by adding new subsections to read:

9                   (c) Except for large employer health care insurance plan premium rates  
 10                   exempted by the director by regulation under (d) of this section, an insurer shall file  
 11                   with the director the premium rates charged for each health care insurance plan before  
 12                   using them. A premium rate or premium rate change must be on file with the director  
 13                   for a waiting period of at least 45 days before the effective date of the premium rate.  
 14                   That period may be extended by the director or the insurer for an additional 15 days if,  
 15                   during the initial 45-day waiting period, notice is given stating that additional time for  
 16                   consideration of the filing is needed. A filing may become effective at the end of the  
 17                   waiting period unless disapproved by the director during the waiting period. If an  
 18                   insurer fails to provide information requested by the director during the waiting  
 19                   period, the filing is considered withdrawn by the insurer, and the premium rate does  
 20                   not become effective.

21                   (d) The director shall adopt regulations

22                               (1) establishing procedures for the filing and use of rates; and

23                               (2) specifying information that must be submitted in a filing required  
 24                   under (c) of this section.

25           \* **Sec. 78.** AS 21.54.020(a) is amended to read:

26                   (a) On the written request of a covered person, a health care insurer shall pay  
 27                   amounts due under a health insurance policy directly to the provider of medical care  
 28                   services. A health insurance policy may not contain a provision that requires services  
 29                   be provided by a particular hospital or person, except as applicable to a [MANAGED  
 30                   CARE PLAN UNDER AS 21.07 OR A] health maintenance organization under  
 31                   AS 21.86. If a health care insurer makes a claim payment to the covered person after

1 the covered person has given written notice electing direct payment to the provider of  
 2 the service, the health care insurer shall also pay that amount to the provider of the  
 3 service.

4 \* **Sec. 79.** AS 21.54 is amended by adding a new section to article 2 to read:

5 **Sec. 21.54.180. Individual health care insurance policies offered in the**  
 6 **group market.** (a) Except as provided in (b) of this section, a person may not sell,  
 7 solicit, or negotiate an individual health care insurance policy to an employer or  
 8 employee of an employer, and an insurer may not issue an individual health care  
 9 insurance policy to an employee of an employer.

10 (b) Notwithstanding the definition of "group market" in AS 21.54.500, a  
 11 person may sell, solicit, or negotiate an individual health care insurance policy to an  
 12 employer or employee of an employer, and an insurer may issue an individual health  
 13 care insurance policy to an employee of an employer, only if

14 (1) the employee is not an eligible employee as defined in  
 15 AS 21.56.250; or

16 (2) the employer does not offer a health benefit plan and has not  
 17 offered a health benefit plan in the last six months.

18 (c) An individual health care insurance policy offered under (b) of this section  
 19 is health care insurance offered in the individual market and subject to the  
 20 requirements of AS 21.51. In this subsection, "individual market" means the market  
 21 for health care insurance that does not include coverage under a health care insurance  
 22 plan as defined in AS 21.54.500.

23 \* **Sec. 80.** AS 21.54.500(16) is amended to read:

24 (16) "health care insurance plan" means a health care insurance policy  
 25 or contract [PROVIDED BY A HEALTH CARE INSURER] but does not include an  
 26 excepted benefits policy or contract;

27 \* **Sec. 81.** AS 21.59.070 is amended to read:

28 **Sec. 21.59.070. Other provisions applicable.** In addition to the provisions of  
 29 this chapter, the following provisions of this title shall apply to automobile service  
 30 corporations, to the extent applicable and not in conflict with the express provisions of  
 31 this chapter and the reasonable implications of the express provisions, and, for the

1 purposes of the application, the corporations shall be considered to be stock insurers:

- 2 (1) AS 21.03;  
 3 (2) AS 21.06;  
 4 (3) AS 21.09.050;  
 5 (4) AS 21.09.100;  
 6 (5) AS 21.09.120 - 21.09.210;  
 7 (6) AS 21.09.245;  
 8 (7) AS 21.09.247;  
 9 (8) AS 21.12;  
 10 (9) [(7)] AS 21.36;  
 11 (10) [(8)] AS 21.69;  
 12 (11) [(9)] AS 21.78;  
 13 (12) [(10)] AS 21.97.

14 \* **Sec. 82.** AS 21.66.020 is amended by adding new subsections to read:

15 (b) When a title insurance company holding a certificate of authority under  
 16 this chapter is found to be insolvent by a proceeding in a court of competent  
 17 jurisdiction, the director shall take control of deposits made by the title insurance  
 18 company and held in this state. If the finding of insolvency is from a court in another  
 19 state, the director shall file for an ancillary receivership under AS 21.78 to administer  
 20 the deposits and other assets in this state and pay claims in this state. Any funds  
 21 remaining after payment of all claims under policies in this state shall be forwarded to  
 22 the receiver.

23 (c) On request of a title insurance company, the director shall return the assets  
 24 held on deposit when the company is no longer authorized to write insurance in this  
 25 state, the director is satisfied that there are no risks in the state covered by contracts of  
 26 the company, and the assets are no longer required to be held by any provision of law.

27 (d) In addition to the provisions of this section, the following provisions of  
 28 this title also apply with respect to deposits under this section to the extent applicable  
 29 and not in conflict with the express provisions of this chapter and the reasonable  
 30 implications of the express provisions:

- 31 (1) AS 21.24.040(a), (d), and (e);

1 (2) AS 21.24.060.

2 \* **Sec. 83.** AS 21.66.210(a) is amended to read:

3 (a) Two or more title insurance companies or two or more title insurance  
4 limited producers, or a combination of title insurance companies and title insurance  
5 limited producers, may apply to the director of insurance to form an association,  
6 corporation, or other legal entity, for the purpose of engaging in the business of  
7 preparing abstracts of title searches from public records or from records to be owned  
8 by the entity, upon the basis of which a title insurance limited producer or a title  
9 insurance company will issue title policies. The owners or participants are considered  
10 to be in compliance with the provisions of this section and AS 21.66.200 if the title  
11 plant of the association, corporation, or other legal entity complies with the provisions  
12 of this section. The application must contain

13 (1) a copy of the proposed articles of incorporation or association and  
14 the bylaws or agreement governing the operation of the entity;

15 (2) a list of the owners or participants;

16 (3) the names and addresses of the persons who will operate the entity,  
17 with a description of their experience and qualifications;

18 (4) the conditions under which ownership or participation in the entity  
19 may be sold or acquired;

20 (5) a statement of whether or not title information will be compiled and  
21 sold to persons other than owners of or participants in the entity;

22 (6) a pro forma balance sheet and other financial information to  
23 indicate the sufficiency of financing the entity; **and**

24 **(7) basic information, including the joint title plan name, the**  
25 **physical address, the mailing address, the electronic mailing address, and**  
26 **telephone numbers.**

27 \* **Sec. 84.** AS 21.69.390(d) is amended to read:

28 (d) To meet the requirements of (a) of this section, a domestic insurer shall  
29 keep at its principal place of business in the state the following records of assets,  
30 transactions, and affairs:

31 (1) a general ledger;

1 (2) copies of reports prepared to comply with AS 21.09.200 -  
2 21.09.210;

3 (3) if prepared in the normal course of business, financial statements  
4 prepared under generally accepted accounting principles on which a licensed certified  
5 public accountant has expressed an opinion;

6 (4) filings made by a domestic insurer or affiliates of the domestic  
7 insurer with a government agency with which a domestic insurer or affiliates of the  
8 domestic insurer's securities may be registered;

9 (5) a state certificate of authority;

10 (6) filings made under AS 21.21;

11 (7) original **contract** [POLICY] and claim files for insurance **and**  
12 **other products sold to consumers** [OF PROPERTY OR A RISK RESIDENT OR  
13 LOCATED IN THE STATE];

14 (8) a corporate minutes book;

15 (9) articles of incorporation;

16 (10) corporate bylaws;

17 (11) **administrative management** contracts; and

18 (12) other records required by the director by regulation.

19 \* **Sec. 85.** AS 21.72.170 is amended to read:

20 **Sec. 21.72.170. Other provisions applicable.** In addition to the provisions  
21 contained in the chapter, other chapters and provisions of this title shall apply to  
22 benevolent associations, to the extent applicable, as follows:

23 (1) AS 21.03;

24 (2) AS 21.06;

25 (3) AS 21.09.010, 21.09.050, 21.09.100, and 21.09.130 - 21.09.190;

26 (4) **AS 21.09.247;**

27 **(5)** AS 21.18.010 and 21.18.030;

28 **(6)** [(5)] AS 21.36;

29 **(7)** [(6)] AS 21.42;

30 **(8)** [(7)] AS 21.69.370, 21.69.390, 21.69.400, 21.69.630, and  
31 21.69.640;

1                                    **(9)** [(8)] AS 21.78.

2        \* **Sec. 86.** AS 21.75.060(b) is amended to read:

3                    (b) The proposed attorney-in-fact shall fulfill the requirements of and shall  
4        execute and file with the director when applying for a certificate of authority, a  
5        declaration setting out

6                                    (1) the name of the insurer;

7                                    (2) the location of the insurer's principal office, which shall be the  
8        same as that of the attorney-in-fact and shall be maintained in this state, **and the**  
9        **mailing address, electronic mailing address, and telephone numbers:**

10                                   (3) the kinds of insurance proposed to be transacted;

11                                   (4) the names and addresses of the original subscribers;

12                                   (5) the designation and appointment of the proposed attorney-in-fact  
13        and a copy of the power of attorney;

14                                   (6) the names and addresses of the officers and directors of the  
15        attorney-in-fact, if a corporation, or its members, if a firm;

16                                   (7) the powers of the subscribers' advisory committee, and the names  
17        and terms of office of the members;

18                                   (8) that all money paid to the reciprocal insurer shall, after deducting  
19        any sum payable to the attorney-in-fact, be held in the name of the insurer and for the  
20        purposes specified in the subscribers' agreement;

21                                   (9) a copy of the subscribers' agreement;

22                                   (10) a statement that each of the original subscribers has in good faith  
23        applied for insurance of a kind proposed to be transacted and that the insurer has  
24        received from each subscriber the full premium or premium deposit required for the  
25        policy applied for, for a term of not less than six months at an adequate rate filed with  
26        and approved by the director;

27                                   (11) a statement of the financial condition of the insurer, a schedule of  
28        its assets, and a statement that the surplus as required by AS 21.75.050 is on hand;

29                                   (12) a copy of each policy, endorsement, and application form it then  
30        proposes to issue or use.

31        \* **Sec. 87.** AS 21.79.025(a) is amended to read:

1 (a) The benefits for which the association may become liable may not exceed  
2 the lesser of

3 (1) the contractual obligations for which the insurer is liable or would  
4 have been liable if it were not an impaired or insolvent insurer;

5 (2) with respect to any one life, regardless of the number of policies or  
6 contracts,

7 (A) \$300,000 in life insurance death benefits, but not more than  
8 \$100,000 in net cash surrender and net cash withdrawal values for life  
9 insurance;

10 (B) in health insurance benefits,

11 (i) \$100,000 for coverage not defined as disability  
12 insurance long-term care insurance, or basic hospital, medical, and  
13 surgical insurance or major medical insurance, including any net cash  
14 surrender and net cash withdrawal values;

15 (ii) \$300,000 for disability insurance as defined in  
16 AS 21.12.052 and long-term care insurance as defined in  
17 AS 21.53.200;

18 (iii) \$500,000 for basic hospital, medical, and surgical  
19 insurance or major medical insurance;

20 (C) \$250,000 [\$100,000] in the present value of annuity  
21 benefits, including net cash surrender and net cash withdrawal values;

22 (3) with respect to any one contract holder or plan sponsor whose plan  
23 owns directly or in trust one or more unallocated annuity contracts not included in (4)  
24 of this subsection, \$5,000,000 in unallocated annuity contract benefits, irrespective of  
25 the number of contracts held by that contract holder or plan sponsor except that, in the  
26 case of one or more unallocated annuity contracts that are covered under this chapter  
27 and that are owned by a trust or other entity for the benefit of two or more plan  
28 sponsors, coverage shall be provided by the association if the largest interest in the  
29 trust or entity owning the contract is held by a plan sponsor whose principal place of  
30 business is in this state; however, the association is not liable to cover more than  
31 \$5,000,000 in benefits with respect to an unallocated annuity contract not included in

1 (4) of this subsection;

2 (4) with respect to an individual participating in a governmental  
3 retirement benefit plan established under 26 U.S.C. 401, 26 U.S.C. 403(b), or 26  
4 U.S.C. 457 and covered by an unallocated annuity contract, or to a beneficiary of the  
5 individual if the individual is deceased, in the aggregate, \$100,000 in present-value  
6 annuity benefits, including net cash surrender and net cash withdrawal values; or

7 (5) with respect to each payee of a structured settlement annuity, or  
8 beneficiary of the payee if the payee is deceased, \$100,000 in present-value annuity  
9 benefits in the aggregate, including net cash surrender and net cash withdrawal values,  
10 if any.

11 \* **Sec. 88.** AS 21.84.335(b) is amended to read:

12 (b) In addition to the provisions of this chapter, the following provisions of  
13 this title apply to fraternal benefit societies to the extent applicable and not in conflict  
14 with the express provisions of this chapter and the reasonable implications of this  
15 chapter:

16 (1) AS 21.03;

17 (2) AS 21.06;

18 (3) AS 21.09.050;

19 (4) AS 21.09.100;

20 (5) AS 21.09.200;

21 (6) AS 21.09.205;

22 (7) AS 21.09.245;

23 (8) AS 21.09.247;

24 (9) AS 21.18;

25 (10) [(8)] AS 21.21;

26 (11) [(9)] AS 21.27;

27 (12) [(10)] AS 21.33;

28 (13) [(11)] AS 21.36;

29 (14) [(12)] AS 21.42.290;

30 (15) [(13)] AS 21.42.355;

31 (16) [(14)] AS 21.53;

- 1                    (17) [(15)] AS 21.54;  
 2                    (18) [(16)] AS 21.56;  
 3                    (19) [(17)] AS 21.69.370;  
 4                    (20) [(18)] AS 21.69.640;  
 5                    (21) [(19)] AS 21.78; and  
 6                    (22) [(20)] AS 21.96.060.

7        \* **Sec. 89.** AS 21.85.030(a) is amended to read:

8                    (a) The director may not issue a certificate of authority to a self-funded  
 9                    multiple employer welfare arrangement unless the arrangement establishes to the  
 10                    satisfaction of the director that

11                    (1) employers participating in the arrangement are members of a bona  
 12                    fide association or group of two or more businesses in the same or a closely related  
 13                    trade, profession, or industry that provide support, services, or supplies primarily to  
 14                    that trade, profession, or industry;

15                    (2) employers or employees participating in the arrangement exercise  
 16                    direct control over the arrangement; as described in this paragraph,

17                    (A) subject to (B) of this paragraph, direct control exists if the  
 18                    employers or employees participating in the arrangement have the right to elect  
 19                    at least 75 percent of the individuals designated in the arrangement's  
 20                    organizational documents as having control over the operations of the  
 21                    arrangement and the individuals designated in the arrangement's organizational  
 22                    documents in fact exercise control over the operation of the arrangement;

23                    (B) use of a third-party administrator to process claims and to  
 24                    assist in the administration of the arrangement is not evidence of the lack of  
 25                    exercise of control over the operations of the arrangement;

26                    (3) the arrangement is a nonprofit organization;

27                    (4) the arrangement provides only allowable benefits, except the  
 28                    arrangement may **also** provide

29                    (A) life or disability insurance coverage to its participants if  
 30                    the life or disability insurance coverage is provided under contracts with  
 31                    other insurers that comply with this title; or

1                                    **(B) limited short-term disability insurance coverage, if**  
2                                    **approved by the director;**

3                                    (5) the arrangement has adequate facilities and competent personnel, as  
4                                    determined by the director, to service the health benefit plan or has contracted with a  
5                                    third-party administrator licensed under AS 21.27 to service the health benefit plan;

6                                    (6) the arrangement provides allowable benefits to not less than two  
7                                    employers and not less than 75 employees;

8                                    (7) the arrangement does not solicit participation in the arrangement  
9                                    from the general public, except the arrangement may employ or independently  
10                                    contract with a licensed insurance producer who may be paid a commission or other  
11                                    remuneration to enroll employers in the arrangement;

12                                    (8) the arrangement is not organized or maintained solely as a conduit  
13                                    for the collection of premiums and the forwarding of premiums to an insurance  
14                                    company, except that the arrangement may act as a conduit for the collection and  
15                                    forwarding of premiums for life insurance coverage under (4) of this subsection;

16                                    (9) the arrangement

17                                    (A) has deposited \$200,000 with the director to be used for the  
18                                    payment of claims in the event the arrangement becomes insolvent and has  
19                                    submitted to the director a written plan of operation that, in the discretion of  
20                                    the director, ensures the financial integrity of the arrangement; and

21                                    (B) is able to remain financially solvent; the director may  
22                                    consider the following in determining the ability of the arrangement to remain  
23                                    financially solvent:

24                                    (i) pro forma financial statements;

25                                    (ii) types and levels of stop-loss insurance coverage,  
26                                    including attachment points of the coverage;

27                                    (iii) whether a deposit is required for each employee  
28                                    covered under the arrangement equal to at least one month's cost of  
29                                    providing benefits under the arrangement;

30                                    (iv) the experience of the individuals who will be  
31                                    involved in the management of the arrangement, including employees,

1 independent contractors, and consultants; and

2 (v) other factors the director considers relevant to  
3 determining the ability of the arrangement to remain financially  
4 solvent.

5 \* **Sec. 90.** AS 21.85.040 is amended to read:

6 **Sec. 21.85.040. Application for a certificate of authority.** To apply for an  
7 original certificate of authority, a self-funded multiple employer welfare arrangement  
8 shall file with the director its application, accompanied by the applicable fees set  
9 under AS 21.06.250, showing its name, the location of its home office, its date of  
10 organization, its state of domicile, and additional information that the director may  
11 reasonably require. The application shall be submitted together with

12 (1) a copy of all articles, bylaws, agreements, trusts, or other  
13 documents or instruments describing the rights and obligations of the employers,  
14 employees, and beneficiaries of the arrangement;

15 (2) a copy of each summary plan description of the arrangement filed  
16 or required to be filed with the United States Department of Labor, including any  
17 amendments to each description;

18 (3) evidence of coverage of or letter of intent to participate executed by  
19 at least two employers providing allowable benefits to at least 75 employees;

20 (4) a copy of the arrangement's most recent financial statement in  
21 compliance with AS 21.85.080 or, if the arrangement has been in existence for less  
22 than one year, pro forma financial statements, including a balance sheet, an income  
23 statement, a statement of changes in financial condition, and an actuarial opinion that  
24 the unpaid claim liability of the arrangement satisfies the standards in AS 21.18.080 -  
25 21.18.086;

26 (5) proof that the arrangement maintains and will continue to maintain  
27 fidelity bonds required by the United States Department of Labor under 29 U.S.C.  
28 1001 - 1461 (Employee Retirement Income Security Act of 1974);

29 (6) a copy of any stop-loss insurance policies maintained or proposed  
30 to be maintained by the arrangement;

31 (7) biographical reports, on forms prescribed by the National

1 Association of Insurance Commissioners, evidencing the general trustworthiness and  
 2 competence of each individual who is serving or who will serve as a managing  
 3 employee or fiduciary of the arrangement;

4 (8) a notarized statement executed by an officer of the arrangement  
 5 certifying, to the best knowledge and belief of the officer, that the information  
 6 provided in the application is true and correct and that the arrangement is in  
 7 compliance with the requirements in

8 (A) AS 21.85.020;

9 (B) 29 U.S.C. 1001 - 1461 (Employee Retirement Income  
 10 Security Act of 1974) or a statement of any requirements with which the  
 11 arrangement is not in compliance and a statement of proposed corrective  
 12 action; and

13 (C) AS 21.85.050;

14 (9) base contribution rates for participation under the arrangement for  
 15 its initial year of operations; **and**

16 **(10) for a foreign multiple employer welfare arrangement,**

17 **(A) a certificate of the public official having supervision of**  
 18 **insurance in its state or country of domicile or state of entry into the**  
 19 **United States, showing that it is authorized to transact the kinds of**  
 20 **insurance proposed to be transacted in this state or an affidavit attesting**  
 21 **to the reasons why a certificate is not available;**

22 **(B) a copy of the arrangement's most recent financial**  
 23 **statement filed with its state of domicile, if any, with an actuarial opinion**  
 24 **on reported unpaid claims;**

25 **(C) a copy of a management discussion and analysis filed**  
 26 **with its state of domicile, if any; and**

27 **(D) a copy of the report of last examination, if any, made of**  
 28 **the insurer, issued by the insurance supervisory official of its state of**  
 29 **domicile or state of entry into the United States.**

30 \* **Sec. 91.** AS 21.86 is amended by adding a new section to read:

31 **Sec. 21.86.045. Biographical affidavits.** A domestic health maintenance

1 organization shall file with the director a complete affidavit of biographical  
 2 information not later than 30 days after the appointment of an officer or member of the  
 3 governing body of the organization. If requested by the director, a foreign health  
 4 maintenance organization shall file with the director an affidavit of biographical  
 5 information for the appointment of an officer or member of the governing body of that  
 6 organization. A filing under this section must be on a form approved by the director. A  
 7 filing is not required if a biographical affidavit of the officer or director has been  
 8 submitted to the director within one year before the date of appointment. A  
 9 biographical affidavit filed under this section is confidential and not subject to public  
 10 inspection.

