ALASKA LEGISLATURE
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1 (8) the annual percentage of health claims paid in the state that meets
2 the requirements of **AS 21.36.128(a) and (d)** [AS 21.54.020(a) AND (d)]; and
3 * Sec. 2. AS 21.06.160(a) is amended to read:
4 (a) Each person examined, other than examinations under AS 21.06.130, shall
5 pay a reasonable rate calculated on salary, benefit costs, and estimated division
6 overhead for time spent directly or indirectly related to the examination. Each person
7 examined, other than examinations under AS 21.06.130, shall pay actual out-of-pocket
8 business expenses, including travel expenses, incurred by division staff examiners and
9 shall pay the compensation of a contract examiner, to be set at a reasonable customary
10 rate, for conducting the examination upon presentation of a detailed account of the
11 charges and expenses by the director or under an order of the director. The accounting
12 may either be presented periodically during the course of the examination or at the
13 termination of the examination. A person may not pay and an examiner may not
14 accept additional compensation for an examination. **A person shall pay examination
15 expenses to the division under this subsection using an electronic payment
16 method specified by the director.**
17 * Sec. 3. AS 21.07.010(a) is amended to read:
18 (a) A contract between a participating health care provider and a managed care
19 entity that offers a [GROUP] managed care plan must contain a provision that
20 (1) provides for a reasonable mechanism to identify all **medical**
21 [HEALTH] care services to be provided by the managed care entity;
22 (2) clearly states or references an attachment that states the health care
23 provider's rate of compensation;
24 (3) clearly states all ways in which the contract between the health care
25 provider and managed care entity may be terminated; a provision that provides for
26 discretionary termination by either party must apply equitably to both parties;
27 (4) provides that, in the event of a dispute between the parties to the
28 contract, a fair, prompt, and mutual dispute resolution process must be used; at a
29 minimum, the process must provide
30 (A) for an initial meeting at which all parties are present or
31 represented by individuals with authority regarding the matters in dispute; the

1 meeting shall be held within 10 working days after the plan receives written
2 notice of the dispute or gives written notice to the provider, unless the parties
3 otherwise agree in writing to a different schedule;
4 (B) that if, within 30 days following the initial meeting, the
5 parties have not resolved the dispute, the dispute shall be submitted to
6 mediation directed by a mediator who is mutually agreeable to the parties and
7 who is not regularly under contract to or employed by either of the parties;
8 each party shall bear its proportionate share of the cost of mediation, including
9 the mediator fees;
10 (C) that if, after a period of 60 days following commencement
11 of mediation, the parties are unable to resolve the dispute, either party may
12 seek other relief allowed by law;
13 (D) that the parties shall agree to negotiate in good faith in the
14 initial meeting and in mediation;
15 (5) states that a health care provider may not be penalized or the health
16 care provider's contract terminated by the managed care entity because the health care
17 provider acts as an advocate for a covered person in seeking appropriate, medically
18 necessary **medical** [HEALTH] care services;
19 (6) protects the ability of a health care provider to communicate openly
20 with a covered person about all appropriate diagnostic testing and treatment options;
21 and
22 (7) defines words in a clear and concise manner.
23 * **Sec. 4.** AS 21.07.010(b) is amended to read:
24 (b) A contract between a participating health care provider and a managed
25 care entity that offers a [GROUP] managed care plan may not contain a provision that
26 (1) has as its predominant purpose the creation of direct financial
27 incentives to the health care provider for withholding covered **medical** [HEALTH]
28 care services that are medically necessary; nothing in this paragraph shall be construed
29 to prohibit a contract between a participating health care provider and a managed care
30 entity from containing incentives for efficient management of the utilization and cost
31 of covered **medical** [HEALTH] care services;

1 (2) requires the provider to contract for all products that are currently
2 offered or that may be offered in the future by the managed care entity; or
3 (3) requires the health care provider to be compensated for **medical**
4 [HEALTH] care services performed at the same rate as the health care provider has
5 contracted with another managed care entity.
6 * **Sec. 5.** AS 21.07.020 is amended to read:
7 **Sec. 21.07.020. Required contract provisions for [GROUP] managed care**
8 **plans.** A [GROUP] managed care plan must contain
9 (1) a provision that preauthorization for a covered medical procedure
10 on the basis of medical necessity may not be retroactively denied unless the
11 preauthorization is based on materially incomplete or inaccurate information provided
12 by or on behalf of the provider;
13 (2) a provision for emergency room services if any coverage is
14 provided for treatment of a medical emergency;
15 (3) a provision that covered **medical** [HEALTH] care services be
16 reasonably available in the community in which a covered person resides or that, if
17 referrals are required by the plan, adequate referrals outside the community be
18 available if the **medical** [HEALTH] care service is not available in the community;
19 (4) a provision that any utilization review decision
20 (A) must be made within 72 hours after receiving the request
21 for preapproval for nonemergency situations; for emergency situations,
22 utilization review decisions for care following emergency services must be
23 made as soon as is practicable but in any event **not** [NO] later than 24 hours
24 after receiving the request for preapproval or for coverage determination; and
25 (B) to deny, reduce, or terminate a health care benefit or to
26 deny payment for a **medical** [HEALTH] care service because that service is
27 not medically necessary shall be made by an employee or agent of the
28 managed care entity who is a licensed health care provider;
29 (5) a provision that provides for an internal appeal mechanism for a
30 covered person who disagrees with a utilization review decision made by a managed
31 care entity; except as provided under (6) of this section, this appeal mechanism must

1 provide for a written decision
2 (A) from the managed care entity within 18 working days after
3 the date written notice of an appeal is received; and
4 (B) on the appeal by an employee or agent of the managed care
5 entity who holds the same professional license as the health care provider who
6 is treating the covered person;
7 (6) a provision that provides for an internal appeal mechanism for a
8 covered person who disagrees with a utilization review decision made by a managed
9 care entity in any case in which delay would, in the written opinion of the treating
10 provider, jeopardize the covered person's life or materially jeopardize the covered
11 person's health; the managed care entity shall
12 (A) decide an appeal described in this paragraph within 72
13 hours after receiving the appeal; and
14 (B) provide for a written decision on the appeal by an
15 employee or agent of the managed care entity who holds the same professional
16 license as the health care provider who is treating the covered person;
17 (7) a provision that discloses the existence of the right to an external
18 appeal of a utilization review decision made by a managed care entity; the external
19 appeal shall be as conducted in accordance with AS 21.07.050;
20 (8) a provision that discloses covered benefits, optional supplemental
21 benefits, and benefits relating to and restrictions on nonparticipating provider services;
22 (9) a provision that describes the preapproval requirements and
23 whether clinical trials or experimental or investigational treatment are covered;
24 (10) a provision describing a mechanism for assignment of benefits for
25 health care providers and payment of benefits;
26 (11) a provision describing availability of prescription medications or a
27 formulary guide, and whether medications not listed are excluded; if a formulary guide
28 is made available, the guide must be updated annually; and
29 (12) a provision describing available translation or interpreter services,
30 including audiotape or braille information.
31 * Sec. 6. AS 21.07.030 is amended to read:

New Text Underlined [DELETED TEXT BRACKETED]

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

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

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

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

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

1 [GROUP] managed care plan shall permit <u>a covered person</u> [AN ENROLLEE] to
2 receive medically necessary or appropriate specialty care, subject to appropriate
3 referral procedures, from any qualified participating health care provider that is
4 available to accept the individual for medical care. This subsection does not apply to
5 specialty care if the managed care entity clearly informs <u>covered persons</u>
6 [ENROLLEES] of the limitations on choice of participating health care providers with
7 respect to medical care. In this subsection,
8 (1) "appropriate referral procedures" means procedures for referring
9 patients to other health care providers as set out in the applicable member contract and
10 as described under (a) of this section;
11 (2) "specialty care" means care provided by a health care provider with
12 training and experience in treating a particular injury, illness, or condition.
13 (f) If a contract between a health care provider and a managed care entity is
14 terminated, a covered person may continue to be treated by that health care provider as
15 provided in this subsection. If a covered person is pregnant or being actively treated by
16 a provider on the date of the termination of the contract between that provider and the
17 managed care entity, the covered person may continue to receive <u>medical</u> [HEALTH]
18 care services from that provider as provided in this subsection, and the contract
19 between the managed care entity and the provider shall remain in force with respect to
20 the continuing treatment. The covered person shall be treated for the purposes of
21 benefit determination or claim payment as if the provider were still under contract
22 with the managed care entity. However, treatment is required to continue only while
23 the [GROUP] managed care plan remains in effect and
24 (1) for the period that is the longest of the following:
25 (A) the end of the current plan year;
26 (B) up to 90 days after the termination date, if the event
27 triggering the right to continuing treatment is part of an ongoing course of
28 treatment; [OR]
29 (C) through completion of postpartum care, if the covered
30 person is pregnant on the date of termination; or
31 (2) until the end of the medically necessary treatment for the condition,