11 \* **Sec. 92.** AS 21.87.340 is amended to read:

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

- 18 (1) AS 21.03;  
 19 (2) AS 21.06;  
 20 (3) AS 21.07;  
 21 (4) AS 21.09, except AS 21.09.090;  
 22 (5) AS 21.18.010;  
 23 (6) AS 21.18.030;  
 24 (7) AS 21.18.040;  
 25 (8) AS 21.18.080 - 21.18.086;  
 26 (9) AS 21.36;  
 27 (10) AS 21.42.110, 21.42.345 - 21.42.395 [AS 21.42.345 - 21.42.395];  
 28 (11) AS 21.51.120 and 21.51.400;  
 29 (12) AS 21.51.405;  
 30 (13) AS 21.53;  
 31 (14) [(13)] AS 21.54;

1                    **(15)** [(14)] AS 21.56;

2                    **(16)** [(15)] AS 21.69.400;

3                    **(17)** [(16)] AS 21.69.520;

4                    **(18)** [(17)] AS 21.69.600, 21.69.620, and 21.69.630;

5                    **(19)** [(18)] AS 21.78;

6                    **(20)** [(19)] AS 21.96.060;

7                    **(21)** [(20)] AS 21.97.

8                    \* **Sec. 93.** AS 21.96.030 is amended to read:

9                                       **Sec. 21.96.030. Payment. Unless another form of payment is agreed to by**  
 10                    **the policy holder or beneficiary, an** [AN] insurance company doing business in this  
 11                    state may not pay a judgment or settlement of a claim in this state for a loss incurred in  
 12                    this state with an instrument other than a negotiable bank check payable on demand  
 13                    and bearing even date with the date of writing or by electronic funds transfer.

14                    \* **Sec. 94.** AS 21.07.040, 21.07.250(7), 21.07.250(8), 21.07.250(9); AS 21.27.020(e),  
 15                    21.27.025(b), 21.27.340, 21.27.900(13); AS 21.53.200(5); and AS 21.87.190(b) are repealed.

16                    \* **Sec. 95.** The uncodified law of the State of Alaska is amended by adding a new section to  
 17                    read:

18                                       **TRANSITION: LONG-TERM CARE INSURANCE LICENSEES COURSE**  
 19                    **REQUIREMENT.** A person licensed and selling, soliciting, or negotiating long-term care  
 20                    insurance on the effective date of this section may not continue to sell, solicit, or negotiate  
 21                    long-term care insurance beginning one year after the effective date of this section unless the  
 22                    person has successfully completed a one-time course, as required by AS 21.53.066, enacted  
 23                    by sec. 73 of this Act.

24                    \* **Sec. 96.** The uncodified law of the State of Alaska is amended by adding a new section to  
 25                    read:

26                                       **TRANSITION: REGULATION ADOPTION.** The director of insurance may adopt  
 27                    regulations necessary to implement the changes made by this Act. The regulations take effect  
 28                    under AS 44.62 (Administrative Procedure Act), but not before the effective date of the law  
 29                    implemented by the regulation.

30                    \* **Sec. 97.** The uncodified law of the State of Alaska is amended by adding a new section to  
 31                    read:

1 REVISOR'S INSTRUCTIONS. The revisor of statutes is instructed to change the  
2 following:

3 (1) the chapter heading of AS 21.07 from "Regulation of Managed Care  
4 Insurance Plans" to "Patient Protections under Health Care Insurance Policies";

5 (2) the catch line of AS 21.34.170 from "Monthly reports, summary of  
6 exported business" to "Quarterly reports, summary of exported business."

7 \* **Sec. 98.** Section 96 of this Act takes effect immediately under AS 01.10.070(c).

8 \* **Sec. 99.** Sections 46 - 58 of this Act take effect July 21, 2011.

9 \* **Sec. 100.** Sections 62 and 77 of this Act take effect January 1, 2012.

10 \* **Sec. 101.** Except as provided in secs. 98 - 100 of this Act, this Act takes effect July 1,  
11 2011.

*Adopted  
4/1/11*

27-LS0444\I  
Bailey  
4/1/11

**CS FOR HOUSE BILL NO. 164( )**

**IN THE LEGISLATURE OF THE STATE OF ALASKA**

**TWENTY-SEVENTH LEGISLATURE - FIRST SESSION**

**BY**

**Offered:**

**Referred:**

**Sponsor(s): HOUSE LABOR AND COMMERCE COMMITTEE**

**A BILL**

**FOR AN ACT ENTITLED**

1 **"An Act relating to health care insurance, exemption of certain insurers, reporting,**  
2 **notice, and record-keeping requirements for insurers, biographical affidavits,**  
3 **qualifications of alien insurers assuming ceded insurance, risk-based capital for**  
4 **insurers, insurance holding companies, licensing, federal requirements for nonadmitted**  
5 **insurers, surplus lines insurance, insurance fraud, life insurance policies and annuity**  
6 **contracts, rate filings by health care insurers, long-term care insurance, automobile**  
7 **service corporations, guaranty fund deposits of a title insurer, joint title plants, fraternal**  
8 **benefit societies, multiple employer welfare arrangements, hospital and medical service**  
9 **corporations, health maintenance organizations, and alternate forms of payment to**  
10 **policyholders; and providing for an effective date."**

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

12 **\* Section 1. AS 21.03.021 is amended by adding a new subsection to read:**

1 (f) If an insurer is not required to obtain a certificate of authority in this state  
2 under AS 21.09.020(5), the provisions of the title do not apply to policies or contracts  
3 issued by the insurer.

4 \* **Sec. 2.** AS 21.07.010 is amended to read:

5 **Sec. 21.07.010. Patient and health care provider protection.** (a) A contract  
6 between a participating health care provider and a **health care insurer** [MANAGED  
7 CARE ENTITY THAT OFFERS A MANAGED CARE PLAN] must contain a  
8 provision that

9 (1) provides for a reasonable mechanism to identify all medical care  
10 services to be provided by the **health care insurer** [MANAGED CARE ENTITY];

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

13 (3) clearly states all ways in which the contract between the health care  
14 provider and **health care insurer** [MANAGED CARE ENTITY] may be terminated;  
15 a provision that provides for discretionary termination by either party must apply  
16 equitably to both parties;

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

20 (A) for an initial meeting at which all parties are present or  
21 represented by individuals with authority regarding the matters in dispute; the  
22 meeting shall be held within 10 working days after the **health care insurer**  
23 [PLAN] receives written notice of the dispute or gives written notice to the  
24 provider, unless the parties otherwise agree in writing to a different schedule;

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

31 (C) that if, after a period of 60 days following commencement

1 of mediation, the parties are unable to resolve the dispute, either party may  
2 seek other relief allowed by law;

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

5 (5) states that a health care provider may not be penalized or the health  
6 care provider's contract terminated by the health care insurer [MANAGED CARE  
7 ENTITY] because the health care provider acts as an advocate for a covered person in  
8 seeking appropriate, medically necessary medical care services;

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

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

13 (b) A contract between a participating health care provider and a health care  
14 insurer [MANAGED CARE ENTITY] that offers a health care insurance policy  
15 [MANAGED CARE PLAN] may not contain a provision that

16 (1) has as its predominant purpose the creation of direct financial  
17 incentives to the health care provider for withholding covered medical care services  
18 that are medically necessary; nothing in this paragraph shall be construed to prohibit a  
19 contract between a participating health care provider and a health care insurer  
20 [MANAGED CARE ENTITY] from containing incentives for efficient management  
21 of the utilization and cost of covered medical care services;

22 (2) requires the provider to contract for all products that are currently  
23 offered or that may be offered in the future by the health care insurer [MANAGED  
24 CARE ENTITY]; or

25 (3) requires the health care provider to be compensated for medical  
26 care services performed at the same rate as the health care provider has contracted  
27 with another health care insurer [MANAGED CARE ENTITY].

28 (c) A health care insurer [MANAGED CARE ENTITY] may not enter into a  
29 contract with a health care provider that requires the provider to indemnify or hold  
30 harmless the health care insurer [MANAGED CARE ENTITY] for the acts or  
31 conduct of the health care insurer [MANAGED CARE ENTITY]. An

1 indemnification or hold harmless clause entered into in violation of this subsection is  
2 void.

3 \* **Sec. 3.** AS 21.07.020 is amended to read:

4 **Sec. 21.07.020. Required contract provisions for health care insurance**  
5 **policy [MANAGED CARE PLANS]. A health care insurance policy [MANAGED**  
6 **CARE PLAN] must contain**

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

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

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

17 (4) a provision that any utilization review decision

18 (A) must be made within 72 hours after receiving the request  
19 for preapproval for nonemergency situations; for emergency situations,  
20 utilization review decisions for care following emergency services must be  
21 made as soon as is practicable but in any event not later than 24 hours after  
22 receiving the request for preapproval or for coverage determination; and

23 (B) to deny, reduce, or terminate a health care benefit or to  
24 deny payment for a medical care service because that service is not medically  
25 necessary shall be made by an employee or agent of the health care insurer  
26 [MANAGED CARE ENTITY] who is a licensed health care provider;

27 (5) a provision that provides for an internal appeal mechanism for a  
28 covered person who disagrees with a utilization review decision made by a health  
29 care insurer [MANAGED CARE ENTITY]; except as provided under (6) of this  
30 section, this appeal mechanism must provide for a written decision

31 (A) from the health care insurer [MANAGED CARE

1 ENTITY] within 18 working days after the date written notice of an appeal is  
2 received; and

3 (B) on the appeal by an employee or agent of the health care  
4 insurer [MANAGED CARE ENTITY] who holds the same professional  
5 license as the health care provider who is treating the covered person;

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

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

14 (B) provide for a written decision on the appeal by an  
15 employee or agent of the health care insurer [MANAGED CARE ENTITY]  
16 who holds the same professional license as the health care provider who is  
17 treating the covered person;

18 (7) a provision that discloses the existence of the right to an external  
19 appeal of a utilization review decision made by a health care insurer [MANAGED  
20 CARE ENTITY]; the external appeal shall be [AS] conducted in accordance with  
21 AS 21.07.050;

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

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

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

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

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

1 including audiotape or braille information.

2 \* **Sec. 4.** AS 21.07.030(a) is amended to read:

3 (a) If a **health care insurer** [MANAGED CARE ENTITY] offers a **health**  
4 **care insurance policy** [MANAGED CARE PLAN] that provides for coverage of  
5 medical care services only if the services are furnished through a network of health  
6 care providers that have entered into a contract with the **health care insurer**  
7 [MANAGED CARE ENTITY], the **health care insurer** [MANAGED CARE  
8 ENTITY] shall also offer a non-network option to covered persons at initial  
9 enrollment, as provided under (c) of this section. The non-network option may require  
10 that a covered person pay a higher deductible, copayment, or premium for the plan if  
11 the higher deductible, copayment, or premium results from increased costs caused by  
12 the use of a non-network provider. [THE MANAGED CARE ENTITY SHALL  
13 PROVIDE AN ACTUARIAL DEMONSTRATION OF THE INCREASED COSTS  
14 TO THE DIRECTOR AT THE DIRECTOR'S REQUEST. IF THE INCREASED  
15 COSTS ARE NOT JUSTIFIED, THE DIRECTOR SHALL REQUIRE THE  
16 MANAGED CARE ENTITY TO RECALCULATE THE APPROPRIATE COSTS  
17 ALLOWED AND RESUBMIT THE APPROPRIATE DEDUCTIBLE,  
18 COPAYMENT, OR PREMIUM TO THE DIRECTOR.] This subsection does not  
19 apply to a covered person who is offered non-network coverage through another  
20 **health care insurance policy** [MANAGED CARE PLAN] or through another **health**  
21 **care insurer** [MANAGED CARE ENTITY].

22 \* **Sec. 5.** AS 21.07.030(b) is amended to read:

23 (b) The amount of any additional premium charged by the **health care**  
24 **insurer** [MANAGED CARE ENTITY] for the additional cost of the creation and  
25 maintenance of the option described in (a) of this section and the amount of any  
26 additional cost sharing imposed under this option shall be paid by the covered person  
27 unless it is paid by an employer or other person through agreement with the **health**  
28 **care insurer** [MANAGED CARE ENTITY].

29 \* **Sec. 6.** AS 21.07.030(c) is amended to read:

30 (c) A covered person may make a change to the medical care coverage option  
31 provided under this section only during a time period determined by the **health care**

1        **insurer** [MANAGED CARE ENTITY]. The time period described in this subsection  
2        must occur at least annually and last for at least 15 working days.

3        \* **Sec. 7.** AS 21.07.030(d) is amended to read:

4                (d) If a **health care insurer** [MANAGED CARE ENTITY] that offers a  
5        **health care insurance policy** [MANAGED CARE PLAN] requires or provides for a  
6        designation by a covered person of a participating primary care provider, the **health**  
7        **care insurer** [MANAGED CARE ENTITY] shall permit the covered person to  
8        designate any participating primary care provider that is available to accept the  
9        covered person.

10        \* **Sec. 8.** AS 21.07.030(e) is amended to read:

11                (e) Except as provided in this subsection, a **health care insurer** [MANAGED  
12        CARE ENTITY] that offers a **health care insurance policy** [MANAGED CARE  
13        PLAN] shall permit a covered person to receive medically necessary or appropriate  
14        specialty care, subject to appropriate referral procedures, from any qualified  
15        participating health care provider that is available to accept the individual for medical  
16        care. This subsection does not apply to specialty care if the **health care insurer**  
17        [MANAGED CARE ENTITY] clearly informs covered persons of the limitations on  
18        choice of participating health care providers with respect to medical care. In this  
19        subsection,

20                        (1) "appropriate referral procedures" means procedures for referring  
21        patients to other health care providers as set out in the applicable member **policy**  
22        [CONTRACT] and as described under (a) of this section;

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

25        \* **Sec. 9.** AS 21.07.030(f) is amended to read:

26                (f) If a contract between a health care provider and a **health care insurer**  
27        [MANAGED CARE ENTITY] is terminated, a covered person may continue to be  
28        treated by that health care provider as provided in this subsection. If a covered person  
29        is pregnant or being actively treated by a provider on the date of the termination of the  
30        contract between that provider and the **health care insurer** [MANAGED CARE  
31        ENTITY], the covered person may continue to receive medical care services from that

1 provider as provided in this subsection, and the contract between the health care  
2 insurer [MANAGED CARE ENTITY] and the provider shall remain in force with  
3 respect to the continuing treatment. The covered person shall be treated for the  
4 purposes of benefit determination or claim payment as if the provider were still under  
5 contract with the health care insurer [MANAGED CARE ENTITY]. However,  
6 treatment is required to continue only while the health care insurance policy  
7 [MANAGED CARE PLAN] remains in effect and

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

9 (A) the end of the current policy or plan year;

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

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

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

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

19 (a) A health care insurer [MANAGED CARE ENTITY] offering a health  
20 care insurance policy [MANAGED CARE PLAN] shall provide for an external  
21 appeal process that meets the requirements of this section in the case of an externally  
22 appealable decision for which a timely appeal is made in writing either by the health  
23 care insurer [MANAGED CARE ENTITY] or by the covered person.

24 \* **Sec. 11.** AS 21.07.050(b) is amended to read:

25 (b) A health care insurer [MANAGED CARE ENTITY] may condition the  
26 use of an external appeal process in the case of an externally appealable decision upon  
27 a final decision in an internal appeal under AS 21.07.020, but only if the decision is  
28 made in a timely basis consistent with the deadlines provided under this chapter.

29 \* **Sec. 12.** AS 21.07.050(c) is amended to read:

30 (c) Except as provided in this subsection, the external appeal process shall be  
31 conducted under a contract between the health care insurer [MANAGED CARE

1 ENTITY] and one or more external appeal agencies that are [HAVE] qualified under  
2 AS 21.07.060. The health care insurer [MANAGED CARE ENTITY] shall provide

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

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

8 (3) that all costs of the process, except those incurred by the covered  
9 person or treating professional in support of the appeal, shall be paid by the health  
10 care insurer [MANAGED CARE ENTITY] and not by the covered person.

11 \* **Sec. 13.** AS 21.07.050(d) is amended to read:

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

13 (1) a fair, de novo determination based on coverage provided by the  
14 policy [PLAN] and by applying terms as defined by the policy [PLAN]; however,  
15 nothing in this paragraph may be construed as providing for coverage of items and  
16 services for which benefits are excluded under the policy [PLAN] or coverage;

17 (2) an external appeal agency shall determine whether the health care  
18 insurer's [MANAGED CARE ENTITY'S] decision is

19 (A) in accordance with the medical needs of the patient  
20 involved, as determined by the health care insurer [MANAGED CARE  
21 ENTITY], taking into account, as of the time of the health care insurer's  
22 [MANAGED CARE ENTITY'S] decision, the patient's medical needs and any  
23 relevant and reliable evidence the agency obtains under (3) of this subsection;  
24 [.] and

25 (B) in accordance with the scope of the covered benefits under  
26 the policy [PLAN]; if the agency determines the decision complies with this  
27 paragraph, the agency shall affirm the decision, and, to the extent that the  
28 agency determines the decision is not in accordance with this paragraph, the  
29 agency shall reverse or modify the decision;

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

1 (A) the decision made by the health care insurer  
2 [MANAGED CARE ENTITY] upon internal appeal under AS 21.07.020 and  
3 any guidelines or standards used by the health care insurer [MANAGED  
4 CARE ENTITY] in reaching a decision;

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

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

9 (D) the health care insurance policy [MANAGED CARE  
10 PLAN];

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

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

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

19 (C) practice and treatment guidelines prepared or financed in  
20 whole or in part by government agencies;

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

22 (E) generally accepted principles of professional medical  
23 practice;

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

28 (G) to the extent that the agency determines them [IT] to be  
29 free of any conflict of interest, the results of peer reviews conducted by the  
30 health care insurer [MANAGED CARE ENTITY] involved;

31 (H) the community standard of care; and

- 1 (I) anomalous utilization patterns;
- 2 (5) an external appeal agency shall determine
- 3 (A) whether a denial of a claim for benefits is an externally
- 4 appealable decision;
- 5 (B) whether an externally appealable decision involves an
- 6 expedited appeal; and
- 7 (C) for purposes of initiating an external review, whether the
- 8 internal appeal process has been completed;
- 9 (6) a party to an externally appealable decision may submit evidence
- 10 related to the issues in dispute;
- 11 (7) the health care insurer [MANAGED CARE ENTITY] involved
- 12 shall provide the external appeal agency with access to information and to provisions
- 13 of the policy [PLAN OR HEALTH INSURANCE COVERAGE] relating to the
- 14 matter of the externally appealable decision, as determined by the external appeal
- 15 agency; and
- 16 (8) a determination by the external appeal agency on the decision must
- 17 (A) be made orally or in writing and, if it is made orally, shall
- 18 be supplied to the parties in writing as soon as possible;
- 19 (B) be made in accordance with the medical exigencies of the
- 20 case involved, but in no event later than 21 working days after the appeal is
- 21 filed, or, in the case of an expedited appeal, 72 hours after the time of
- 22 requesting an external appeal of the health care insurer's [MANAGED
- 23 CARE ENTITY'S] decision;
- 24 (C) state, in layperson's language, the basis for the
- 25 determination, including, if relevant, any basis in the terms or conditions of the
- 26 policy [PLAN OR COVERAGE]; and
- 27 (D) inform the covered person of the individual's rights,
- 28 including any time limits, to seek further review by the courts of the external
- 29 appeal determination.
- 30 \* **Sec. 14.** AS 21.07.050(e) is amended to read:
- 31 (e) If the external appeal agency reverses or modifies the denial of a claim for

1 benefits, the health care insurer [MANAGED CARE ENTITY] shall

2 (1) upon receipt of the determination, authorize benefits in accordance  
3 with that determination;

4 (2) take action as may be necessary to provide benefits, including  
5 items or services, in a timely manner consistent with the determination; and

6 (3) submit information to the external appeal agency documenting  
7 compliance with the agency's determination.