1 disease, illness, or injury if the person has a terminal condition, disease, illness, or
2 injury; in this paragraph, "terminal" means a life expectancy of less than one year.
3 (g) The requirements of this section do not apply to **medical** [HEALTH] care
4 services covered by Medicaid.
5 *** Sec. 7.** AS 21.07.040(c) is amended to read:
6 (c) Nothing in this section may be construed to prohibit the exchange of
7 medical information between and among health care providers of an applicant or a
8 person currently or formerly covered by a managed care plan for purposes of
9 providing **medical** [HEALTH] care services.
10 *** Sec. 8.** AS 21.07.050(a) is amended to read:
11 (a) A managed care entity offering **a managed care plan** [GROUP HEALTH
12 INSURANCE COVERAGE] shall provide for an external appeal process that meets
13 the requirements of this section in the case of an externally appealable decision for
14 which a timely appeal is made in writing either by the managed care entity or by the
15 **covered person** [ENROLLEE].
16 *** Sec. 9.** AS 21.07.050(c) is amended to read:
17 (c) Except as provided in this subsection, the external appeal process shall be
18 conducted under a contract between the managed care entity and one or more external
19 appeal agencies that have qualified under AS 21.07.060. The managed care entity shall
20 provide
21 (1) that the selection process among external appeal agencies
22 qualifying under AS 21.07.060 does not create any incentives for external appeal
23 agencies to make a decision in a biased manner;
24 (2) for auditing a sample of decisions by external appeal agencies to
25 **ensure** [ASSURE] that decisions are not made in a biased manner; and
26 (3) that all costs of the process, except those incurred by the **covered**
27 **person** [ENROLLEE] or treating professional in support of the appeal, shall be paid
28 by the managed care entity and not by the **covered person** [ENROLLEE].
29 *** Sec. 10.** AS 21.07.050(d) is amended to read:
30 (d) An external appeal process must include at least the following:
31 (1) a fair, de novo determination based on coverage provided by the

1 plan and by applying terms as defined by the plan; however, nothing in this paragraph
2 may be construed as providing for coverage of items and services for which benefits
3 are excluded under the plan or coverage;
4 (2) an external appeal agency shall determine whether the managed
5 care entity's decision is (A) in accordance with the medical needs of the patient
6 involved, as determined by the managed care entity, taking into account, as of the time
7 of the managed care entity's decision, the patient's medical needs and any relevant and
8 reliable evidence the agency obtains under (3) of this subsection, and (B) in
9 accordance with the scope of the covered benefits under the plan; if the agency
10 determines the decision complies with this paragraph, the agency shall affirm the
11 decision, and, to the extent that the agency determines the decision is not in
12 accordance with this paragraph, the agency shall reverse or modify the decision;
13 (3) the external appeal agency shall include among the evidence taken
14 into consideration
15 (A) the decision made by the managed care entity upon internal
16 appeal under AS 21.07.020 and any guidelines or standards used by the
17 managed care entity in reaching a decision;
18 (B) any personal health and medical information supplied with
19 respect to the individual whose denial of claim for benefits has been appealed;
20 (C) the opinion of the individual's treating physician or health
21 care provider; and
22 (D) the [GROUP] managed care plan;
23 (4) the external appeal agency may also take into consideration the
24 following evidence:
25 (A) the results of studies that meet professionally recognized
26 standards of validity and replicability or that have been published in peer-
27 reviewed journals;
28 (B) the results of professional consensus conferences
29 conducted or financed in whole or in part by one or more government
30 agencies;
31 (C) practice and treatment guidelines prepared or financed in