8 \* **Sec. 15.** AS 21.07.050(h) is amended to read:

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

10 (1) means

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

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

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

21 \* **Sec. 16.** AS 21.07.060 is amended to read:

22 **Sec. 21.07.060. Qualifications of external appeal agencies.** (a) An external  
23 appeal agency qualifies to consider external appeals if, with respect to a health care  
24 insurance policy [MANAGED CARE PLAN], the agency is certified by a qualified  
25 private standard-setting organization approved by the director or by a health insurer  
26 operating in this state as meeting the requirements imposed under (b) of this section.

27 (b) An external appeal agency is qualified to consider appeals of health care  
28 insurance policy [MANAGED CARE PLAN] health care decisions if the agency  
29 meets the following requirements:

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

31 (2) the agency conducts external appeal activities through a panel of

1 two clinical peers, unless otherwise agreed to by both parties; and

2 (3) the agency has sufficient medical, legal, and other expertise and  
3 sufficient staffing to conduct external appeal activities for the health care insurer  
4 [MANAGED CARE ENTITY] on a timely basis consistent with this chapter.

5 (c) A clinical peer or other entity meets the independence requirements of this  
6 section if

7 (1) the peer or entity does not have a familial, financial, or professional  
8 relationship with a related party;

9 (2) compensation received by a peer or entity in connection with the  
10 external review is reasonable and not contingent on any decision rendered by the peer  
11 or entity;

12 (3) the health care insurer has [PLAN AND THE ISSUER HAVE]  
13 no recourse against the peer or entity in connection with the external review; and

14 (4) the peer or entity does not otherwise have a conflict of interest with  
15 a related party.

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

17 (1) a health care insurer or, with respect to group health care  
18 insurance, a plan sponsor, including any officer, director, management employee,  
19 or fiduciary of the health care insurer or the plan sponsor [WITH RESPECT TO

20 (A) A MANAGED CARE PLAN, THE PLAN OR THE  
21 INSURER OFFERING THE COVERAGE; OR

22 (B) INDIVIDUAL HEALTH INSURANCE COVERAGE,  
23 THE INSURER OFFERING THE COVERAGE, OR ANY PLAN SPONSOR,  
24 FIDUCIARY, OFFICER, DIRECTOR, OR MANAGEMENT EMPLOYEE  
25 OF THE PLAN OR ISSUER];

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

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

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

1 (5) the covered person; or

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

5 \* **Sec. 17.** AS 21.07.070 is amended to read:

6 **Sec. 21.07.070. Limitation on liability of reviewers.** An external appeal  
7 agency qualifying under AS 21.07.060 and having a contract with a **health care**  
8 **insurer** [MANAGED CARE ENTITY], and a person who is employed by the agency  
9 or who furnishes professional services to the agency, may not be held by reason of the  
10 performance of any duty, function, or activity required or authorized under this  
11 chapter to have violated any criminal law, or to be civilly liable if due care was  
12 exercised in the performance of the duty, function, or activity and there was no actual  
13 malice or gross misconduct in the performance of the duty, function, or activity.

14 \* **Sec. 18.** AS 21.07.080 is amended to read:

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

17 (1) restrict or limit the right of a **health care insurer** [MANAGED  
18 CARE ENTITY] to include services provided by a religious nonmedical provider as  
19 medical care services covered by the **health care insurance policy** [MANAGED  
20 CARE PLAN];

21 (2) require a **health care insurer** [MANAGED CARE ENTITY],  
22 when determining coverage for services provided by a religious nonmedical provider,  
23 to

24 (A) apply medically based eligibility standards;

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

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

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

31 (3) require a **health care insurance policy** [MANAGED CARE

1 PLAN] to exclude coverage for services provided by a religious nonmedical provider  
2 because the religious nonmedical provider is not providing medical or other data  
3 required from a health care provider if the medical or other data is inconsistent with  
4 the religious nonmedical treatment or nursing care being provided.

5 \* **Sec. 19.** AS 21.07.250(12) is amended to read:

6 (12) "participating health care provider" means a health care provider  
7 who has entered into an agreement with a **health care insurer** [MANAGED CARE  
8 ENTITY] to provide services or supplies to a patient covered by a **health care**  
9 **insurance policy** [MANAGED CARE PLAN];

10 \* **Sec. 20.** AS 21.07.250(16) is amended to read:

11 (16) "utilization review" means a system of reviewing the medical  
12 necessity, appropriateness, or quality of medical care services and supplies provided  
13 under a **health care insurance policy** [MANAGED CARE PLAN] using specified  
14 guidelines, including preadmission certification, the application of practice guidelines,  
15 continued stay review, discharge planning, preauthorization of ambulatory procedures,  
16 and retrospective review.

17 \* **Sec. 21.** AS 21.07.250 is amended by adding a new paragraph to read:

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

19 \* **Sec. 22.** AS 21.09.020 is amended to read:

20 **Sec. 21.09.020. Exception from [EXCEPTIONS,] certificate of authority**  
21 **requirement.** A certificate of authority is not required of an insurer, not otherwise  
22 authorized in this state, **with** [IN] regard to

23 (1) transactions relative to its policies lawfully written in the state, or  
24 liquidation of assets and liabilities of the insurer, ~~[( ) other than collection of new~~  
25 ~~premiums, ( )~~, ALL AS] resulting from its former authorized operations in the state;

26 (2) related transactions subsequent to issuance of a policy covering  
27 only subjects of insurance not resident, located, or expressly to be performed in the  
28 state at time of issuance, and which coverage was lawfully solicited, written, and  
29 delivered outside the state;

30 (3) transactions under surplus lines coverages lawfully written under  
31 AS 21.34; [OR]

1 (4) reinsurance, except as to domestic reinsurers; or

2 (5) transactions relative to policies issued in another state, but only

3 if

4 (A) the insurer does not market insurance in this state;

5 (B) the laws of the state of issue apply to this state's  
6 residents covered under the policies; and

7 (C) the insurer complies with other requirements the  
8 director adopts by regulation to qualify for an exception under this  
9 paragraph.

10 \* **Sec. 23.** AS 21.09.200(e) is amended to read:

11 (e) An insurer shall pay to the division \$100 for each day the insurer fails to  
12 file a [THE ANNUAL] statement or report in the form and location required and  
13 within the time established in [(a) OF] this section. The authority of the insurer to  
14 enter into new obligations or issue new or renewal policies of insurance in this state  
15 may be suspended by the director if a statement or report required by this section  
16 [THE ANNUAL STATEMENT] has not been filed by the due date [MARCH 1].

17 \* **Sec. 24.** AS 21.09.245(b) is amended to read:

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

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

23 **Sec. 21.09.247. Biographical affidavits.** A domestic insurer shall file with the  
24 director a complete affidavit of biographical information not later than 30 days after  
25 the appointment of an officer or director of the insurer. If requested by the director, a  
26 foreign insurer shall file with the director an affidavit of biographical information for  
27 the appointment of an officer or director of the insurer. A filing under this section  
28 must be on a form approved by the director. A filing is not required if a biographical  
29 affidavit of the officer or director has been submitted to the director within one year  
30 before the date of appointment. A biographical affidavit filed under this section is  
31 confidential and not subject to public inspection.

1 \* **Sec. 26.** AS 21.09.320 is amended to read:

2 **Sec. 21.09.320. Maintenance of records.** (a) A foreign [AN] insurer  
3 [DOMICILED IN A JURISDICTION OTHER THAN THIS STATE] shall keep at its  
4 principal place of business a complete record of its assets, transactions, and affairs in  
5 accordance with the methods and systems that are customary or suitable to the kind of  
6 business [INSURANCE] transacted.

7 (b) To meet the requirements of (a) of this section, the insurer shall keep the  
8 records as required [SPECIFIED] in AS 21.69.390(d) [FOR FIVE YEARS FROM  
9 THE DATE THE RECORD WAS CREATED] or as required by the record  
10 maintenance requirements of the insurer's domicile jurisdiction, whichever is longer.

11 \* **Sec. 27.** AS 21.12.020(a) is amended to read:

12 (a) Credit for reinsurance transactions shall be allowed a domestic ceding  
13 insurer as either an asset or a deduction from liability on account of reinsurance ceded  
14 only with respect to cessions of a kind or class of business that the assuming insurer is  
15 licensed or permitted to write or assume in its state of domicile or, in the case of a  
16 United States branch of an alien assuming insurer, in the state through which it is  
17 entered and licensed to transact insurance or reinsurance and only if the reinsurance is  
18 ceded to an

19 (1) assuming insurer that is licensed to transact insurance or  
20 reinsurance in this state;

21 (2) assuming insurer that is accredited as a reinsurer in this state; an  
22 accredited reinsurer is one that

23 (A) files evidence of submission to this state's jurisdiction,  
24 submits to this state's authority to examine its books and records under  
25 AS 21.06.120, is licensed to transact insurance or reinsurance in at least one  
26 state that is accredited by the National Association of Insurance  
27 Commissioners, or, in the case of a United States branch of an alien admitted  
28 insurer, is entered through and licensed to transact insurance or reinsurance in  
29 at least one state that is accredited by the National Association of Insurance  
30 Commissioners;

31 (B) maintains at least \$20,000,000 in policyholder surplus and

1           whose accreditation has not been denied by the director within 90 days after  
2           application to the director, or maintains less than \$20,000,000 in policyholder  
3           surplus and whose application for accreditation has been approved by the  
4           director; and

5                       (C) files annually with the director a copy of the reinsurer's  
6           annual financial statement filed with the insurance department of the  
7           reinsurer's state of domicile or state of entry and a copy of the reinsurer's most  
8           recent audited financial statement;

9                       (3) assuming insurer that is domiciled in a state, or, in the case of a  
10          United States branch of an alien assuming insurer, is entered through a state accredited  
11          by the National Association of Insurance Commissioners that employs standards  
12          regarding credit for reinsurance ceded substantially similar to those applicable under  
13          (1) and (2) of this subsection, the assuming insurer maintains a policyholder surplus of  
14          at least \$20,000,000, and the assuming insurer submits to the authority of this state to  
15          examine its books and records; the surplus requirements in this paragraph do not apply  
16          to reinsurance ceded and assumed under a pooling arrangement among insurers in the  
17          same holding company system;

18                      (4) assuming alien insurer that

19                               (A) maintains a trust fund in a qualified United States financial  
20          institution for the payment of the valid claims of its United States domiciled  
21          [POLICYHOLDERS AND] ceding insurers, and their assigns and successors  
22          in interest, that conforms to the following requirements:

23                                       (i) the trust and each amendment to the trust shall be  
24          established in a form approved by the insurance supervisory official of  
25          the state where the trust is domiciled or the insurance supervisory  
26          official of another state who, under the terms of the trust instrument,  
27          has accepted responsibility for regulatory oversight of the trust; the  
28          form of the trust and each trust amendment shall be filed with the  
29          insurance supervisory official of every state in which the beneficiaries  
30          of the trust are domiciled; the trust instrument must provide that  
31          contested claims are valid and enforceable upon the final order of any

1 court of competent jurisdiction in the United States; the trust shall vest  
2 legal title to its assets in the trustees of the trust for its United States  
3 **domiciled** [POLICYHOLDERS AND] ceding insurers, their assigns,  
4 and successors in interest; the trust and the assuming insurer are subject  
5 to examination as determined by the director, and the assuming insurer  
6 shall submit to examination of its books and records by the director and  
7 bear the expense of examination; the trust must remain in effect for so  
8 long as the assuming insurer has outstanding liabilities due under the  
9 reinsurance agreements subject to the trust;

10 (ii) on or before March 1 of each year, the trustees shall  
11 report in writing to the director on the balance of the trust and list the  
12 trust's investments at the end of the preceding year, and shall certify the  
13 date of termination of the trust, if so planned, or certify that the trust  
14 does not expire before the following December 31;

15 (iii) in the case of a single assuming insurer, the trust  
16 shall consist of trust **assets not less than** [MONEY REPRESENTING]  
17 the assuming insurer's liabilities attributable to **reinsurance ceded by**  
18 [BUSINESS WRITTEN IN] the United States **domiciled ceding**  
19 **insurers** and, in addition, include a trust surplus of not less than  
20 \$20,000,000 **for the benefit of the United States domiciled ceding**  
21 **insurers as additional security for the liabilities covered by the**  
22 **trust**; the single assuming insurer shall make available to the director  
23 an annual certification of the insurer's solvency by an independent  
24 certified public accountant or an accountant holding a substantially  
25 equivalent designation as determined by the director;

26 (iv) in the case of a group, including incorporated and  
27 individual unincorporated insurers, the trust shall consist of trust **assets**  
28 [MONEY] representing the group's liabilities attributable to business  
29 ceded by [THE] United States domiciled ceding insurers and, in  
30 addition, include a trust surplus not less than \$100,000,000 held jointly  
31 for the benefit of the United States domiciled ceding insurers **of** [OR]

1 any member of the group for all years of account as additional  
2 security for the group's liabilities covered by the trust; the  
3 incorporated members of the group may not be engaged in any business  
4 other than underwriting as a member of the group and are subject to the  
5 same level of solvency regulation and control by the group's  
6 domiciliary regulator as are the unincorporated members; within 90  
7 days after its financial statements are due to be filed with the group's  
8 domiciliary regulator, the group shall make available to the director an  
9 annual certification of the solvency of each insurer by the group's  
10 domiciliary regulator or, if the certification is unavailable, financial  
11 statements, prepared by an independent certified public accountant, or  
12 an accountant holding a substantially equivalent designation as  
13 determined by the director, for each underwriter member of the group;

14 (v) in the case of a group of incorporated insurers under  
15 common administration that complies with the reporting requirements  
16 contained in (ii) of this subparagraph, that has continuously transacted  
17 an insurance business outside the United States for at least three years  
18 immediately before making application for accreditation, that submits  
19 to this state's authority to examine its books and records and bears the  
20 expense of the examination, and that has aggregate policyholders'  
21 surplus of \$10,000,000,000, the trust shall consist of trust assets [BE]  
22 in an amount not less than [EQUAL TO] the group's several liabilities  
23 attributable to business ceded by United States domiciled ceding  
24 insurers to a member of the group under reinsurance contracts issued in  
25 the name of the group, and the group shall maintain a joint trustee  
26 surplus, of which \$100,000,000 shall be held jointly for the benefit of  
27 United States domiciled ceding insurers of a member of the group as  
28 additional security for the group's liabilities covered by the trust, and,  
29 within 90 days after its financial statements are due to be filed with the  
30 group's domiciliary regulator, each member of the group shall make  
31 available to the director an annual certification of the underwriter

1 member's solvency by the member's domiciliary regulator and financial  
2 statement of each underwriter member prepared by its independent  
3 certified public accountant, or an accountant holding a substantially  
4 equivalent designation as determined by the director; and

5 (B) reports annually to the director information substantially  
6 the same as that required to be reported on the National Association of  
7 Insurance Commissioners' annual statement form by licensed insurers to  
8 enable the director to determine the sufficiency of the trust fund;

9 (5) assuming insurer that does not meet the requirements of (1) - (4) of  
10 this subsection, but only with respect to the insurance of risks located in jurisdictions  
11 where the reinsurance is required by applicable law or regulation of that jurisdiction.

12 \* **Sec. 28.** AS 21.12.050(b) is amended to read:

13 (b) Health care insurance means that part of health insurance that provides,  
14 delivers, arranges for, pays for, or reimburses any of the costs of [BENEFITS  
15 FOR] medical care [WHETHER PROVIDED DIRECTLY, THROUGH  
16 REIMBURSEMENT, OR OTHER METHOD].

17 \* **Sec. 29.** AS 21.14.200(4) is amended to read:

18 (4) "company action level event" means a report, an adjusted report  
19 that has not been challenged, or an adjusted report for which a challenge has been  
20 rejected [,] that is filed under AS 21.14.010 and that indicates that

21 (A) an insurer's total adjusted capital is greater than or equal to  
22 its regulatory action level risk based capital but is less than its company action  
23 level risk based capital; [OR]

24 (B) if a life and health insurer, the insurer has total adjusted  
25 capital that is greater than or equal to the insurer's company action level risk  
26 based capital but is less than 250 percent of the insurer's authorized control  
27 level risk based capital and that has a negative trend; or

28 (C) if a property and casualty insurer or health  
29 organization, the insurer or organization has total adjusted capital that is  
30 greater than or equal to the company action level risk based capital but is  
31 less than 300 percent of its authorized control level risk based capital and

1 **that has a negative trend:**

2 \* **Sec. 30.** AS 21.14.200(9) is amended to read:

3 (9) "life and health insurer"

4 (A) means an insurer who transacts life insurance as defined in  
5 AS 21.12.040 or health insurance as defined in AS 21.12.050 **and who filed**  
6 **with the director the National Association of Insurance Commissioners**  
7 **Life Risk-Based Capital Report;**

8 (B) does not include a benevolent association under AS 21.72,  
9 a fraternal benefit society under AS 21.84, a health maintenance organization  
10 under AS 21.86, or a hospital or medical service corporation under AS 21.87;

11 \* **Sec. 31.** AS 21.14.200(12) is amended to read:

12 (12) "negative trend" for a life and health insurer, **a property and**  
13 **casualty insurer, and a health organization** means a negative trend over a period of  
14 time, as determined by the "trend test calculation" in the risk based capital  
15 instructions;

16 \* **Sec. 32.** AS 21.14.200(13) is amended to read:

17 (13) "property and casualty insurer" means an insurer who transacts  
18 health insurance as defined in AS 21.12.050, property insurance as defined in  
19 AS 21.12.060, casualty insurance as defined in AS 21.12.070, surety insurance as  
20 defined in AS 21.12.080, marine or wet marine and transportation insurance as defined  
21 in AS 21.12.090, or mortgage guaranty insurance as defined in AS 21.12.110 **and who**  
22 **filed with the director the National Association of Insurance Commissioners**  
23 **Property and Casualty Risk-Based Capital Report;**

24 \* **Sec. 33.** AS 21.14.200 is amended by adding a new paragraph to read:

25 (21) "health organization" means a health maintenance organization,  
26 limited health service organization, dental or vision plan, hospital, medical and dental  
27 indemnity or service corporation, or other managed care organization holding a  
28 certificate of authority under AS 21.86 or AS 21.87, or a company that writes  
29 primarily health insurance as defined in AS 21.12.050 and filed with the director the  
30 National Association of Insurance Commissioners Health Risk-Based Capital Report.

31 \* **Sec. 34.** AS 21.22.060(k) is amended to read:

1 (k) An insurer subject to registration under (a) of this section shall register  
2 annually by May 1 [APRIL 1] of each year for the previous calendar year unless, for  
3 good cause shown, the director extends the time for registration. The director may  
4 require an insurer that is allowed to register as provided under (c) of this section [,] to  
5 furnish a copy of

6 (1) the registration statement;

7 (2) the summary specified in (l) of this section; or

8 (3) other information filed by the insurer with the insurance regulatory  
9 authority of the insurer's state of domicile.

10 \* **Sec. 35.** AS 21.27.020(b) is amended to read:

11 (b) To qualify for issuance or renewal of an individual [OR INDIVIDUAL IN  
12 THE FIRM] license, an applicant or licensee shall comply with this title and  
13 regulations adopted under AS 21.06.090 and

14 (1) shall be 18 years of age or older;

15 (2) if for a resident license, shall be a bona fide resident before  
16 issuance of the license and actually reside in the state;

17 (3) shall successfully pass an examination required under  
18 AS 21.27.060;

19 (4) shall be a trustworthy person;

20 (5) may not use or intend to use the license for the purpose principally  
21 of writing controlled business, as defined in AS 21.27.030;

22 (6) may not have committed an act that is a cause for denial,  
23 nonrenewal, suspension, or revocation of a license in this state or another jurisdiction.

24 \* **Sec. 36.** AS 21.27.020(c) is amended to read:

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

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

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

1 (3) designate one or more compliance officers for the firm;

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

4 (5) notify the director, in writing, within 30 days of a change in the  
5 firm's compliance officer [OR OF THE TERMINATION OF EMPLOYMENT OF  
6 AN INDIVIDUAL IN THE FIRM LICENSEE].

7 \* **Sec. 37.** AS 21.27.025 is repealed and reenacted to read:

8 **Sec. 21.27.025. Required notice of licensee.** (a) A licensee shall notify the  
9 director in writing within 30 days after a change in residence, place of business, legal  
10 name, fictitious name or alias, mailing address, electronic mailing address, or  
11 telephone number. A licensee shall report to the director in writing any administrative  
12 action taken against the licensee by a governmental agency of another state or by a  
13 governmental agency of another jurisdiction within 30 days after the final disposition  
14 of the action. A licensee shall submit to the director the final order and other relevant  
15 legal documents in the action. A licensee shall report to the director any criminal  
16 prosecution of the licensee in this or another state or jurisdiction within 30 days after  
17 the date of filing of the criminal complaint, indictment, information, or citation in the  
18 prosecution. The licensee shall submit to the director a copy of the criminal complaint,  
19 calendaring order, and other relevant legal documents in the prosecution.

20 (b) In addition to any other penalty provided by law, a failure to notify the  
21 director as required by this section is cause for denial, nonrenewal, suspension, or  
22 revocation of a license.

23 \* **Sec. 38.** AS 21.27.040(e) is amended to read:

24 (e) As part of the application required by (a) of this section, a resident [AN]  
25 applicant shall furnish to the director a full set of fingerprints and the fees required by  
26 the Department of Public Safety under AS 12.62.160 for criminal justice information  
27 and a national criminal history record check so that the director may obtain criminal  
28 justice information as provided under AS 12.62 about the applicant. The director shall  
29 submit the completed fingerprint card and fees to the Department of Public Safety for  
30 a report of criminal justice information under AS 12.62 and a national criminal history  
31 record check under AS 12.62.400.

1 \* **Sec. 39.** AS 21.27.100(c) is amended to read:

2 (c) An individual who has entered into an employment contract with a  
3 licensed [IN A FIRM WHO ACTS SOLELY ON BEHALF OF A] firm that is  
4 appointed as an agent or a managing general agent on behalf of an admitted insurer  
5 under this section may not be required to also have an appointment under this section  
6 if the individual has entered into an employment contract [IN THE FIRM IS  
7 LICENSED] with that firm for a specific class of authority.

8 \* **Sec. 40.** AS 21.27.140(b) is amended to read:

9 (b) A firm may not be licensed as an insurance producer, managing general  
10 agent, reinsurance intermediary broker, reinsurance intermediary manager, surplus  
11 lines broker, or independent adjuster, or transact insurance unless each individual  
12 employed by the firm as an insurance producer, managing general agent, surplus lines  
13 broker, trainee independent adjuster, or independent adjuster [BY THE FIRM] is  
14 licensed and has entered into an employment contract with the firm [AS AN  
15 INDIVIDUAL IN THE FIRM].

16 \* **Sec. 41.** AS 21.27 is amended by adding a new section to read:

17 **Sec. 21.27.215. Employment contracts.** (a) A firm may enter into an  
18 employment contract with a licensed individual to conduct business under the  
19 supervision of and in the name of the firm. The employment contract must be in  
20 writing and must specify the lines and classes of authorities of the individual and the  
21 firm. The individual and the firm shall retain a copy of the contract and shall reply in  
22 writing within three working days to an inquiry of the director regarding any business  
23 transacted by the individual and the firm.

24 (b) The firm shall examine the credentials of the individual to determine that  
25 the individual is licensed to conduct the kinds of business described in the contract.

26 (c) A licensed individual may, if authorized by the firm and an insurer for  
27 which the firm is an agent, issue on the firm's behalf contracts of insurance in  
28 accordance with a written agency employment contract.

29 (d) A firm shall be responsible for the actions of an individual transacting  
30 insurance under the firm's employment contracts. In any disciplinary proceeding under  
31 this title, the existence of the employment contract shall be prima facie evidence that

1 the firm knew of the activities of the individual.

2 (e) The individual and the firm shall maintain a current list of all of their  
3 respective contracts that identifies, for each contract, the parties to the contract, the  
4 parties' mailing addresses, electronic mailing addresses, and telephone numbers, and  
5 the parties' license numbers, and the effective and termination dates of employment.

6 (f) A licensee shall retain the records of an employment contract and make the  
7 records available for examination and inspection by the director, at any business time  
8 during the five years immediately following the date of the termination of the  
9 employment contract unless the director orders a longer period of retention. If the  
10 licensee assumes the business of another licensee or former licensee by merger,  
11 purchase, or otherwise, the requirements of AS 21.27.350(c) apply.

12 \* **Sec. 42.** AS 21.27.350(e) is amended to read:

13 (e) A licensee shall reply in writing within 10 working days to a records  
14 inquiry of the director. The director may inspect or request summary or detailed copies  
15 of records for examination by the division. Accounting and financial records inspected  
16 or examined under this section are confidential when in the possession of the division,  
17 but may be used by the director in a proceeding against the licensee. For purposes of  
18 this section, the records of a firm shall include and be considered the records of an  
19 individual licensee who has entered into an employment contract with the firm  
20 [ACTING ON BEHALF OF THE FIRM].

21 \* **Sec. 43.** AS 21.27.360(f) is amended to read:

22 (f) This section does not apply to an individual licensee who has entered into  
23 an employment contract with a [IN THE] firm and who acts solely on behalf of a  
24 firm that maintains compliance with this section.

25 \* **Sec. 44.** AS 21.27.790 is amended to read:

26 **Sec. 21.27.790. Surplus lines broker qualifications.** In addition to the general  
27 qualifications under AS 21.27.020, to qualify for issuance or for renewal of a resident  
28 surplus lines broker license, an applicant or licensee shall

29 (1) be licensed as either an insurance producer or managing general  
30 agent for property and casualty lines of authority;

31 (2) if required by the director by regulation, maintain a bond as

1 described in AS 21.27.190 in an amount acceptable to the director that requires the  
2 surplus lines broker to conduct business under this title, promptly remit the taxes and  
3 fees required by law, return premiums promptly when due, and pay proper losses  
4 promptly;

5 (3) if the director requires, maintain an errors and omissions insurance  
6 policy acceptable to the director.

7 \* **Sec. 45.** AS 21.27.900(22) is amended to read:

8 (22) "resident" means

9 (A) for an individual [OR AN INDIVIDUAL IN THE FIRM],  
10 a natural person who is domiciled in this state, whose principal place of  
11 business is in this state, who has a present intent to remain in this state while  
12 licensed, and who manifests that intent by establishing an ongoing physical  
13 presence in this state;

14 (B) for a firm, a person whose principal place of business is in  
15 this state;

16 \* **Sec. 46.** AS 21.33.055(a) is repealed and reenacted to read:

17 (a) Except as to premiums on lawfully procured surplus lines insurance  
18 exported under AS 21.34 and premiums on independently procured insurance on  
19 which a tax has been paid under AS 21.33.061, every nonadmitted insurer shall pay to  
20 the director, on or before March 1 following the calendar year in which the insurance  
21 was procured, continued, or renewed, a premium-receipts tax of 3.7 percent of gross  
22 premiums written for the insurance other than wet marine and transportation insurance  
23 and a premium-receipts tax of three-fourths of one percent of gross premiums charged  
24 for the wet marine and transportation insurance if the insured's home state is this state.  
25 If the insurance covers properties, risks, or exposures located or to be performed both  
26 in and out of this state, the tax payable shall be computed based on an amount equal to  
27 that portion of the gross premiums allocated under (b) of this section to this state, plus  
28 an amount equal to the portion of the premiums allocated under (b) of this section to  
29 other properties, risks, or exposures located or to be performed outside of this state.  
30 The insurance on subjects resident, located, or to be performed in this state procured  
31 through negotiations or an application, in whole or in part occurring or made in or

1 from in or out of this state, or for which premiums in whole or in part are remitted  
2 directly or indirectly from in or out of this state, shall be considered to be insurance  
3 procured or continued or renewed in this state. The tax paid by the insurer under this  
4 section is in lieu of all insurer taxes and fire department dues. In this subsection,  
5 "premium" includes all premiums, membership fees, assessments, dues, and any other  
6 consideration for insurance.

7 \* **Sec. 47.** AS 21.33.055 is amended by adding a new subsection to read:

8 (d) On default of a nonadmitted insurer in the payment of the tax, the insured  
9 shall pay the tax within 30 days after written notice from the director of the default by  
10 the nonadmitted insurer. If the tax prescribed by this section is not paid by the  
11 nonadmitted insurer within the time stated or by the insured within the time stated  
12 after notice of default by the nonadmitted insurer, the tax may be increased by

13 (1) a late payment fee of \$1,000 or 10 percent of the tax due,  
14 whichever is greater;

15 (2) interest at the rate of one percent a month or part of a month from  
16 the date the payment was originally due to the date paid; and

17 (3) a penalty not to exceed \$100 a day or 25 percent of the tax due,  
18 whichever is greater, from the date the payment was due to the date paid.

19 \* **Sec. 48.** AS 21.33.061(c) is repealed and reenacted to read:

20 (c) If the insured's home state is this state, the insured shall pay to the director,  
21 on or before March 1 following the calendar year in which the insurance was  
22 procured, continued, or renewed, a tax of 3.7 percent of the gross premiums paid for  
23 the insurance other than wet marine and transportation insurance, less any return  
24 premiums. For wet marine and transportation insurance, if the insured's home state is  
25 this state, the insured shall pay to the director a tax of three-fourths of one percent of  
26 the gross premiums paid for the wet marine and transportation insurance. If the  
27 insurance covers properties, risks, or exposures located or to be performed both in and  
28 out of this state, the tax payable shall be computed based on an amount equal to that  
29 portion of the gross premiums allocated under (d) of this section to this state, plus an  
30 amount equal to the portion of the premiums allocated under (d) of this section to  
31 other properties, risks, or exposures located or to be performed outside of this state. In

1 the event of cancellation and rewriting of the insurance contract, the additional  
2 premium for tax purposes is the premium in excess of the unearned premium of the  
3 cancelled insurance contract. In this subsection, "premium" includes all premiums,  
4 membership fees, assessments, dues, and any other consideration for insurance.

5 \* **Sec. 49.** AS 21.33.061 is amended by adding a new subsection to read:

6 (j) If the tax payable under (c) of this section is not paid within the time stated,  
7 the tax may be increased by

8 (1) a late payment fee of \$1,000 or 10 percent of the tax due,  
9 whichever is greater;

10 (2) interest at the rate of one percent a month or part of a month from  
11 the date the payment was due to the date paid; and

12 (3) a penalty not to exceed \$100 a day or 25 percent of the tax due,  
13 whichever is greater, from the date the payment was due to the date paid.

14 \* **Sec. 50.** AS 21.33 is amended by adding a new section to read:

15 **Sec. 21.33.063. Agreements with other states.** The director is authorized to  
16 participate in an agreement with another state for the purposes of collecting and  
17 disbursing to the other state any premium tax collected under this chapter and payable  
18 to the other state and for receiving from the other state premium tax it has collected  
19 and is owed to this state. To the extent that another state where a portion of the  
20 properties, risks, or exposures reside has failed to enter into an agreement with this  
21 state, the director shall retain all of the net premium tax collected by this state.

22 \* **Sec. 51.** AS 21.34.020(b) is repealed and reenacted to read:

23 (b) If a policyholder meets the standards of an exempt commercial purchaser  
24 under this title and regulations adopted by the director, insurance may be procured  
25 from a surplus lines broker without complying with (a)(2), (3), and (4) of this section  
26 if

27 (1) the broker procuring or placing the surplus lines insurance has  
28 disclosed to the exempt commercial purchaser that the insurance may or may not be  
29 available from the admitted market that may provide greater protection with more  
30 regulatory oversight; and

31 (2) the exempt commercial purchaser has subsequently requested in

1 writing that the broker procure or place the insurance from a nonadmitted insurer.

2 \* **Sec. 52.** AS 21.34.040(c) is amended to read:

3 (c) A nonadmitted insurer may be eligible to provide coverage in this state if it  
4 qualifies under one of the following:

5 (1) a foreign but nonalien stock insurer may qualify under this  
6 subsection if it has the minimum unimpaired basic capital and additional surplus equal  
7 to that required in its domiciliary jurisdiction, or maintains [\$10,000,000 AS OF  
8 DECEMBER 31, 1991, \$12,500,000 AS OF DECEMBER 31, 1992, AND]  
9 \$15,000,000 [AS OF DECEMBER 31, 1993], whichever is greater;

10 (2) a foreign but nonalien mutual insurer, a reciprocal insurer, or a  
11 mutual protection and indemnity association may qualify under this subsection if it has  
12 the minimum unimpaired basic surplus and additional surplus equal to that required in  
13 its domiciliary jurisdiction or maintains [\$10,000,000 AS OF DECEMBER 31, 1991,  
14 \$12,500,000 AS OF DECEMBER 31, 1992, AND] \$15,000,000 [AS OF  
15 DECEMBER 31, 1993], whichever is greater;

16 (3) an alien insurer other than an alien mutual protection and  
17 indemnity association may qualify under this subsection if it meets the minimum  
18 requirements in (1) or (2) of this subsection and maintains in the United States an  
19 irrevocable trust fund in an amount not less than \$2,500,000 in a solvent federally  
20 insured bank acceptable to the director, as security to the full amount, for the  
21 protection of all its policyholders and creditors of each member of the mutual insurer,  
22 reciprocal insurer, or mutual protection and indemnity association in the United States;  
23 the trust fund must consist of instruments of substantially the same character and  
24 quality as those that are eligible investments for the capital and statutory reserves of  
25 admitted insurers authorized to write like kinds of insurance in this state or of  
26 irrevocable, clean, and unconditional letters of credit; the trust fund must have an  
27 expiration date that at no time is less than five years;

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

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

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

19 (6) an alien mutual protection and indemnity association may qualify  
20 under this subsection if it has the minimum unimpaired basic capital and additional  
21 surplus equal to that required in its domiciliary jurisdiction or \$10,000,000, whichever  
22 is greater, and maintains in the United States an irrevocable trust fund in an amount  
23 not less than \$1,000,000 in a federally insured bank acceptable to the director, as  
24 security to the full amount, for the protection of all its policyholders and creditors or  
25 each member of the mutual protection and indemnity association in the United States;  
26 the trust fund must consist of instruments of substantially the same character and  
27 quality as those that are eligible investments for the capital and statutory reserves of  
28 admitted insurers authorized to write wet marine and transportation insurance in this  
29 state or of irrevocable, clean, and unconditional letters of credit; the trust fund must  
30 have an expiration date that at no time is less than five years;

31 **(7) an insurer not domiciled in the United States or its territories**

1 qualifies under this subsection if it is listed on the Quarterly Listing of Alien  
2 Insurers maintained by the National Association of Insurance Commissioners  
3 International Insurers Department.

4 \* **Sec. 53.** AS 21.34.040 is amended by adding new subsections to read:

5 (f) If an insurer has less than the minimum capital and surplus required in (c)  
6 of this section, the insurer may satisfy the requirements of this section upon an  
7 affirmative finding of acceptability by the director. The director's finding must be  
8 based on factors including quality of management, capital and surplus of any parent  
9 company, company underwriting profit and investment income trends, market  
10 availability, and company record and reputation within the industry. The director may  
11 not make an affirmative finding of acceptability when the nonadmitted insurer's  
12 capital and surplus is less than \$4,500,000.

13 (g) The director may participate in interstate agreements formed for the  
14 purpose of developing additional and alternative nationwide uniform eligibility  
15 requirements that are applicable to nonadmitted insurers domiciled in another state or  
16 territory of the United States.

17 \* **Sec. 54.** AS 21.34.080(a) is amended to read:

18 (a) A surplus lines broker shall execute and file with the [MONTHLY] report  
19 required by AS 21.34.170 a written report, which shall be kept confidential, regarding  
20 each surplus lines insurance transaction occurring in the preceding period  
21 [CALENDAR MONTH]. The report must include

22 (1) the name and address of the insured;

23 (2) the identity of each insurer including the National Association of  
24 Insurance Commissioners company number and the percentage of coverage provided  
25 by each;

26 (3) a complete description of the subject and location of the risk;

27 (4) the amount of gross premium written for the insurance; and

28 (5) other information required by the director.

29 \* **Sec. 55.** AS 21.34.170(a) is amended to read:

30 (a) A surplus lines broker shall file with the director [ON OR BEFORE THE  
31 END OF EACH MONTH], on forms prescribed by the director, a report of all surplus

1 lines insurance, by type of insurance as required to be reported in the annual statement  
2 that must be filed with the director by admitted insurers. The report must include all  
3 surplus lines insurance transactions during the preceding period [CALENDAR  
4 MONTH] showing the aggregate gross premiums written, the aggregate return  
5 premiums, the amount of aggregate tax remitted to this state, and the amount of  
6 aggregate tax remitted to each other state for which an allocation is made under  
7 AS 21.34.180. The forms shall be filed quarterly on March 1, June 1,  
8 September 1, and December 1 of each year.

9 \* **Sec. 56.** AS 21.34.180 is repealed and reenacted to read:

10 **Sec. 21.34.180. Surplus lines tax.** (a) In addition to collecting the full amount  
11 of gross premiums written by an insurer for surplus lines insurance, the surplus lines  
12 broker shall collect and pay to the director a tax of 2.7 percent on the net premium,  
13 which is the total gross premiums written, less any return premiums, for the insurance.  
14 Where the insurance covers properties, risks, or exposures located or to be performed  
15 both in and out of this state, the tax payable shall be computed based on an amount  
16 equal to 2.7 percent on that portion of the net premiums allocated under (f) of this  
17 section to this state, plus an amount equal to the portion of the premiums allocated  
18 under (f) of this section to other states or territories based on the tax rates and fees  
19 applicable to other properties, risks, or exposures located or to be performed outside of  
20 this state.

21 (b) The surplus lines broker may not absorb the tax or any part of it and may  
22 not rebate, for any reason, any part of the tax.

23 (c) If, under AS 21.09.210, an admitted insurer is required to collect and pay  
24 premium tax on a portion of a subscription policy, the surplus lines broker is not  
25 required to collect any amount that would constitute double taxation of that portion of  
26 the insurance.

27 (d) The director may participate in an agreement with another state formed for  
28 the purpose of collecting and disbursing to a remitting state any funds collected under  
29 (a) of this section applicable to other properties, risks, or exposures located or to be  
30 performed outside of this state. To the extent that another state where a portion of the  
31 properties, risks, or exposures resides has failed to enter into an agreement with this

1 state, the director shall retain all of the net premium tax collected by this state.

2 (e) At the time of filing the quarterly report as set out in AS 21.34.170, each  
3 surplus lines broker shall pay the premium tax due for transactions occurring during  
4 the period covered by the report. The tax must be paid by electronic or other means as  
5 specified by the director.