1 whole or in part by government agencies;
2 (D) government-issued coverage and treatment policies;
3 (E) generally accepted principles of professional medical
4 practice;
5 (F) to the extent that the agency determines it to be free of any
6 conflict of interest, the opinions of individuals who are qualified as experts in
7 one or more fields of health care that are directly related to the matters under
8 appeal;
9 (G) to the extent that the agency determines it to be free of any
10 conflict of interest, the results of peer reviews conducted by the managed care
11 entity involved;
12 (H) the community standard of care; and
13 (I) anomalous utilization patterns;
14 (5) an external appeal agency shall determine
15 (A) whether a denial of a claim for benefits is an externally
16 appealable decision;
17 (B) whether an externally appealable decision involves an
18 expedited appeal; and
19 (C) for purposes of initiating an external review, whether the
20 internal appeal process has been completed;
21 (6) a party to an externally appealable decision may submit evidence
22 related to the issues in dispute;
23 (7) the managed care entity involved shall provide the external appeal
24 agency with access to information and to provisions of the plan or health insurance
25 coverage relating to the matter of the externally appealable decision, as determined by
26 the external appeal agency; and
27 (8) a determination by the external appeal agency on the decision must
28 (A) be made orally or in writing and, if it is made orally, shall
29 be supplied to the parties in writing as soon as possible;
30 (B) be made in accordance with the medical exigencies of the
31 case involved, but in no event later than 21 working days after the appeal is

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

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

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

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

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

(1) means

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

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

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

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

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

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

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

1 (1) the agency meets the independence requirements of this section;
2 (2) the agency conducts external appeal activities through a panel of
3 two clinical peers, unless otherwise agreed to by both parties; and
4 (3) the agency has sufficient medical, legal, and other expertise and
5 sufficient staffing to conduct external appeal activities for the managed care entity on
6 a timely basis consistent with this chapter.
7 * **Sec. 14.** AS 21.07.060(d) is amended to read:
8 (d) In this section, "related party" means
9 (1) with respect to
10 (A) a **managed care** [GROUP HEALTH] plan [OR HEALTH
11 INSURANCE COVERAGE OFFERED IN CONNECTION WITH A PLAN],
12 the plan or the insurer offering the coverage; or
13 (B) individual health insurance coverage, the insurer offering
14 the coverage, or any plan sponsor, fiduciary, officer, director, or management
15 employee of the plan or issuer;
16 (2) the health care professional that provided the health care involved
17 in the coverage decision;
18 (3) the institution at which the health care involved in the coverage
19 decision is provided;
20 (4) the manufacturer of any drug or other item that was included in the
21 health care involved in the coverage decision;
22 (5) the covered person; or
23 (6) any other party that, under the regulations that the director may
24 prescribe, is determined by the director to have a substantial interest in the coverage
25 decision.
26 * **Sec. 15.** AS 21.07.080 is amended to read:
27 **Sec. 21.07.080. Religious nonmedical providers.** This chapter may not be
28 construed to
29 (1) restrict or limit the right of a managed care entity to include
30 [HEALTH CARE] services provided by a religious nonmedical provider as **medical**
31 [HEALTH] care services covered by the managed care plan;