6 (f) In determining the amount of premiums taxable in this state, all premiums  
7 written, procured, or received in this state shall be considered written on properties,  
8 risks, or exposures located or to be performed in this state except premiums that are  
9 properly allocated or apportioned and reported as taxable premiums of a remitting  
10 state. Allocation of the amount of premiums taxable for surplus lines insurance  
11 covering properties, risks, or exposures only partially located or to be performed in  
12 this state shall be determined by reference to an allocation schedule established by  
13 regulation adopted by the director subject to the following:

14 (1) if a policy covers more than one classification, the following apply:

15 (A) for any portion of the coverage identified by a  
16 classification on the allocation schedule, the tax shall be computed by using the  
17 allocation schedule for the corresponding portion of the premium;

18 (B) for any portion of the coverage not identified by a  
19 classification on the allocation schedule, the tax shall be computed by using an  
20 alternative equitable method of allocation for the property or risk;

21 (C) for any portion of the coverage where the premium is  
22 indivisible, the tax shall be computed by using the method of allocation that  
23 pertains to the classification describing the predominant coverage;

24 (2) if the information provided by the surplus lines broker is  
25 insufficient to substantiate the method of allocation used by the surplus lines broker,  
26 or if the director determines that the broker's method is incorrect, the director shall  
27 determine the equitable and appropriate amount of tax due to this state as follows:

28 (A) by use of the allocation schedule if the risk is appropriately  
29 identified in the schedule;

30 (B) if the allocation schedule does not identify a classification  
31 appropriate to the coverage, the director may give significant weight to

1 documented evidence of the underwriting bases and other rating criteria used  
2 by the insurer; the director may also consider other available information to the  
3 extent sufficient and relevant, including the percentage of the insured's  
4 physical assets in this state, the percentage of the insured's sales in this state,  
5 the percentage of income or resources derived from this state, and the amount  
6 of premium tax paid to another jurisdiction for the policy.

7 (g) If the amount of tax due under (a) of this section is less than \$50 in any  
8 jurisdiction, the tax must be paid in the jurisdiction in which the reports and summary  
9 of exported business are filed.

10 (h) The director shall, at least annually, furnish to the commissioner of a  
11 remitting state a copy of all filings reporting an allocation of taxes required by this  
12 section.

13 (i) This section does not apply to insurance of risks of state government or its  
14 political subdivisions, to an agency of state government or its political subdivisions, or  
15 to insurance of aircraft primarily engaged in interstate or foreign commerce.

16 (j) A surplus lines broker shall pay to the division a late payment fee of \$50 a  
17 month plus five percent of the tax due each calendar month or part of a month during  
18 which the broker fails to pay the full amount of the tax or a portion of the tax and  
19 interest at the rate of one percent of the tax due each calendar month or part of a  
20 month for the period the broker fails to pay the tax. The late payment fee, not  
21 including interest, may not exceed \$250 plus 25 percent of the tax due. The tax  
22 payment shall be made in the form required by the director, or a penalty shall be added  
23 to the tax equal to 25 percent of the tax due, not to exceed \$2,000, with a minimum  
24 penalty of \$100. In addition to any other penalty provided by law, if the provisions of  
25 this section are wilfully violated, a civil penalty may be assessed of not more than  
26 \$10,000. The director may suspend or revoke the license of a broker that fails to pay  
27 its taxes, a penalty, or a late payment fee required under this section.

28 \* **Sec. 57.** AS 21.34.190(a) is amended to read:

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

1 filing of the statement.

2 \* **Sec. 58.** AS 21.34.900 is amended by adding new paragraphs to read:

3 (10) "affiliate" or "affiliated" means, with respect to an insured, any  
4 entity that controls, is controlled by, or is under common control with the insured;

5 (11) "affiliated group" means any group of entities that are all  
6 affiliated;

7 (12) "control" means for purposes of an entity having "control" over  
8 another entity

9 (A) the entity directly or indirectly or acting through 1 or more  
10 other persons owns, controls, or has the power to vote 25 percent or more of  
11 any class of voting securities of the other entity; or

12 (B) the entity controls in any manner the election of a majority  
13 of the directors or trustees of the other entity;

14 (13) "exempt commercial purchaser" has the meaning given under 15  
15 U.S.C. 8206 (Nonadmitted and Reinsurance Reform Act of 2010);

16 (14) "home state" means, for purposes of determining the home state  
17 of an insured in a multistate placement of nonadmitted insurance,

18 (A) except as provided in (B) of this paragraph, "home state"  
19 means, with respect to an insured:

20 (i) the state in which an insured maintains its principal  
21 place of business or, in the case of an individual, the individual's  
22 principal residence; or

23 (ii) if 100 percent of the insured risk is located out of  
24 the state referred to in (i) of this subparagraph, the state to which the  
25 greatest percentage of the insured's taxable premium for that insurance  
26 contract is allocated;

27 (B) if two or more insureds from an affiliated group are named  
28 insureds on a single policy, "home state" under (A) of this paragraph is based  
29 on the member of the affiliated group that has the largest percentage of  
30 premium attributed to it under the insurance contract;

31 (C) for purposes of (A) of this paragraph, the principal place of

1 business of an insured is the state where the insured maintains its headquarters  
2 and where the insured's high-level officers direct control and coordinate the  
3 business activities of the insured;

4 (15) "remitting state" means a state that has entered into an agreement  
5 with this state for remitting to this state any premium tax collected by the other state  
6 on premiums allocated to properties, risks, or exposures located in this state.

7 \* **Sec. 59.** AS 21.36 is amended by adding a new section to read:

8 **Sec. 21.36.225. Notice of health insurance coverage cancellation, coverage**  
9 **change, or premium change.** (a) Except for a health care insurance policy subject to  
10 AS 21.51.400 or AS 21.54.130, an insurer may not cancel a health insurance policy  
11 unless the insurer provides written notice to a covered individual at least 45 days  
12 before the effective date of the cancellation.

13 (b) An insurer shall provide written notice to a covered individual of changes  
14 in coverage or premium at least 45 days before the effective date of the change in  
15 coverage or premium.

16 \* **Sec. 60.** AS 21.36.360(q) is amended to read:

17 (q) A fraudulent or criminal insurance act described in

18 (1) (b) of this section that is committed to obtain \$10,000 or more is a  
19 class B felony;

20 (2) (c), (d), or (p)(4) [(c) OR (d)] of this section is a class B felony;

21 (3) (b) of this section that is committed to obtain \$500 or more but less  
22 than \$10,000 is a class C felony;

23 (4) (e), (f), (g), or (h), of this section is a class C felony;

24 (5) (b) of this section that is committed to obtain less than \$500 is a  
25 class A misdemeanor;

26 (6) (i), (j), (k), (l), (m), or (n) of this section is a class A misdemeanor;

27 (7) (o) of this section is a class B misdemeanor;

28 (8) (p)(1) of this section is a class B misdemeanor unless another  
29 specific penalty is provided for the violation of the provision; and

30 (9) (p)(2) and (3) [(p)(2) - (4)] of this section may be prosecuted under  
31 AS 11.46.

1 \* **Sec. 61.** AS 21.45.020 is amended by adding new subsections to read:

2 (c) A life insurance policy or annuity contract delivered or issued for delivery  
3 in this state and each life insurance policy or annuity contract application must contain  
4 a notice prominently printed on or attached to the first page stating

5 (1) on written request, an insurer is required to provide, within a  
6 reasonable time, reasonable factual information regarding the benefits and provisions  
7 of the policy or contract to the policy or contract holder; and

8 (2) if, for any reason, the policy or contract holder is not satisfied with  
9 the policy or contract, the policy or contract holder may return the policy or contract  
10 within 10 days after the policy or contract is delivered and, except as provided in (d)  
11 of this section, receive a refund of all money paid.

12 (d) For a variable life insurance policy or variable annuity contract, the refund  
13 under (c) of this section must equal the sum of

14 (1) the difference between the premiums paid, including any policy or  
15 contract fees or other charges; and

16 (2) the amounts allocated to any separate accounts under the policy or  
17 contract on the date the returned policy is received by the insurer or its insurance  
18 producer.

19 \* **Sec. 62.** AS 21.51.405 is amended by adding new subsections to read:

20 (b) An insurer shall file with the director the premium rates charged for an  
21 individual health care insurance plan before using them. A premium rate or premium  
22 rate change must be on file with the director for a waiting period of at least 45 days  
23 before the effective date of the premium rate. That period may be extended by the  
24 director or the insurer for an additional 15 days if, during the initial 45-day waiting  
25 period, notice is given stating that additional time for consideration of the filing is  
26 needed. A filing may become effective at the end of the waiting period unless  
27 disapproved by the director during the waiting period. If an insurer fails to provide  
28 information requested by the director during the waiting period, the filing is  
29 considered withdrawn by the insurer, and the premium rate does not become effective.

30 (c) The director shall adopt regulations

31 (1) establishing procedures for filing and use of rates; and

1 (2) specifying information that must be submitted in a filing required  
2 under (b) of this section.

3 \* **Sec. 63.** AS 21.53.020 is amended to read:

4 **Sec. 21.53.020. Disclosure and performance standards.** An insurer, hospital  
5 or medical service corporation, or [A] fraternal benefit society that delivers or issues  
6 for delivery a long-term care insurance policy may not

7 (1) cancel, fail to renew, or otherwise terminate the policy on the  
8 grounds of age or deterioration of the mental or physical health of the insured [OR  
9 CERTIFICATE HOLDER];

10 (2) include a provision requiring a new waiting period in the event  
11 existing coverage is converted to or replaced by a new or another form of health  
12 insurance within the same company, unless there is an increase in benefits voluntarily  
13 selected by the insured or group policyholder; or

14 (3) provide coverage only for skilled nursing care [,] or provide  
15 significantly more coverage for skilled care in a facility than is provided for coverage  
16 for lower levels of care [; EVALUATION OF THE COVERAGE PROVIDED  
17 UNDER THIS PARAGRAPH MUST BE BASED ON THE NUMBER OF DAYS OF  
18 COVERAGE PROVIDED FOR LOWER LEVELS OF CARE, WHEN COMPARED  
19 TO THE NUMBER OF DAYS OF COVERAGE PROVIDED FOR SKILLED  
20 CARE].

21 \* **Sec. 64.** AS 21.53.030(a) is amended to read:

22 (a) An insurer, hospital or medical service corporation, or [A] fraternal benefit  
23 society may not include, in a long-term care insurance policy or certificate, a  
24 definition of "preexisting condition" that is more restrictive than the following:  
25 preexisting condition means [THE EXISTENCE OF SYMPTOMS THAT WOULD  
26 CAUSE AN ORDINARILY PRUDENT PERSON TO SEEK DIAGNOSIS, CARE,  
27 OR TREATMENT, OR] a condition for which medical advice or treatment was  
28 recommended by, or received from, a provider of health care services [,] within six  
29 months preceding the effective date of coverage of an insured person.

30 \* **Sec. 65.** AS 21.53.030(b) is amended to read:

31 (b) In a long-term care insurance policy, [OR CERTIFICATE] an insurer,

1 hospital or medical service corporation, or [A] fraternal benefit society may not  
2 exclude coverage for a loss or confinement that is the result of a preexisting condition,  
3 unless the loss or confinement begins within six months following the effective date of  
4 coverage of an insured person.

5 \* **Sec. 66.** AS 21.53.030(d) is amended to read:

6 (d) This section does not prohibit an insurer, hospital or medical service  
7 corporation, or [A] fraternal benefit society from using an application form designed  
8 to elicit the complete health history of an applicant, and, on the basis of the answers on  
9 the application, from applying that insurer's, hospital or medical service corporation's,  
10 or fraternal benefit society's established underwriting standards. Unless otherwise  
11 provided in the policy [OR CERTIFICATE], a preexisting condition, regardless of  
12 whether it is disclosed on the application, need not be covered until the waiting period  
13 described in (b) of this section expires. A long-term care insurance policy [OR  
14 CERTIFICATE] may not exclude, limit, or reduce, or use waivers or riders of any  
15 kind to exclude, limit, or reduce coverage or benefits for specifically named or  
16 described preexisting diseases or physical conditions after the waiting period  
17 described in (b) of this section, unless the waiver or rider has been specifically  
18 approved by the director.

19 \* **Sec. 67.** AS 21.53.040 is amended to read:

20 **Sec. 21.53.040. Prior hospital or institutional care conditions prohibited.**

21 (a) A long-term care insurance policy may not be delivered or issued for delivery in  
22 this state if the policy conditions eligibility

23 (1) on a prior hospitalization requirement;

24 (2) on the receipt of a higher level of institutional care, when care is  
25 provided in an institutional setting;

26 (3) for noninstitutional benefits on a prior institutional stay of more  
27 than 30 days for which benefits are paid; [OR]

28 (4) on admission to an institutional care facility for the same or a  
29 related condition within a period of less than 30 days after discharge from the  
30 institution, if the policy provides benefits only following institutionalization; or

31 (5) for a benefit, other than a waiver of premium.

1 postconfinement, postacute care, or recuperative benefit, on a prior  
2 institutionalization.

3 (b) A long-term care insurance policy containing a postconfinement,  
4 postacute care, or recuperative benefit must clearly label the limitations or  
5 conditions, including any required number of days of confinement, "Limitations  
6 or Conditions on Eligibility for Benefits" [MAY CONTAIN A LIMITATION OR  
7 CONDITION ON ELIGIBILITY FOR BENEFITS, NOT PROHIBITED IN (a) OF  
8 THIS SECTION, IF THE LIMITATION OR CONDITION IS CLEARLY SET OUT]  
9 in a separate paragraph of the policy [OR CERTIFICATE].

10 \* Sec. 68. AS 21.53.050(a) is amended to read:

11 (a) A long-term care insurance applicant may return a policy within 30 days  
12 after delivery and have the premium refunded if, after examination of the policy, the  
13 applicant is not satisfied with the policy. A long-term care insurance policy must have  
14 a notice prominently printed on the first page of the policy or separately attached  
15 stating that the applicant has the right to return the policy within 30 days of its  
16 delivery and to have the premium refunded if, after examination of the policy, the  
17 applicant is not satisfied with the policy for any reason. This subsection also applies  
18 to application denials, and any refund must be made within 30 days after return  
19 or denial.

20 \* Sec. 69. AS 21.53.050(b) is amended to read:

21 (b) An insurer, hospital or medical service corporation, or [A] fraternal benefit  
22 society shall deliver an outline of coverage to a prospective applicant for long-term  
23 care insurance at the time of initial solicitation by a means that prominently directs the  
24 attention of the recipient to the document and its purpose. In the case of agent  
25 solicitations, an agent shall deliver the outline of coverage before the presentation of  
26 an application or enrollment form. In the case of direct response solicitations, the  
27 outline of coverage must be presented in conjunction with an application or enrollment  
28 form. The outline of coverage must include

29 (1) a description of the principal benefits and coverage provided in the  
30 policy;

31 (2) a statement of the principal exclusions, reductions, and limitations

1 contained in the policy;

2 (3) a statement of the terms under which the policy [OR  
3 CERTIFICATE, OR BOTH,] may be continued in force or discontinued, including a  
4 reservation in the policy of a right to change the premium; continuation or conversion  
5 provisions of group coverage must be specifically described;

6 (4) a statement that the outline of coverage is a summary only, not a  
7 contract of insurance, and that the policy or group master policy contains governing  
8 contractual provisions;

9 (5) a description of the terms under which the policy [OR  
10 CERTIFICATE] may be returned and premium refunded; [AND]

11 (6) a brief description of the relationship between the cost of care and  
12 benefits; and

13 (7) a statement that discloses to the policyholder whether the  
14 policy is intended to be a federal qualified long-term care insurance contract  
15 under 26 U.S.C. 7702B(b) (Internal Revenue Code).

16 \* **Sec. 70.** AS 21.53.050 is amended by adding new subsections to read:

17 (d) For a policy issued to a group defined in AS 21.53.200(3)(A), an insurer,  
18 hospital or medical service corporation, or fraternal benefit society is not required to  
19 provide an outline of coverage if the information required on the outline of coverage  
20 under (b) of this section is contained in other enrollment materials. An insurer,  
21 hospital or medical service corporation, and fraternal benefit society shall provide the  
22 enrollment materials to the director on request.

23 (e) If an application for a long-term care insurance policy is approved, the  
24 insurer shall deliver the policy to the applicant not later than 30 days after the date of  
25 approval.

26 \* **Sec. 71.** AS 21.53.060(a) is amended to read:

27 (a) In addition to the requirements of AS 21.45, at the time of policy delivery,  
28 a policy summary shall be included with an individual life insurance policy if the  
29 policy or policy rider provides long-term care benefits. In the case of direct response  
30 solicitations, the insurer shall deliver the policy summary upon the applicant's request  
31 [,] but, regardless of request, shall deliver a policy summary not later than the time of

1 policy delivery. The summary must include

2 (1) an explanation of how the long-term care benefits interact with  
3 other components of the policy, including deductions from death benefits;

4 (2) an illustration of the amount and length of benefits, and guaranteed  
5 lifetime benefits, if any, for each covered person;

6 (3) an explanation of each exclusion, reduction, and limitation on long-  
7 term care benefits; [AND]

8 (4) if applicable to the policy type,

9 (A) disclosure of the effects of exercising other rights under the  
10 policy;

11 (B) disclosure of guarantees related to the long-term care costs  
12 of insurance charges; and

13 (C) current and projected maximum lifetime benefits; and

14 (5) if the director adopts a regulation that permits but does not  
15 require inflation protection, and the policy does not provide for inflation  
16 protection, a statement that inflation protection is not available under the policy.

17 \* **Sec. 72.** AS 21.53.060 is amended by adding a new subsection to read:

18 (c) If a claim under a long-term care insurance policy is denied by an insurer,  
19 the insurer shall, within 60 days after the date of a written request by a policyholder or  
20 a representative of a policyholder,

21 (1) provide a written explanation of the reasons for the denial; and

22 (2) make available all information directly related to the denial.

23 \* **Sec. 73.** AS 21.53 is amended by adding new sections to read:

24 **Sec. 21.53.062. Incontestability period.** (a) If a long-term care insurance  
25 policy has been in force for less than six months, an insurer may rescind the policy or  
26 deny an otherwise valid long-term care claim under the policy on a showing of  
27 misrepresentation that is material to the acceptance for coverage.

28 (b) If a long-term care insurance policy has been in force for at least six  
29 months but less than two years, an insurer may rescind the policy or deny an otherwise  
30 valid long-term care claim under the policy on a showing of misrepresentation that is  
31 both material to the acceptance for coverage and pertains to the condition for which

1 benefits are sought.

2 (c) If a long-term care insurance policy has been in force for two years or  
3 more, the policy is not contestable on the grounds of misrepresentation alone and may  
4 only be contested on a showing that the insured knowingly and intentionally  
5 misrepresented relevant facts relating to the insured's health.

6 (d) If an insurer has paid benefits under a long-term care insurance policy, the  
7 insurer may not recover the benefit payments if the policy is rescinded.

8 (e) This section applies to a life insurance policy that accelerates benefits for  
9 long-term care. However, if an insured dies, this section does not apply to the  
10 remaining death benefit of a life insurance policy that accelerates benefits for long-  
11 term care, and the remaining death benefit under the policy is subject to AS 21.45.040.

12 **Sec. 21.53.064. Nonforfeiture benefits.** (a) Except as provided in (b) of this  
13 section, a long-term care insurance policy may not be delivered or issued for delivery  
14 in this state unless the policyholder has been offered the option of purchasing a policy  
15 including a nonforfeiture benefit. The insurer may offer a nonforfeiture benefit in the  
16 form of a rider to the policy. If a policyholder declines the nonforfeiture benefit, the  
17 insurer shall provide a contingent benefit upon lapse that is available for a specified  
18 period of time following a substantial increase in premium rates.

19 (b) With respect to group long-term care insurance, an insurer shall make the  
20 offer required in (a) of this section to the group policyholder. For a policy issued as  
21 group long-term care insurance, other than a continuing care retirement community or  
22 other similar entity, the insurer shall make the offer required in (a) of this section to  
23 each proposed certificate holder.

24 **Sec. 21.53.066. Producer training requirements.** (a) A person may not sell,  
25 solicit, or negotiate long-term care insurance unless the person is licensed as an  
26 insurance producer for health or life insurance lines of authority and has completed a  
27 one-time training course that meets the requirements in (d) of this section.

28 (b) A person currently licensed and selling, soliciting, or negotiating long-term  
29 care insurance may not continue to sell, solicit, or negotiate long-term care insurance  
30 unless the person has completed a one-time training course that meets the  
31 requirements in (d) of this section.

1 (c) A person who sells, solicits, or negotiates long-term care insurance shall  
2 complete ongoing training that meets the requirements in (e) of this section.

3 (d) The one-time training course required under this section

4 (1) must be at least eight credit hours;

5 (2) may not include training that is insurer or company product  
6 specific or that includes any sales or marketing information, materials, or training,  
7 other than those required by state or federal law;

8 (3) must consist of topics related to long-term care insurance, long-  
9 term care services, and, if applicable, qualified long-term care insurance partnership  
10 programs, including

11 (A) state and federal requirements and the relationship between  
12 qualified state long-term care insurance partnership programs and other public  
13 and private coverage of long-term care services;

14 (B) available long-term care services and providers;

15 (C) changes or improvements in long-term care services or  
16 providers;

17 (D) alternatives to the purchase of private long-term care  
18 insurance;

19 (E) the effect of inflation on benefits and the importance of  
20 inflation protections; and

21 (F) consumer suitability standards and guidelines.

22 (e) The ongoing training course required under (c) of this section must be at  
23 least four credit hours every 24 months and must comply with the requirements in  
24 (d)(2) and (3) of this section.

25 (f) The director may approve the training requirements in (d) and (e) of this  
26 section as continuing education courses under AS 21.27.020.

27 (g) An insurer shall

28 (1) obtain verification that a producer received the training required  
29 under this section before a producer is permitted to sell, solicit, or negotiate the  
30 insurer's long-term care insurance products;

31 (2) maintain records of required training subject to the state's record

1 retention requirements;

2 (3) make the verification required under (1) of this subsection available  
3 to the director on request.

4 (h) An insurer shall maintain

5 (1) records with respect to the training of its producers concerning the  
6 distribution of its partnership policies that allows the director to provide assurance to  
7 the medical assistance program under AS 47.07 that producers have received the  
8 training described in (d)(3) of this section and that producers have demonstrated an  
9 understanding of the partnership policies and their relationship to public and private  
10 coverage of long-term care in this state; and

11 (2) the records described under (1) of this subsection in accordance  
12 with the record requirements under AS 21.09.320 and shall make the records available  
13 to the director on request.

14 **Sec. 21.53.068. Limitations related to producers and third-party**  
15 **administrators.** An insurer that authorizes issuance of a long-term care insurance  
16 policy by a producer or a third-party administrator under the underwriting authority of  
17 the insurer granted to the producer or a third-party administrator using the insurer's  
18 underwriting guidelines may issue a long-term care insurance policy through the  
19 producer or a third-party administrator only if the insurer compensates the issuer based  
20 on the number of policies issued.

21 \* **Sec. 74.** AS 21.53.090 is amended to read:

22 **Sec. 21.53.090. Required regulations.** The director shall adopt regulations  
23 regarding

24 (1) the sale of long-term care insurance that provide minimum  
25 standards for

- 26 (A) terms of renewability;
- 27 (B) initial and subsequent conditions of eligibility;
- 28 (C) nonduplication of coverage provisions;
- 29 (D) coverage of dependents;
- 30 (E) benefit triggers;
- 31 (F) preexisting conditions and recurrent conditions;

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- (G) termination of insurance, including incontestability periods;
- (H) continuation or conversion;
- (I) probationary periods, limitations, exceptions, reductions, and elimination periods; [AND]
- (J) requirements for replacement;
- (K) producer training, education, compensation, and testing;
- (L) marketing practices;
- (M) independent review of benefit determinations;
- (N) penalties and reporting practices; and
- (O) premium rates, including rate filing requirements;
- (2) standard definitions of long-term care insurance terms;
- (3) nonforfeiture or minimum value requirements; [AND]
- (4) consumer protection standards, including standards for full and fair disclosure setting out the manner and content of required disclosures; and
- (5) the standard format and content of the outline of coverage required under AS 21.53.050.

\* Sec. 75. AS 21.53.200(3) is amended to read:

(3) "group long-term care insurance" means a long-term care insurance policy, subscriber's contract, or fraternal benefit society certificate that is delivered or issued for delivery in this state and issued to

(A) one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination of them, for employees or former employees or a combination of them, or for members or former members or a combination of them, of the labor organization;

(B) a professional, trade, or occupational association for its members or former or retired members, or combination of them, if the association is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation, and has been maintained

1 in good faith for purposes other than obtaining insurance;

2 (C) an association or a trust or the trustee of a fund established,  
3 created, or maintained for the benefit of members of one or more associations  
4 **that meets the requirements in AS 21.53.080;**

5 (D) a group other than described in this paragraph if the  
6 director determines that the issuance of the group policy is not contrary to the  
7 best interest of the public, would result in economies of acquisition or  
8 administration, and the benefits are reasonable in relation to the premiums  
9 charged;

10 \* Sec. 76. AS 21.53.200(4) is amended to read:

11 (4) "long-term care insurance"

12 (A) means an individual or group insurance policy, including  
13 group and individual life insurance or annuities, a subscriber's contract,  
14 fraternal benefit society certificate, or rider advertised, marketed, offered, or  
15 designed to provide coverage for not less than 12 consecutive months for each  
16 covered person on an expense incurred, indemnity, prepaid, or other basis, for  
17 one or more necessary or medically necessary diagnostic, preventive,  
18 therapeutic, rehabilitative, maintenance, or personal care services that are  
19 provided in a setting other than an acute care unit of a hospital, and includes a  
20 policy or rider that provides for payment of benefits based on cognitive  
21 impairment or loss of functional capacity;

22 (B) ["LONG-TERM CARE INSURANCE"] does not include

23 (i) an insurance policy, subscriber's contract, or  
24 fraternal benefit society certificate that is offered primarily to provide  
25 basic Medicare supplement coverage, basic hospital expense coverage,  
26 basic medical-surgical expense coverage, hospital confinement  
27 indemnity coverage, major medical expense coverage, disability  
28 insurance and related asset protection coverage, catastrophic coverage,  
29 comprehensive coverage, accident only coverage, specified disease or  
30 specified accident coverage, or limited benefit health coverage; **or**

31 **(ii) a life insurance policy that accelerates the death**

1 benefit specifically for one or more of the qualifying events of  
2 terminal illness, medical conditions requiring extraordinary  
3 medical intervention, or permanent institutional confinement and  
4 that provides the option of a lump-sum payment for that benefit if  
5 the benefit and the eligibility for the benefit under the life  
6 insurance policy are not conditioned on the receipt of long-term  
7 care;

8 \* Sec. 77. AS 21.54.015 is amended by adding new subsections to read:

9 (c) Except for large employer health care insurance plan premium rates  
10 exempted by the director by regulation under (d) of this section, an insurer shall file  
11 with the director the premium rates charged for each health care insurance plan before  
12 using them. A premium rate or premium rate change must be on file with the director  
13 for a waiting period of at least 45 days before the effective date of the premium rate.  
14 That period may be extended by the director or the insurer for an additional 15 days if,  
15 during the initial 45-day waiting period, notice is given stating that additional time for  
16 consideration of the filing is needed. A filing may become effective at the end of the  
17 waiting period unless disapproved by the director during the waiting period. If an  
18 insurer fails to provide information requested by the director during the waiting  
19 period, the filing is considered withdrawn by the insurer, and the premium rate does  
20 not become effective.

21 (d) The director shall adopt regulations

22 (1) establishing procedures for the filing and use of rates; and

23 (2) specifying information that must be submitted in a filing required  
24 under (c) of this section.

25 \* Sec. 78. AS 21.54.020(a) is amended to read:

26 (a) On the written request of a covered person, a health care insurer shall pay  
27 amounts due under a health insurance policy directly to the provider of medical care  
28 services. A health insurance policy may not contain a provision that requires services  
29 be provided by a particular hospital or person, except as applicable to a [MANAGED  
30 CARE PLAN UNDER AS 21.07 OR A] health maintenance organization under  
31 AS 21.86. If a health care insurer makes a claim payment to the covered person after

1 the covered person has given written notice electing direct payment to the provider of  
2 the service, the health care insurer shall also pay that amount to the provider of the  
3 service.

4 \* **Sec. 79.** AS 21.54 is amended by adding a new section to article 2 to read:

5 **Sec. 21.54.180. Individual health care insurance policies offered in the**  
6 **group market.** (a) Except as provided in (b) of this section, a person may not sell,  
7 solicit, or negotiate an individual health care insurance policy to an employer or  
8 employee of an employer, and an insurer may not issue an individual health care  
9 insurance policy to an employee of an employer.

10 (b) Notwithstanding the definition of "group market" in AS 21.54.500, a  
11 person may sell, solicit, or negotiate an individual health care insurance policy to an  
12 employer or employee of an employer, and an insurer may issue an individual health  
13 care insurance policy to an employee of an employer, only if

14 (1) the employee is not an eligible employee as defined in  
15 AS 21.56.250; or

16 (2) the employer does not offer a health benefit plan and has not  
17 offered a health benefit plan in the last six months.

18 (c) An individual health care insurance policy offered under (b) of this section  
19 is health care insurance offered in the individual market and subject to the  
20 requirements of AS 21.51. In this subsection, "individual market" means the market  
21 for health care insurance that does not include coverage under a health care insurance  
22 plan as defined in AS 21.54.500.

23 \* **Sec. 80.** AS 21.54.500(16) is amended to read:

24 (16) "health care insurance plan" means a health care insurance policy  
25 or contract [PROVIDED BY A HEALTH CARE INSURER] but does not include an  
26 excepted benefits policy or contract;

27 \* **Sec. 81.** AS 21.59.070 is amended to read:

28 **Sec. 21.59.070. Other provisions applicable.** In addition to the provisions of  
29 this chapter, the following provisions of this title shall apply to automobile service  
30 corporations, to the extent applicable and not in conflict with the express provisions of  
31 this chapter and the reasonable implications of the express provisions, and, for the

1 purposes of the application, the corporations shall be considered to be stock insurers:

2 (1) AS 21.03;

3 (2) AS 21.06;

4 (3) AS 21.09.050;

5 (4) AS 21.09.100;

6 (5) AS 21.09.120 - 21.09.210;

7 (6) AS 21.09.245;

8 (7) AS 21.09.247;

9 (8) AS 21.12;

10 (9) [(7)] AS 21.36;

11 (10) [(8)] AS 21.69;

12 (11) [(9)] AS 21.78;

13 (12) [(10)] AS 21.97.

14 \* **Sec. 82.** AS 21.66.020 is amended by adding new subsections to read:

15 (b) When a title insurance company holding a certificate of authority under  
16 this chapter is found to be insolvent by a proceeding in a court of competent  
17 jurisdiction, the director shall take control of deposits made by the title insurance  
18 company and held in this state. If the finding of insolvency is from a court in another  
19 state, the director shall file for an ancillary receivership under AS 21.78 to administer  
20 the deposits and other assets in this state and pay claims in this state. Any funds  
21 remaining after payment of all claims under policies in this state shall be forwarded to  
22 the receiver.

23 (c) On request of a title insurance company, the director shall return the assets  
24 held on deposit when the company is no longer authorized to write insurance in this  
25 state, the director is satisfied that there are no risks in the state covered by contracts of  
26 the company, and the assets are no longer required to be held by any provision of law.

27 (d) In addition to the provisions of this section, the following provisions of  
28 this title also apply with respect to deposits under this section to the extent applicable  
29 and not in conflict with the express provisions of this chapter and the reasonable  
30 implications of the express provisions:

31 (1) AS 21.24.040(a), (d), and (e);

1 (2) AS 21.24.060.

2 \* **Sec. 83.** AS 21.66.210(a) is amended to read:

3 (a) Two or more title insurance companies or two or more title insurance  
4 limited producers, or a combination of title insurance companies and title insurance  
5 limited producers, may apply to the director of insurance to form an association,  
6 corporation, or other legal entity, for the purpose of engaging in the business of  
7 preparing abstracts of title searches from public records or from records to be owned  
8 by the entity, upon the basis of which a title insurance limited producer or a title  
9 insurance company will issue title policies. The owners or participants are considered  
10 to be in compliance with the provisions of this section and AS 21.66.200 if the title  
11 plant of the association, corporation, or other legal entity complies with the provisions  
12 of this section. The application must contain

13 (1) a copy of the proposed articles of incorporation or association and  
14 the bylaws or agreement governing the operation of the entity;

15 (2) a list of the owners or participants;

16 (3) the names and addresses of the persons who will operate the entity,  
17 with a description of their experience and qualifications;

18 (4) the conditions under which ownership or participation in the entity  
19 may be sold or acquired;

20 (5) a statement of whether or not title information will be compiled and  
21 sold to persons other than owners of or participants in the entity;

22 (6) a pro forma balance sheet and other financial information to  
23 indicate the sufficiency of financing the entity; **and**

24 **(7) basic information, including the joint title plan name, the**  
25 **physical address, the mailing address, the electronic mailing address, and**  
26 **telephone numbers.**

27 \* **Sec. 84.** AS 21.69.390(d) is amended to read:

28 (d) To meet the requirements of (a) of this section, a domestic insurer shall  
29 keep at its principal place of business in the state the following records of assets,  
30 transactions, and affairs:

31 (1) a general ledger;

1 (2) copies of reports prepared to comply with AS 21.09.200 -  
2 21.09.210;

3 (3) if prepared in the normal course of business, financial statements  
4 prepared under generally accepted accounting principles on which a licensed certified  
5 public accountant has expressed an opinion;

6 (4) filings made by a domestic insurer or affiliates of the domestic  
7 insurer with a government agency with which a domestic insurer or affiliates of the  
8 domestic insurer's securities may be registered;

9 (5) a state certificate of authority;

10 (6) filings made under AS 21.21;

11 (7) original contract [POLICY] and claim files for insurance and  
12 other products sold to consumers [OF PROPERTY OR A RISK RESIDENT OR  
13 LOCATED IN THE STATE];

14 (8) a corporate minutes book;

15 (9) articles of incorporation;

16 (10) corporate bylaws;

17 (11) administrative management contracts; and

18 (12) other records required by the director by regulation.

19 \* **Sec. 85.** AS 21.72.170 is amended to read:

20 **Sec. 21.72.170. Other provisions applicable.** In addition to the provisions  
21 contained in the chapter, other chapters and provisions of this title shall apply to  
22 benevolent associations, to the extent applicable, as follows:

23 (1) AS 21.03;

24 (2) AS 21.06;

25 (3) AS 21.09.010, 21.09.050, 21.09.100, and 21.09.130 - 21.09.190;

26 (4) AS 21.09.247;

27 (5) AS 21.18.010 and 21.18.030;

28 (6) [(5)] AS 21.36;

29 (7) [(6)] AS 21.42;

30 (8) [(7)] AS 21.69.370, 21.69.390, 21.69.400, 21.69.630, and  
31 21.69.640;

1                    ~~(9)~~ [(8)] AS 21.78.

2       \* **Sec. 86.** AS 21.75.060(b) is amended to read:

3                    (b) The proposed attorney-in-fact shall fulfill the requirements of and shall  
4                    execute and file with the director when applying for a certificate of authority, a  
5                    declaration setting out

6                    (1) the name of the insurer;

7                    (2) the location of the insurer's principal office, which shall be the  
8                    same as that of the attorney-in-fact and shall be maintained in this state, and the  
9                    mailing address, electronic mailing address, and telephone numbers;

10                    (3) the kinds of insurance proposed to be transacted;

11                    (4) the names and addresses of the original subscribers;

12                    (5) the designation and appointment of the proposed attorney-in-fact  
13                    and a copy of the power of attorney;

14                    (6) the names and addresses of the officers and directors of the  
15                    attorney-in-fact, if a corporation, or its members, if a firm;

16                    (7) the powers of the subscribers' advisory committee, and the names  
17                    and terms of office of the members;

18                    (8) that all money paid to the reciprocal insurer shall, after deducting  
19                    any sum payable to the attorney-in-fact, be held in the name of the insurer and for the  
20                    purposes specified in the subscribers' agreement;

21                    (9) a copy of the subscribers' agreement;

22                    (10) a statement that each of the original subscribers has in good faith  
23                    applied for insurance of a kind proposed to be transacted and that the insurer has  
24                    received from each subscriber the full premium or premium deposit required for the  
25                    policy applied for, for a term of not less than six months at an adequate rate filed with  
26                    and approved by the director;

27                    (11) a statement of the financial condition of the insurer, a schedule of  
28                    its assets, and a statement that the surplus as required by AS 21.75.050 is on hand;

29                    (12) a copy of each policy, endorsement, and application form it then  
30                    proposes to issue or use.

31       \* **Sec. 87.** AS 21.79.025(a) is amended to read:

1 (a) The benefits for which the association may become liable may not exceed  
2 the lesser of

3 (1) the contractual obligations for which the insurer is liable or would  
4 have been liable if it were not an impaired or insolvent insurer;

5 (2) with respect to any one life, regardless of the number of policies or  
6 contracts,

7 (A) \$300,000 in life insurance death benefits, but not more than  
8 \$100,000 in net cash surrender and net cash withdrawal values for life  
9 insurance;

10 (B) in health insurance benefits,

11 (i) \$100,000 for coverage not defined as disability  
12 insurance long-term care insurance, or basic hospital, medical, and  
13 surgical insurance or major medical insurance, including any net cash  
14 surrender and net cash withdrawal values;

15 (ii) \$300,000 for disability insurance as defined in  
16 AS 21.12.052 and long-term care insurance as defined in  
17 AS 21.53.200;

18 (iii) \$500,000 for basic hospital, medical, and surgical  
19 insurance or major medical insurance;

20 (C) \$250,000 [\$100,000] in the present value of annuity  
21 benefits, including net cash surrender and net cash withdrawal values;

22 (3) with respect to any one contract holder or plan sponsor whose plan  
23 owns directly or in trust one or more unallocated annuity contracts not included in (4)  
24 of this subsection, \$5,000,000 in unallocated annuity contract benefits, irrespective of  
25 the number of contracts held by that contract holder or plan sponsor except that, in the  
26 case of one or more unallocated annuity contracts that are covered under this chapter  
27 and that are owned by a trust or other entity for the benefit of two or more plan  
28 sponsors, coverage shall be provided by the association if the largest interest in the  
29 trust or entity owning the contract is held by a plan sponsor whose principal place of  
30 business is in this state; however, the association is not liable to cover more than  
31 \$5,000,000 in benefits with respect to an unallocated annuity contract not included in

1 (4) of this subsection;

2 (4) with respect to an individual participating in a governmental  
3 retirement benefit plan established under 26 U.S.C. 401, 26 U.S.C. 403(b), or 26  
4 U.S.C. 457 and covered by an unallocated annuity contract, or to a beneficiary of the  
5 individual if the individual is deceased, in the aggregate, \$100,000 in present-value  
6 annuity benefits, including net cash surrender and net cash withdrawal values; or

7 (5) with respect to each payee of a structured settlement annuity, or  
8 beneficiary of the payee if the payee is deceased, \$100,000 in present-value annuity  
9 benefits in the aggregate, including net cash surrender and net cash withdrawal values,  
10 if any.

11 \* **Sec. 88.** AS 21.84.335(b) is amended to read:

12 (b) In addition to the provisions of this chapter, the following provisions of  
13 this title apply to fraternal benefit societies to the extent applicable and not in conflict  
14 with the express provisions of this chapter and the reasonable implications of this  
15 chapter:

16 (1) AS 21.03;

17 (2) AS 21.06;

18 (3) AS 21.09.050;

19 (4) AS 21.09.100;

20 (5) AS 21.09.200;

21 (6) AS 21.09.205;

22 (7) AS 21.09.245;

23 (8) AS 21.09.247;

24 (9) AS 21.18;

25 (10) [(8)] AS 21.21;

26 (11) [(9)] AS 21.27;

27 (12) [(10)] AS 21.33;

28 (13) [(11)] AS 21.36;

29 (14) [(12)] AS 21.42.290;

30 (15) [(13)] AS 21.42.355;

31 (16) [(14)] AS 21.53;

- 1                    (17) [(15)] AS 21.54;  
2                    (18) [(16)] AS 21.56;  
3                    (19) [(17)] AS 21.69.370;  
4                    (20) [(18)] AS 21.69.640;  
5                    (21) [(19)] AS 21.78; and  
6                    (22) [(20)] AS 21.96.060.