1 (2) require a managed care entity, when determining coverage for
2 [HEALTH CARE] services provided by a religious nonmedical provider, to
3 (A) apply medically based eligibility standards;
4 (B) use health care providers to determine access by a covered
5 person;
6 (C) use health care providers in making a decision on an
7 internal or external appeal; or
8 (D) require a covered person to be examined by a health care
9 provider as a condition of coverage; or
10 (3) require a managed care plan to exclude coverage for [HEALTH
11 CARE] services provided by a religious nonmedical provider because the religious
12 nonmedical provider is not providing medical or other data required from a health care
13 provider if the medical or other data is inconsistent with the religious nonmedical
14 treatment or nursing care being provided.
15 * **Sec. 16.** AS 21.07.250(1) is amended to read:
16 (1) "clinical peer" means a health care provider who is licensed to
17 provide the same or similar **medical** [HEALTH] care services and who is trained in
18 the specialty or subspecialty applicable to the **medical** [HEALTH] care services that
19 are provided;
20 * **Sec. 17.** AS 21.07.250(3) is amended to read:
21 (3) "emergency room services" means **medical** [HEALTH] care
22 services provided by a hospital or other emergency facility after the sudden onset of a
23 medical condition that manifests itself by symptoms of sufficient severity, including
24 severe pain, that the absence of immediate medical attention would reasonably be
25 expected by a prudent person who possesses an average knowledge of health and
26 medicine to result in
27 (A) the placing of the person's health in serious jeopardy;
28 (B) a serious impairment to bodily functions; or
29 (C) a serious dysfunction of a bodily organ or part;
30 * **Sec. 18.** AS 21.07.250(5) is amended to read:
31 (5) "health care provider" means a person licensed in this state or

1 another state of the United States to provide <u>**medical**</u> [HEALTH] care services;
2 * **Sec. 19.** AS 21.07.250(10) is amended to read:
3 (10) "managed care entity" means an insurer, a hospital or medical
4 service corporation, a health maintenance organization, an employer or employee
5 health care organization, a managed care contractor that operates a [GROUP]
6 managed care plan, or a person who has a financial interest in <u>**medical**</u> [HEALTH]
7 care services provided to an individual;
8 * **Sec. 20.** AS 21.07.250(12) is amended to read:
9 (12) "participating health care provider" means a health care provider
10 who has entered into an agreement with a managed care entity to provide services or
11 supplies to a patient covered by a [GROUP] managed care plan;
12 * **Sec. 21.** AS 21.07.250(13) is amended to read:
13 (13) "primary care provider" means a health care provider who
14 provides general <u>**medical**</u> [HEALTH] care services and does not specialize in treating
15 a single injury, illness, or condition or who provides obstetrical, gynecological, or
16 pediatric <u>**medical**</u> [HEALTH] care services;
17 * **Sec. 22.** AS 21.07.250(15) is amended to read:
18 (15) "religious nonmedical provider" means a person who [DOES
19 NOT PROVIDE MEDICAL CARE, BUT WHO] provides only religious nonmedical
20 treatment or nursing care for an illness or injury;
21 * **Sec. 23.** AS 21.07.250(16) is amended to read:
22 (16) "utilization review" means a system of reviewing the medical
23 necessity, appropriateness, or quality of <u>**medical**</u> [HEALTH] care services and
24 supplies provided under a [GROUP] managed care plan using specified guidelines,
25 including preadmission certification, the application of practice guidelines, continued
26 stay review, discharge planning, preauthorization of ambulatory procedures, and
27 retrospective review;
28 * **Sec. 24.** AS 21.07.250 is amended by adding new paragraphs to read:
29 (18) "managed care plan" or "plan" means an individual or group
30 health insurance plan operated by a managed care entity;
31 (19) "medical care" has the meaning given in AS 21.90.900.

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

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

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

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

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

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

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

1 report or work papers.