7 \* **Sec. 89.** AS 21.85.030(a) is amended to read:

8                    (a) The director may not issue a certificate of authority to a self-funded  
9 multiple employer welfare arrangement unless the arrangement establishes to the  
10 satisfaction of the director that

11                    (1) employers participating in the arrangement are members of a bona  
12 fide association or group of two or more businesses in the same or a closely related  
13 trade, profession, or industry that provide support, services, or supplies primarily to  
14 that trade, profession, or industry;

15                    (2) employers or employees participating in the arrangement exercise  
16 direct control over the arrangement; as described in this paragraph,

17                    (A) subject to (B) of this paragraph, direct control exists if the  
18 employers or employees participating in the arrangement have the right to elect  
19 at least 75 percent of the individuals designated in the arrangement's  
20 organizational documents as having control over the operations of the  
21 arrangement and the individuals designated in the arrangement's organizational  
22 documents in fact exercise control over the operation of the arrangement;

23                    (B) use of a third-party administrator to process claims and to  
24 assist in the administration of the arrangement is not evidence of the lack of  
25 exercise of control over the operations of the arrangement;

26                    (3) the arrangement is a nonprofit organization;

27                    (4) the arrangement provides only allowable benefits, except the  
28 arrangement may **also** provide

29                    (A) life **or disability** insurance coverage to its participants if  
30 the life **or disability** insurance coverage is provided under contracts **with**  
31 **other insurers** that comply with this title; **or**



1 independent contractors, and consultants; and

2 (v) other factors the director considers relevant to  
3 determining the ability of the arrangement to remain financially  
4 solvent.

5 \* **Sec. 90.** AS 21.85.040 is amended to read:

6 **Sec. 21.85.040. Application for a certificate of authority.** To apply for an  
7 original certificate of authority, a self-funded multiple employer welfare arrangement  
8 shall file with the director its application, accompanied by the applicable fees set  
9 under AS 21.06.250, showing its name, the location of its home office, its date of  
10 organization, its state of domicile, and additional information that the director may  
11 reasonably require. The application shall be submitted together with

12 (1) a copy of all articles, bylaws, agreements, trusts, or other  
13 documents or instruments describing the rights and obligations of the employers,  
14 employees, and beneficiaries of the arrangement;

15 (2) a copy of each summary plan description of the arrangement filed  
16 or required to be filed with the United States Department of Labor, including any  
17 amendments to each description;

18 (3) evidence of coverage of or letter of intent to participate executed by  
19 at least two employers providing allowable benefits to at least 75 employees;

20 (4) a copy of the arrangement's most recent financial statement in  
21 compliance with AS 21.85.080 or, if the arrangement has been in existence for less  
22 than one year, pro forma financial statements, including a balance sheet, an income  
23 statement, a statement of changes in financial condition, and an actuarial opinion that  
24 the unpaid claim liability of the arrangement satisfies the standards in AS 21.18.080 -  
25 21.18.086;

26 (5) proof that the arrangement maintains and will continue to maintain  
27 fidelity bonds required by the United States Department of Labor under 29 U.S.C.  
28 1001 - 1461 (Employee Retirement Income Security Act of 1974);

29 (6) a copy of any stop-loss insurance policies maintained or proposed  
30 to be maintained by the arrangement;

31 (7) biographical reports, on forms prescribed by the National

1 Association of Insurance Commissioners, evidencing the general trustworthiness and  
2 competence of each individual who is serving or who will serve as a managing  
3 employee or fiduciary of the arrangement;

4 (8) a notarized statement executed by an officer of the arrangement  
5 certifying, to the best knowledge and belief of the officer, that the information  
6 provided in the application is true and correct and that the arrangement is in  
7 compliance with the requirements in

8 (A) AS 21.85.020;

9 (B) 29 U.S.C. 1001 - 1461 (Employee Retirement Income  
10 Security Act of 1974) or a statement of any requirements with which the  
11 arrangement is not in compliance and a statement of proposed corrective  
12 action; and

13 (C) AS 21.85.050;

14 (9) base contribution rates for participation under the arrangement for  
15 its initial year of operations; **and**

16 **(10) for a foreign multiple employer welfare arrangement,**

17 **(A) a certificate of the public official having supervision of**  
18 **insurance in its state or country of domicile or state of entry into the**  
19 **United States, showing that it is authorized to transact the kinds of**  
20 **insurance proposed to be transacted in this state or an affidavit attesting**  
21 **to the reasons why a certificate is not available;**

22 **(B) a copy of the arrangement's most recent financial**  
23 **statement filed with its state of domicile, if any, with an actuarial opinion**  
24 **on reported unpaid claims;**

25 **(C) a copy of a management discussion and analysis filed**  
26 **with its state of domicile, if any; and**

27 **(D) a copy of the report of last examination, if any, made of**  
28 **the insurer, issued by the insurance supervisory official of its state of**  
29 **domicile or state of entry into the United States.**

30 \* **Sec. 91.** AS 21.86 is amended by adding a new section to read:

31 **Sec. 21.86.045. Biographical affidavits.** A domestic health maintenance

1 organization shall file with the director a complete affidavit of biographical  
2 information not later than 30 days after the appointment of an officer or member of the  
3 governing body of the organization. If requested by the director, a foreign health  
4 maintenance organization shall file with the director an affidavit of biographical  
5 information for the appointment of an officer or member of the governing body of that  
6 organization. A filing under this section must be on a form approved by the director. A  
7 filing is not required if a biographical affidavit of the officer or director has been  
8 submitted to the director within one year before the date of appointment. A  
9 biographical affidavit filed under this section is confidential and not subject to public  
10 inspection.

11 \* **Sec. 92.** AS 21.87.340 is amended to read:

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

- 18 (1) AS 21.03;
- 19 (2) AS 21.06;
- 20 (3) AS 21.07;
- 21 (4) AS 21.09, except AS 21.09.090;
- 22 (5) AS 21.18.010;
- 23 (6) AS 21.18.030;
- 24 (7) AS 21.18.040;
- 25 (8) AS 21.18.080 - 21.18.086;
- 26 (9) AS 21.36;
- 27 (10) AS 21.42.110, 21.42.345 - 21.42.395 [AS 21.42.345 - 21.42.395];
- 28 (11) AS 21.51.120 and 21.51.400;
- 29 (12) AS 21.51.405;
- 30 (13) AS 21.53;
- 31 (14) [(13)] AS 21.54;

- 1                    (15) [(14)] AS 21.56;  
2                    (16) [(15)] AS 21.69.400;  
3                    (17) [(16)] AS 21.69.520;  
4                    (18) [(17)] AS 21.69.600, 21.69.620, and 21.69.630;  
5                    (19) [(18)] AS 21.78;  
6                    (20) [(19)] AS 21.96.060;  
7                    (21) [(20)] AS 21.97.

8                    \* **Sec. 93.** AS 21.96.030 is amended to read:

9                                       **Sec. 21.96.030. Payment.** Unless another form of payment is agreed to by  
10                    the policy holder or beneficiary, an [AN] insurance company doing business in this  
11                    state may not pay a judgment or settlement of a claim in this state for a loss incurred in  
12                    this state with an instrument other than a negotiable bank check payable on demand  
13                    and bearing even date with the date of writing or by electronic funds transfer.

14                    \* **Sec. 94.** AS 21.07.040, 21.07.250(7), 21.07.250(8), 21.07.250(9); AS 21.27.020(e),  
15                    21.27.025(b), 21.27.340, 21.27.900(13); AS 21.53.200(5); and AS 21.87.190(b) are repealed.

16                    \* **Sec. 95.** The uncodified law of the State of Alaska is amended by adding a new section to  
17                    read:

18                                       **TRANSITION: LONG-TERM CARE INSURANCE LICENSEES COURSE**  
19                    **REQUIREMENT.** A person licensed and selling, soliciting, or negotiating long-term care  
20                    insurance on the effective date of this section may not continue to sell, solicit, or negotiate  
21                    long-term care insurance beginning one year after the effective date of this section unless the  
22                    person has successfully completed a one-time course, as required by AS 21.53.066, enacted  
23                    by sec. 73 of this Act.

24                    \* **Sec. 96.** The uncodified law of the State of Alaska is amended by adding a new section to  
25                    read:

26                                       **TRANSITION: REGULATION ADOPTION.** The director of insurance may adopt  
27                    regulations necessary to implement the changes made by this Act. The regulations take effect  
28                    under AS 44.62 (Administrative Procedure Act), but not before the effective date of the law  
29                    implemented by the regulation.

30                    \* **Sec. 97.** The uncodified law of the State of Alaska is amended by adding a new section to  
31                    read:

1 REVISOR'S INSTRUCTIONS. The revisor of statutes is instructed to change the  
2 following:

3 (1) the chapter heading of AS 21.07 from "Regulation of Managed Care  
4 Insurance Plans" to "Patient Protections under Health Care Insurance Policies";

5 (2) the catch line of AS 21.34.170 from "Monthly reports, summary of  
6 exported business" to "Quarterly reports, summary of exported business."

7 \* **Sec. 98.** Section 96 of this Act takes effect immediately under AS 01.10.070(c).

8 \* **Sec. 99.** Sections 46 - 58 of this Act take effect July 21, 2011.

9 \* **Sec. 100.** Sections 62 and 77 of this Act take effect January 1, 2012.

10 \* **Sec. 101.** Except as provided in secs. 98 - 100 of this Act, this Act takes effect July 1,  
11 2011.

# ALASKA STATE LEGISLATURE

## REPRESENTATIVE KURT OLSON

- Chair: Labor and Commerce
- Vice Chair: Rules, Administrative Regulation Review  
Economic Development Trade & Tourism
- Member: Energy, Legislative Budget & Audit

Session: January – April  
State Capitol, Room 24  
Juneau, AK 99801-1182  
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Interim: May – December  
145 Main Street Loop, Ste 221  
Kenai, AK 99611  
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Official Business

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### Sponsor Statement

#### CS House Bill 164 (L&C)

*"An Act relating to health care insurance, exemption of certain insurers, reporting, notice, and record-keeping requirements for insurers, biographical affidavits, qualifications of alien insurers assuming ceded insurance, risk-based capital for insurers, insurance holding companies, licensing, federal requirements for nonadmitted insurers, surplus lines insurance, insurance fraud, life insurance policies and annuity contracts, rate filings by health care insurers, long-term care insurance, automobile service corporations, guaranty fund deposits of a title insurer, joint title plants, fraternal benefit societies, multiple employer welfare arrangements, hospital and medical service corporations, health maintenance organizations, and alternate forms of payment to policyholders; and providing for an effective date."*

House Bill 164 is a compilation of various provisions to make changes to the Insurance Code to enhance, update and provide uniformity with national standards to improve the regulation of the insurance industry.

First, the bill addresses an amendment to federal law (the Nonadmitted and Reinsurance Reform Act of 2010) effective in June of 2011 that changes how premium taxes on Surplus Lines insurance can be collected and allocated. This change in Alaska law is needed to avoid the loss of revenue from certain premium taxes.

Other areas of improvement include various financial changes such as risk based capital tests, one of which will be an accreditation standard on 1-1-2012, requirements for filing biographical affidavits for domestic insurance company officers and directors and changes in the collateralization of certain reinsurance obligations. Filing of health care premium rates with the director would be required.

Agent licensing would be streamlined significantly by eliminating the requirement of the "individual in a firm" license type which will allow individuals to change employers without additional filings, fees or notification requirements as well as eliminate most late notification penalties. Communication would also be streamlined by changes to various areas of the statute to require both agents and insurance companies to facilitate the mailing of notices from the division by electronic methods.

The bill contains numerous enhancements to the Insurance code and I urge your support.



# Alaska State Legislature

Please enter into the record my testimony to the \_\_\_\_\_ HFIN \_\_\_\_\_  
 \_\_\_\_\_  
 Committee name  
 Committee on \_\_\_\_\_ HB 164 \_\_\_\_\_, dated 3/22/11 \_\_\_\_\_  
 \_\_\_\_\_  
 Bill/Subject

Denali Alaskan Federal Credit Union serves 55,000 members as well as more than 500 sponsor employers, the vast majority of which have fewer than 50 employees. We try to create value to both groups.

Section 79 of HB 164 addresses "Individual Health Care Insurance Policies in the Group Market."

It is our view that the language in this Section severely limits both employer and employee choice of health care insurance and will leave employees without insurance options for extended periods of time.

To illustrate, consider an employer that is forced to drop group health insurance coverage due to declining profitability, increasing cost of insurance, or a combination of both factors.

According to the proposed language, no insurer could issue a policy to those employees for 6 months after the group plan's coverage ended. Clearly this restriction is quite onerous and, indeed, we believe constitutes poor public policy on several levels.

Instead of restricting access to health insurance we believe that employers and employees should have MORE options to obtain health insurance in the circumstances I just described, not less. The language of Section 79 is so broad as to seemingly prohibit even the discussion of individual health insurance policies with employers.

One solution would be to enact legislation that expressly permits the use of federal, tax-favored programs such as Health Reimbursement Accounts when employers eliminate group health insurance benefits. From an employer's perspective HRAs are easy to administer and allow flexibility in determining contribution levels.

From an employee's perspective HRAs allow ultimate flexibility in how those dollars are spent because they can be used for

- a specific list of medical expenses
- Co-insurance, copays, or deductibles in conjunction with health insurance
- Individual health insurance premiums.
- And, there is no 'use it or lose it' provision like Flexible Spending Accounts have.

In some ways individual policies are better than group policies:

- They are portable and not tied to employment which benefits seasonal, part time, temporary workers
- They typically have more stable pricing because the risk rating group is much larger than, say, a 10 person group plan.
- Individuals can currently choose from more than 40 plan designs to optimize coverage and costs.
- In the event that pre-existing conditions prevent a private insurer from issuing coverage, the option remains for individuals to apply to the Alaska Comprehensive Health Insurance Association at which time the employer has the option of increasing the contribution to that employee's HRA.

In conclusion, our view is that Section 79 creates more problems than it solves for working Alaskans and establishing additional alternatives for employees and employers to obtain health insurance would constitute better public policy. Specifically, we believe a statute that absolutely confirms that employers of any size may establish HRAs that may fund individual health insurance expenses without triggering small group health insurance regulation will ably and better serve both employees and employers.

Thank you,

Dale Fosselman

Senior Vice President Corporate Development  
 Denali Alaskan Federal Credit Union  
 907-257-9494

March 22, 2011

TO: House Finance Committee

RE: Comments on Section 78 of HB 164

FROM: Dale Fosselman, SVP Corporate Development  
Denali Alaskan Federal Credit Union

Denali Alaskan Federal Credit Union believes all Alaskan workers and their employers should have freedom of choice when it comes to choosing health insurance coverage. Employees should have unrestricted access to all types of health insurance coverage, and should not be deprived of insurance coverage for months at a time when their group plan is terminated, or when they move or change jobs. Employers should also have unfettered access to information on all types of health insurance coverage, so they may make an informed decision on which type of health insurance is best for the company and its employees.

Section 78 of House Bill 164 severely limits both employer and employee choice of health care insurance, may leave employees without any coverage whatsoever for extended periods of time, and will deprive some employees of health insurance coverage altogether.

Section 78 of HB 164 will adversely affect both employees and employers in several ways:

- **It may leave employees without any health insurance whatsoever for six months or longer.** Unfortunately, the high cost of health insurance has caused, and will continue to cause, many employers to drop their group health insurance plans. Section 78 of HB 164 expressly prohibits an insurance company from issuing an individual health insurance policy to an employee for six months after the employee's group health insurance plan has been terminated. This leaves the employee without any health insurance whatsoever for at least six months. If the employee is also required to complete a probationary period before replacement insurance becomes effective, or if the replacement policy has a pre-existing conditions waiting period, the employee could be entirely deprived of health insurance coverage for a year or longer. This will occur even if the employee *wants* to use his or her own funds to purchase an individual health insurance policy, since the proposed law does not allow an insurance company to issue an individual policy to the employee.
- **It may prevent an employee from obtaining supplemental or additional health insurance coverage.** Section 78 prohibits an insurance company from issuing an individual health insurance policy to an employee who presently has group insurance coverage. This would prevent an employee from obtaining supplemental coverage (additional cancer coverage, for example) or from obtaining additional coverage from other sources. An employee who wants to purchase an individual health insurance policy for whatever reason should not be deprived of the right to do so.

➤ **It may prevent full time seasonal employees from obtaining any health insurance coverage.** The section prohibits an insurer from issuing an individual health insurance policy to an employee if his or her employer offers group coverage. Because of this, a full time seasonal employee, who is not as vested under the employer's group policy may not be able to obtain an individual health insurance policy, even if the seasonal employee was willing to pay for the coverage out of his or her own pocket. This leaves full time seasonal employees without any health insurance coverage whatsoever.

➤ **Section 78 limits employer choice, by limiting employer access to health insurance information.** Section 78 broadly prohibits a person from selling, soliciting or negotiating an individual health insurance policy to an employer, if the employer offers a group health insurance plan. Arguably, this restriction would prohibit an insurance agent from even discussing individual health insurance policies with the employer. Without this information, the employer may not understand the benefits individual health insurance policies may offer to both employees and the employer. Such benefits include:

- **Portability.** When an employer terminates its group health insurance plan, individual employees may be left with no insurance coverage whatsoever. Employees who wish to change jobs, or who are involuntarily terminated also lose their health insurance coverage, after their COBRA benefits expire. Individual health insurance policies, on the other hand, are completely portable, and "go with" the employee regardless of where the employee works.

The employee gets to decide whether he or she wants health insurance coverage—the decision is not left entirely to the employer.

- **Guaranteed renewals.** Individual health insurance policies provide for guaranteed renewal and cannot be terminated. The insurance carrier raise the premium based solely on the health of the insured.

- **Stable pricing.** Individual health insurance policies are less susceptible to the significant premium increases which seem to occur yearly with small group health insurance plans, because the rate is based upon a larger population of insured individuals. Individual health insurance policies are often less costly than group insurance plans, as well.

- **Without a doubt, individual coverage is better than no coverage at all.** Throughout the United States, employers are terminating their group insurance plans due to the frequent and substantial increases in insurance premiums. It is therefore important that employers are made aware that group coverage may not be the only option available for their employees, and that in many instances group plans may be much more expensive than purchasing individual policies. Under Section 78, however, an insurance agent would not be able to inform an employer about the other insurance or health benefit options available to it. Believing group plans are its only alternative, an employer might cancel its group plan, where it might have funded individual policies through an HRA, instead-if given a choice. This is bad for both employees and employers.

- **Individual insurance policies may benefit both employers and employees.** Individual insurance policies funded through an HRA are much

easier for an employer to administer. Since individual policies are portable, there are no COBRA regulations to be complied with. Also, since the premiums for individual policies are more stable than group insurance premiums, employers can better budget for their health benefit costs. And, if an individual's health care premium does increase, the employer has the option of covering the additional cost, or may request that the employee share in the additional cost. This option is not available with group insurance plans. Additionally, in cases where employees are required to pay 30-50% of the cost of group health insurance, all too frequently employees will 'opt out' of the coverage entirely and receive no health benefit contribution from their employer.

We believe the section as written is detrimental to both employees and employers, creates adverse unintended consequences, and seriously impairs Alaskan's ability to obtain quality health insurance at an affordable price.

We suggest the section be amended to delete the six month period during which employees who have lost their group coverage would not be able to obtain individual insurance policies.

We also suggest the section be amended to add a provision which allows the promotion of tax favored federal programs, such as HRAs, which employers may establish in order to enable their employees to pay for variety of direct medical expenses as well as the purchase individual health insurance policies through private providers or,

when pre-existing conditions dictate, through the Alaska Comprehensive Health

Insurance Association.