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

12 (e) In this section,

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

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

17 (A) Casualty Actuarial Society; or

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

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

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

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

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

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

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

1 (4) [(5)] provide to the director documents necessary to verify the
2 information contained in or made in connection with the application; and
3 (5) [(6)] notify the director, in writing, within 30 days of a change in
4 the firm's compliance officer or of the termination of employment of an individual in
5 the firm licensee.
6 * **Sec. 27.** AS 21.27.020(g) is amended to read:
7 (g) The director shall establish a continuing education advisory committee.
8 The committee consists of one representative from the division of insurance, one life
9 and health insurance representative, [ONE LIMITED LINES INSURANCE
10 REPRESENTATIVE,] one property and casualty insurance representative, and one
11 independent insurance adjuster representative. Each committee representative from the
12 insurance industry must possess a valid, current insurance license issued in this state
13 for the field to be represented.
14 * **Sec. 28.** AS 21.27.040 is amended by adding a new subsection to read:
15 (f) If, through inaction, an applicant fails to complete the application process,
16 the applicant's application filed with the director under (a) of this section is considered
17 withdrawn. The withdrawal becomes effective 120 days after the filing of the
18 application. If the director has initiated administrative action with respect to an
19 application, withdrawal becomes effective at the time and on the conditions required
20 by an order issued under this chapter.
21 * **Sec. 29.** AS 21.27.620(a) is amended to read:
22 (a) An insurer may not transact business with a managing general agent unless
23 (1) the insurer holds a certificate of authority in this state;
24 (2) the managing general agent is licensed under this chapter or **has**
25 **filed a certification with the director certifying that** [, WHEN] the managing
26 general agent is operating only for a foreign insurer **and** [,] is licensed by its resident
27 insurance regulator in a state that the director has determined has enacted provisions
28 substantially similar to those contained in this chapter and the state is accredited by the
29 National Association of Insurance Commissioners;
30 (3) a written contract is in effect between the parties that establishes
31 the responsibilities of each party, indicates both party's share of responsibility for a

1 particular function, and specifies the division of responsibilities;
2 (4) a written contract between an insurer and a managing general agent
3 contains the following provisions:
4 (A) the insurer may terminate the contract for cause upon
5 written notice sent by certified mail to the managing general agent and may
6 suspend the underwriting authority of the managing general agent during a
7 dispute regarding the cause for termination;
8 (B) the managing general agent shall render accounts to the
9 insurer detailing all transactions and remit all money due under the contract to
10 the insurer at least monthly;
11 (C) all money collected for the account of an insurer shall be
12 held by the managing general agent as a fiduciary;
13 (D) all payments on behalf of the insurer shall be held by the
14 managing general agent as a fiduciary;
15 (E) the managing general agent may not retain more than three
16 **months'** [MONTHS] estimated claims payments and allocated loss adjustment
17 expenses;
18 (F) the managing general agent shall maintain separate records
19 for each insurer in a form usable by the insurer; the insurer or its authorized
20 representative shall have the right to audit and the right to copy all accounts
21 and records related to the insurer's business; the director, in addition to
22 authority granted in this title, shall have access to all books, bank accounts, and
23 records of the managing general agent in a form usable to the director;
24 (G) the contract may not be assigned in whole or in part by the
25 managing general agent;
26 (H) if the contract permits the managing general agent to do
27 underwriting, the contract must include the following:
28 (i) the managing general agent's maximum annual
29 premium volume;
30 (ii) the rating system and basis of the rates to be
31 charged;

1 (iii) the types of risks that may be written;
2 (iv) maximum limits of liability;
3 (v) applicable exclusions;
4 (vi) territorial limitations;
5 (vii) policy cancellation provisions;
6 (viii) the maximum policy term; and
7 (ix) that the insurer shall have the right to cancel or not
8 renew a policy of insurance subject to applicable state law;
9 (I) if the contract permits the managing general agent to settle
10 claims on behalf of the insurer, the contract must include the following:
11 (i) written settlement authority must be provided by the
12 insurer and may be terminated for cause upon the insurer's written
13 notice sent by certified mail to the managing general agent or upon the
14 termination of the contract, but the insurer may suspend the settlement
15 authority during a dispute regarding the cause of termination;
16 (ii) claims shall be reported to the insurer within 30
17 days;
18 (iii) a copy of the claim file shall be sent to the insurer
19 upon request or as soon as it becomes known that the claim has the
20 potential to exceed an amount determined by the director or exceeds the
21 limit set by the insurer, whichever is less, involves a coverage dispute,
22 may exceed the managing general agent's claims settlement authority,
23 is open for more than six months, involves extra contractual
24 allegations, or is closed by payment in excess of an amount set by the
25 director or an amount set by the insurer, whichever is less;
26 (iv) each party shall comply with unfair claims
27 settlement statutes and regulations;
28 (v) transmission of electronic data at least monthly if
29 electronic claim files are in existence; and
30 (vi) claim files shall be the property of both the insurer
31 and managing general agent; upon an order of liquidation of the