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# ALASKA STATE LEGISLATURE

## REPRESENTATIVE KURT OLSON

- Chair: Labor and Commerce
- Vice Chair: Rules, Administrative Regulation Review  
Economic Development Trade & Tourism
- Member: Energy, Legislative Budget & Audit

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### Sectional Analysis

#### CS House Bill 164 (L&C)

*"An Act relating to health care insurance, exemption of certain insurers, reporting, notice, and record-keeping requirements for insurers, biographical affidavits, qualifications of alien insurers assuming ceded insurance, risk-based capital for insurers, insurance holding companies, licensing, federal requirements for nonadmitted insurers, surplus lines insurance, insurance fraud, life insurance policies and annuity contracts, rate filings by health care insurers, long-term care insurance, automobile service corporations, guaranty fund deposits of a title insurer, joint title plants, fraternal benefit societies, multiple employer welfare arrangements, hospital and medical service corporations, health maintenance organizations, and alternate forms of payment to policyholders; and providing for an effective date."*

This is a summary only. Note that this sectional analysis should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents.

Sec.	Statute	Change	Purpose or Effect
1.	21.03.021	Amended by new subsection (f)	Clarifies that policies issued by a company exempt from licensing in 21.09.020(5) is exempt from the insurance statutes.
2.-21.	21.07		The changes to these sections modify terminology. The terms "managed care entity" and "managed care plan" are replaced with terms used in the other Alaska health insurance statutes. The term managed care entity is only used in AS 21.07 but actually means health care insurer and managed care plan means health care insurance policy which are the terms used in the other insurance statutes. Therefore, the changes to this chapter create consistency and reduce confusion over meaning of the terms.
22.	21.09.020	Amended	Adds an exemption from company licensing for

			companies that have issued a policy in another state that is now in this state and the insurer meets other qualifications for exemption adopted by the director.
23.	21.09.200(e)	Amended	Applies the penalty for a company not filing a statement or report to include the annual audit report and any other report required by this section.
24.	21.09.245(b)	Amended	Adds the electronic mailing address to the list of company changes required to be filed with the director.
25.	21.09	Amended by new section 21.09.247	Adds a requirement that a domestic insurer must file a biographical affidavit with the director when an officer or director of the insurer is appointed. The director is also given the authority to request an affidavit from a foreign insurer.
26.	21.09.320	Amended	Clarifies that foreign company licensees must maintain records as required in statute for domestic companies or as required by the domicile state, whichever is longer.
27.	21.12.020(a)	Amended	Clarifies that alien reinsurer trust funds must cover claims of US ceding insurers and not all US policyholders. This change is from NAIC model law.
28.	21.12.050(b)	Amended	Clarifies the definition of health care insurance to include the delivery, arrangement for, payment for or reimbursement of costs of medical care.
29.	21.14.200(4)	Amended	Adds to the definitions of a company action level event for a property and casualty insurer or health organization a risk based capital result of 300% and a negative trend over time. Presence of the event results in regulatory action. This change is from NAIC model law and is expected to be an accreditation requirement.
30.	21.14.200(9)	Amended	Clarifies the definition of a "life and health insurer" by including the filing of a life risk based capital report as evidence of a life and health insurer. This change is from NAIC model law.
31.	21.14.200(12)	Amended	Adds in the definition of "negative trend" references to property and casualty insurer and health organization for risk based capital purposes. This change is from NAIC model law and is expected to be an accreditation requirement.
32.	21.14.200(13)	Amended	Clarifies the definition of a "property and casualty insurer" by including the filing of a property/casualty risk based capital report as evidence of a property and casualty insurer. This change is NAIC model law.
33.	21.14.200	Amended by new paragraph	Adds a definition for a "health organization" to include several types of health companies, or companies that write primarily health insurance and

		(21)	file the health risk based capital report. This change is NAIC model law.
34.	21.22.060(k)	Amended	Changes the date for filing of the annual holding company registration statement from April 1 to May 1 to allow for a more complete report when filed. This change is a recommendation from the NAIC accreditation team.
35.	21.27.020(b)	Amended	Reference to the "Individual in a firm" was removed due to the proposal to repeal this license type.
36.	21.27.020(c )	Amended	Reference to the requirement that the firm's compliance officer notify the director of a termination of an individual in a firm was removed due to the proposal to repeal the "Individual in a firm" license type.
37.	21.27.025	Repealed and Reenacted	Adds the requirement for a licensee to notify the director of a change in email address to facilitate email communications; removed some notification requirements for "Individual in a firm" license types as well as the requirement for the compliance officer of a firm to notify the director of the termination of an individual in the firm.
38.	21.27.040(e)	Amended	Removes the requirement for nonresidents to submit fingerprints. This change is necessary to comply with the requirements under Gramm-Leach-Bliley Act and national uniformity license standards.
39.	21.27.100(c )	Amended	Indicates that the firm's company appointment would extend to any individual working under an employment contract with a firm since they are no longer licensed as an "Individual in a firm".
40.	21.27.140(b)	Amended	Removes the "Individual in a firm" license type and adds reference to employment contracts for individuals associated with firms.
41.	21.27	Amended by new section 21.27.215	Employment contracts are the mechanism that provides authority to the director to track individuals employed by and representing a firm since we will no longer issue an Individual in a firm license type. This new provision establishes requirements for individuals and firms and requires both parties to retain copies of the contracts to respond to a directors' inquiry. The firm will be held responsible for the actions of an employee transacting business under the firm's contracts.
42.	21.27.350(e)	Amended	Due to the proposed repeal of the "Individual in a firm" license type, this change clarifies that the records for a firm shall include and be considered the records of an individual employed by and representing a firm

			operating under an employment contract.
43.	21.27.360(f)	Amended	Due to the proposed repeal of the "Individual in a firm license type", this change clarifies that all money received by a firm as a fiduciary is not required of an individual employed by and representing a firm operating under an employment contract.
44.	21.27.790	Amended	Removes the requirement for nonresidents to hold an underlying property/casualty producer license to obtain a surplus lines broker license. This change is necessary to comply with the requirements under Gramm-Leach-Bliley Act and national uniformity license standards.
45.	21.27.900(22)	Amended	Reference to "Individual in a firm" license type was eliminated due to the proposal to repeal that license type.
46.	21.33.055(a)	Repealed and Reenacted	Modifies tax rate by combining the 2.7% surplus lines tax with the 1% surplus lines filing fee and allows for 100% collection of taxes for Multi-State risk where Alaska is the home state per federal law.
47.	21.33.055	Amended by new subsection (d)	Adds section to maintain penalties.
48.	21.33.061(c)	Repealed and Reenacted	Modifies the tax rate by combining the 2.7% surplus lines tax with the 1% surplus lines filing fee and allows for 100% collection of taxes in Alaska for risks located both in and out of this state.
49.	21.33.061	Amended by new subsection (j)	Adds section to maintain penalties.
50.	21.33	Amended by new section 21.33.063	Authorizes Director to join a multi-state agreement for the purposes of collecting taxes and distributing to other states where a portion of the risk is located.
51.	21.34.020(b)	Repealed and Reenacted	Amends to clarify an exempt commercial purchaser is not required to satisfy certain marketing requirements to comply with federal law.
52.	21.34.040(c)	Amended	Amends to meet minimum eligibility requirements of federal law and to add ability to use the National Association of Insurance Commissioners quarterly listing for Surplus Lines Insurer eligibility.
53.	21.34.040	Amended by new	Permits Director to approve a company as eligible using alternate eligibility requirements.

		subsection (f)	
		Amended by new subsection (g)	Authorizes Director to join a multi-state agreement to develop uniform eligibility requirements.
54.	21.34.080(a)	Amended	Modifies reporting requirements removing monthly reporting
55.	21.34.170(a)	Amended	Modifies reporting requirements to specified quarterly dates
56.	21.34.180	Repealed and Reenacted	Modifies to allow 100% tax collection in Alaska on risks located both in and out of this state, authorizes the director to participate in an agreement with other states for collecting and disbursing taxes on portions out of this state and authorizes an allocation schedule be adopted by regulation for apportioning taxable premiums.
57	21.34.190(a)	Amended	Corrects reference
58.	21.34.900	Amended by new paragraph (10)	Adds definition of affiliate to comply with federal law.
		Amended by new paragraph (11)	Adds definition of affiliated group to comply with federal law.
		Amended by new paragraph (12)	Adds definition of control to comply with federal law.
		Amended by new paragraph (13)	Adds definition of exempt commercial purchaser to comply with federal law.
		Amended by new paragraph (14)	Adds definition of home state to be used in determination of tax collection and authority over surplus lines transactions to comply with federal law.
		Amended by new paragraph (15)	Adds definition of remitting state to comply with federal law.
59.	21.36	Amended by new section	Current Alaska laws do not require notification to consumers of changes in health insurance contracts provisions, premiums or coverage. This section

		21.36.225	requires insurers to provide advance notice to consumers of such changes.
60.	21.36.360(q)	Amended	Provides that forging an insurance document would be a felony regardless of whether there was intent to defraud
61.	21.45.020	Amended by new subsections (c) and (d)	These sections adds an important protection for consumers by requiring insurers to give consumers at least 10 days to return a policy and receive a refund of premium.
62.	21.51.405	Amended by new subsection (b)	The amendment to this section requires filing and approval of <u>individual</u> health care insurance rates by all insurers in Alaska. This will level the playing field with hospital or medical service corporations in Alaska and will allow the Director to disapprove rates that do not comply with minimum state law prohibiting rates that are excessive, inadequate or unfairly discriminatory to help assure that such rates are not used in Alaska.  Currently only hospital or medical service corporations (Premera Blue Cross) must file rates with the Division of Insurance.
		Amended by new subsection (c)	This section requires the director to adopt regulations implementing the rate requirements in this section.
	AS 21.53		The changes to this chapter update Alaska's long term care statutes which are 20 years old. Long term care insurance has changed over the last 20 years and the changes will allow us to adopt regulations to address the current long term care market. In addition to bringing the laws up to date, adopting the current NAIC Long Term Care model provisions will allow insurers to offer long term care policies in Alaska that comply with the federal long term care partnership policy requirements should Alaska decide to participate in this program in the future. In addition the Division currently has authority to review and approve long term care forms but not rates and the changes will allow the Director to require filing and approval of rates before use for the protection of Alaskan consumers.
63.	21.53.020	Amended	(1) and (2) are technical terminology clean-up and the change in (3) removes the requirement to consider number of days in evaluating the levels of coverage

64.	21.53.030(a)	Amended	Removes the prudent person condition in the definition of preexisting condition in order to remove subjectivity in the determination of whether a preexisting condition.
65.	21.53.030(b)	Amended	Technical terminology clean-up
66.	21.53.030 (d)	Amended	Technical terminology clean-up
67.	21.53.040	Amended	Adds a prohibition against conditioning eligibility for a benefit on prior institutionalization with specified exceptions and clarifies disclosure of postconfinement, postacute care or recuperative benefit limitations or conditions in the policy.
68.	21.53.050(a)	Amended	Adds right to receive refunds of premium within 30 days if a policy is return within 30 days or if an application is denied.
69.	21.53.050(b)	Amended	Adds a requirement to include in the outline of coverage a statement regarding whether the policy is intended to be a federally qualified long term care policy.
70.	21.53.050	Amended by new subsection (d)	Adds an exemption for group policies from the requirement to provide an outline of coverage if information is contained in other enrollment materials
		Amended by new subsection (e)	Requires an insurer to deliver a policy no later than 30 days after approval.
71.	21.53.060(a)	Amended	Adds a requirement that the policy summary state that inflation protection is not available under the policy, if the director adopts a regulation that does not require inflation protection
72.	21.53.060	Amended by new subsection (c)	Requires insurers to provide a written explanation of the reasons for claim denial and to make all information directly related to the denial available to the policyholder within 60 days of request
73.	21.53	Amended by new section 21.53.062	<p>---Restricts an insurer from rescinding or denying a claim</p> <p>*within 6 months except upon showing of misrepresentation material to acceptance of coverage.</p> <p>*within 6 months to 2 years upon showing of misrepresentation material to acceptance of coverage and pertaining to the condition for which benefits are sought</p> <p>*prohibiting an insurer from recovering payments if a policy is rescinded</p> <p>hours that is not product or company specific or sales or marketing, and must consist of long term care insurance topics</p>

		Amended by new section 21.53.064	---Requires insurers to offer non-forfeiture benefits and if policyholder declines, the insurer must provide a contingent benefit upon lapse
		Amended by new section 21.53.066	---Requires producers to complete a one-time long term care specific training of at least 8 credit hours
		Amended by new section 21.53.068	Requires insurers to compensate a producer or third-party administrator based on the number of policies issued when the producer or third party administrator is granted underwriting authority by the insurer
74.	21.53.090	Amended	Adds authority to adopt regulations relating to incontestability periods; producer training, education, compensation, and testing; marketing practices, independent review of benefit determinations; penalties and reporting practices; premium rates including rate filing requirements; and format and content of outline of coverage.
75.	21.53.200(3)	Amended	Adds reference to applicable existing association requirements in the definition of group long term care insurance.
76.	21.53.200(4)	Amended	Adds an exception to the long term care insurance definition for accelerated death benefits in life insurance policies that are not conditioned on the receipt of long term care.
77.	21.54.015	Amended by new subsection (c)	This section requires filing and approval of <u>group</u> health care insurance rates by all insurers in Alaska will level the playing field with hospital or medical service corporations in Alaska and will allow the Director to disapprove rates that do not comply with minimum state law prohibiting rates that are excessive, inadequate or unfairly discriminatory to help assure that such rates are not used in Alaska.  Currently only hospital or medical service corporations (Premera Blue Cross) must file rates with the Division of Insurance.
		Amended by new subsection (d)	This section requires the director to adopt regulations implementing the rate requirements in this section.
78.	21.54.020(a)	Amended	Removes reference to managed care plan in AS 21.07 because the reference is incorrect and the term is no longer used.
79.	21.54	Amended by new	The change to this section prohibits sales of individual policies to employers or employees except as specified.

		section 21.54.180	This change is needed in order to help preserve the group insurance protections provided to employees under state and federal law, including guarantee issue to eligible employees of small employers, and the prohibition on discrimination based on health status in enrollment and rates.
80.	21.54.500(16)	Amended	Technical clean-up.
81.	21.59.070	Amended	Adds to the list of statutes applicable to a domestic automobile service corporation requirements to file company information with the director when changes occur in that information and to file biographical affidavits by domestic automobile services corporations when an officer or director is appointed. The director is also given authority to request an affidavit from a foreign automobile service corporation.
82.	21.66.020	Amended by new subsection (b)	Adds administrative statutes giving the director authority to take control of a title company deposit held by the director when a title insurer is insolvent, and authority to pay claims with the funds. For a title insurer domiciled in another state, the director shall file for ancillary receivership.
		Amended by new subsection (c)	Adds administrative statutes to specify when title company deposits can be returned to the company by the director.
		Amended by new subsection (d)	Adds references to deposit administration statutes in Chapter 21.24 for administration of deposits of insurance companies with the director. These references include the requirement of a custodial agreement, that the expenses of the deposit account are paid by the company, and neither the director or state is liable for the safekeeping of the deposit.
83.	21.66.210(a)	Amended	Adds requirement that an application for a joint title plan must include basic identifying information and location information including an electronic mailing address.
84.	21.69.390(d)	Amended	Clarifies that the requirement for maintenance of documents by an Alaska company must include the contract and claim files for insurance and other products sold and is not limited to only risks in the state. The company's documents also must include administrative and management contracts.
85.	21.72.170	Amended	Adds to the list of statutes applicable to benevolent associations requirements to file biographical affidavits by domestic benevolent associations when officers and directors change and gives the director

			authority to request an affidavit from a foreign association.
86.	21.75.060(b)	Amended	Adds that an application for licensing of a reciprocal insurer must include the mailing address, electronic mailing address and phone number.
87.	21.79.025(a)	Amended	Adopts revisions to the Alaska Life and Health Guaranty Association payment limitations by allowing a limit of \$300,000 for long term care insurance and increasing from \$100,000 to \$250,000 the claim limit on annuity benefits. This change is from NAIC model law.
88.	21.84.335(b)	Amended	Adds to the list of statutes applicable to fraternal benefit societies requirements to file company information with the director when changes occur in that information and to file biographical affidavits by domestic fraternal benefit societies when an officer or director of the insurer is appointed. The director is also given authority to request an affidavit from a foreign fraternal benefit society.
89.	21.85.030(a)	Amended	Allows a multiple employer welfare association to offer disability insurance coverage complying with the insurance statutes or limited short term disability coverage if approved by the director.
90.	21.85.040	Amended	Adds requirements for a foreign multiple employer welfare arrangement to file in their license application copies of certificates issued by the domicile state and financial information, analyses, and examination reports filed by the entity in their domicile state.
91.	21.86	Amended by new section 21.86.045	Adds a requirement that a domestic health maintenance organization must file biographical affidavits when an officer or a director of the organization is appointed. The director is also given authority to request an affidavit from a foreign health maintenance organization.
92.	21.87.340	Amended	Adds to the list of statutes applicable to hospital and medical service corporations the requirement comply with the new rate requirements in Sec. 58 and 73.
93.	21.96.030	Amended	Will allow for forms of payment other than a negotiable bank check, such as retained asset accounts, if agreed to by the policyholder or beneficiary.
94.	21.07.040	Repealed	This section is repealed because confidentiality of health information is addressed in AS 21.36.510 and regulations adopted by the director as required by that statute.
	21.07.250(7)	Repealed	Term is no longer used
	21.07.250(8)	Repealed	Term is no longer used
	21.07.250(9)	Repealed	Term is no longer used

	21.27.020(e)	Repealed	The provision that an individual licensed as an "Individual in a firm" remain licensed while changing employers is no longer required due to the proposal to repeal this license type.
	21.27.025(b)	Repealed	The requirement to notify the director when individuals leave or join the firm has been eliminated
	21.27.340	Repealed	Antiquated requirement to display life or health insurance license is no longer necessary due to electronic access to information.
	21.27.900(14)	Repealed	Definition for "Individual in a firm" was repealed, streamlining our license processes by eliminating filing and notification requirements, while moving us towards compliance with national license uniformity standards.
	21.53.200(5)	Repealed	The definition of policy is already defined in AS 21.90.900 and this is not consistent with that definition.
	21.87.190(b)	Repealed	Hospital or medical service corporations will be subject to the new rate requirements in Section 58 and Section 73 and therefore must be deleted.
95.	Uncodified Law of State of Alaska	Amended by new section	This section provides a transition period for producers to complete the necessary education course required by Section 72.
96.	Uncodified Law of State of Alaska	Amended by new section	Allows the division to start adoption of regulations to implement this act but such regulations cannot be effective before the effective date of the relevant statute.
97.	Uncodified Law of State of Alaska	Amended by new section	This section modifies the heading of AS 21.07 because the term managed care is no longer used and modified the heading of AS 21.34.170 to reflect the modification to the reporting requirements.
98.	Effective Date	Section 96	Immediate effective date to start adoption of regulations
99.	Effective Date	Sections 46-57	Changes to unauthorized insurers statutes in Chapter 33 and surplus lines insurance statutes in Chapter 34 are effective July 21, 2011
100.	Effective Date	Sections 62, 77	Effective January 1, 2012
101.	Effective Date	All Sections except 98	Effective July 1, 2011.

# ALASKA STATE LEGISLATURE

## REPRESENTATIVE KURT OLSON

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Economic Development Trade & Tourism
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### MEMORANDUM

TO: Representative Bill Stoltze, Co-Chair  
Representative Bill Thomas, Co-Chair  
House Finance Committee

FROM: Rep. Kurt Olson

DATE: March 9, 2011

RE: Hearing Request

I respectfully request that HB 164 be scheduled for a hearing in the House Finance Committee at your earliest convenience.

Attached to this memo you will find the following documents:

- The current version of CS HB 164 (L&C)
- Sponsor Statement
- Sectional Analysis
- Fiscal Note

At this time only my staff and Linda Hall, Director of the Division of Insurance will be testifying.

Please contact my staff, Konrad Jackson at 465-4954 with any questions regarding this legislation.

Thank you for your attention to this matter.