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

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

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

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

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

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

1 BY THE NATIONAL ASSOCIATION OF INSURANCE
2 COMMISSIONERS]; and
3 (L) [IF THE CONTRACT IS NOT REQUIRED TO BE
4 APPROVED IN ADVANCE BY THE DIRECTOR,] the insurer shall provide
5 written notification to the director within 30 days of the [ENTRY INTO OR]
6 termination of a contract with a managing general agent [; THE NOTICE
7 MUST INCLUDE A STATEMENT OF DUTIES TO BE PERFORMED BY
8 THE MANAGING GENERAL AGENT ON BEHALF OF THE INSURER,
9 THE KINDS AND CLASSES OF INSURANCE FOR WHICH THE
10 MANAGING GENERAL AGENT HAS AUTHORIZATION TO ACT, AND
11 OTHER INFORMATION REQUIRED BY THE DIRECTOR].
12 * **Sec. 30.** AS 21.27.650(a) is amended to read:
13 (a) An insurer may not transact business with a third-party administrator
14 unless
15 (1) the insurer holds a certificate of authority in this state if required
16 under this title;
17 (2) the third-party administrator is registered under this chapter or the
18 third-party administrator has filed a certification with the director certifying that the
19 third-party administrator is operating only for a foreign insurer other than a self-
20 funded multiple employer welfare arrangement regulated under AS 21.85 and is
21 registered as a third-party administrator by the third-party administrator's resident
22 insurance regulator in a state that the director has determined has enacted provisions
23 substantially similar to those contained in AS 21.27.630 - 21.27.650 and that is
24 accredited by the National Association of Insurance Commissioners;
25 (3) the third-party administrator provides the director on January 1,
26 April 1, July 1, and October 1 of each year
27 (A) a list of **persons who supervise or have responsibility**
28 **over personnel performing administrative functions, including claims**
29 **administration and payment, marketing administrative functions,**
30 **premium accounting, premium billing, coverage verification,**
31 **underwriting, or certificate issuance** [CURRENT EMPLOYEES,

1 IDENTIFYING THOSE TRANSACTING BUSINESS IN THIS STATE OR]
2 upon a subject resident, located, or to be performed in this state;
3 (B) a list of current insurers under contract; and
4 (C) other information the director may require;
5 (4) a written contract is in effect between the parties that establishes
6 the responsibilities of each party, indicates both parties' share of responsibility for a
7 particular function, and specifies the division of responsibilities;
8 (5) there is in effect a written contract between the insurer and third-
9 party administrator that contains the following provisions:
10 (A) the insurer may terminate the contract for cause upon
11 written notice sent by certified mail to the third-party administrator and may
12 suspend the underwriting authority of the third-party administrator during a
13 dispute regarding the cause for termination; but the insurer must fulfill all
14 lawful obligations with respect to policies affected by the written agreement,
15 regardless of any dispute between the insurer and the third-party administrator;
16 (B) the third-party administrator shall render accounts to the
17 insurer detailing all transactions and remit all money due under the contract to
18 the insurer at least monthly;
19 (C) all money collected for the account of an insurer shall be
20 held by the third-party administrator as a fiduciary;
21 (D) all payments on behalf of the insurer shall be held by the
22 third-party administrator as a fiduciary;
23 (E) the third-party administrator may not retain more than three
24 **months'** [MONTHS] estimated claims payments and allocated loss adjustment
25 expenses;
26 (F) the third-party administrator shall maintain separate records
27 for each insurer in a form usable by the insurer; the insurer or its authorized
28 representative shall have the right to audit and the right to copy all accounts
29 and records related to the insurer's business; the director, in addition to other
30 authority granted in this title, shall have access to all books, bank accounts, and
31 records of the third-party administrator in a form usable to the director; any

1 trade secrets contained in books and records reviewed by the director,
2 including the identity and addresses of policyholders and certificate holders,
3 shall be kept confidential, except that the director may use the information in a
4 proceeding instituted against the third-party administrator or the insurer;
5 (G) the contract may not be assigned in whole or in part by the
6 third-party administrator;
7 (H) if the contract permits th hird-party administrator to do
8 underwriting, the contract must include the following:
9 (i) the third-party administrator's maximum annual
10 premium volume;
11 (ii) the rating system and basis of the rates to be
12 charged;
13 (iii) the types of risks that may be written;
14 (iv) maximum limits of liability;
15 (v) applicable exclusions;
16 (vi) territorial limitations;
17 (vii) policy cancellation provisions;
18 (viii) the maximum policy term; and
19 (ix) that the insurer shall have the right to cancel or not
20 renew a policy of insurance subject to applicable state law;
21 (I) if the contract permits the third-party administrator to
22 administer claims on behalf of the insurer, the contract must include the
23 following:
24 (i) written settlement authority must be provided by the
25 insurer and may be terminated for cause upon the insurer's written
26 notice sent by certified mail to the third-party administrator or upon the
27 termination of the contract, but the insurer may suspend the settlement
28 authority during a dispute regarding the cause of termination;
29 (ii) claims shall be reported to the insurer within 30
30 days;
31 (iii) a copy of the claim file shall be sent to the insurer

1 upon request or as soon as it becomes known that the claim has the
2 potential to exceed an amount determined by the director or exceeds the
3 limit set by the insurer, whichever is less, involves a coverage dispute,
4 may exceed the third-party administrator's claims settlement authority,
5 is open for more than six months, involves extra contractual
6 allegations, or is closed by payment in excess of an amount set by the
7 director or an amount set by the insurer, whichever is less;
8 (iv) each party to the contract shall comply with unfair
9 claims settlement statutes and regulations;
10 (v) transmission of electronic data must occur at least
11 monthly if electronic claim files are in existence; and
12 (vi) claim files shall be the sole property of the insurer;
13 upon an order of liquidation of the insurer, the third-party administrator
14 shall have reasonable access to and the right to copy the files on a
15 timely basis; and
16 (J) the contract may not provide for commissions, fees, or
17 charges contingent upon savings obtained in the adjustment, settlement, and
18 payment of losses covered by the insurer's obligations; but a third-party
19 administrator may receive performance-based compensation for providing
20 hospital or other auditing services or may receive compensation based on
21 premiums or charges collected or the number of claims paid or processed.
22 * **Sec. 31.** AS 21.34.050 is repealed and reenacted to read:
23 **Sec. 21.34.050. Listing eligible surplus lines insurers.** (a) In addition to
24 meeting the requirements of AS 21.34.040, a nonadmitted insurer shall be considered
25 an eligible surplus lines insurer if it pays fees required by regulation and appears on
26 the most recent list of eligible surplus lines insurers published by the director. The list
27 is to be published at least semi-annually by
28 (1) posting the list on the division's Internet website; and
29 (2) providing a copy of the list to a person on request to the division.
30 (b) Nothing in this section requires the director to place or maintain the name
31 of a nonadmitted insurer on the list of eligible surplus lines insurers.

1 (c) A nonadmitted insurer shall be removed from the list of eligible surplus
2 lines insurers if the nonadmitted insurer fails to pay, before July 1 of each year, the fee
3 authorized under this section or fails to meet the requirement under AS 21.34.040(d).
4 However, the director may reinstate a nonadmitted insurer on the list of eligible
5 surplus lines insurers if
6 (1) the nonadmitted insurer inadvertently failed to pay the fee or meet
7 the requirement under AS 21.34.040(d);
8 (2) the nonadmitted insurer has remedied the reason for removal from
9 the list; and
10 (3) the nonadmitted insurer pays a late fee as established by regulation.
11 * **Sec. 32.** AS 21.36 is amended by adding a new section to read:
12 **Sec. 21.36.128. Prompt payment of health care insurance claims.** (a) A
13 health care insurer shall pay or deny indemnities under a health care insurance policy,
14 whether or not services were provided by a participating provider, within 30 calendar
15 days after the insurer or a third-party administrator under contract with the insurer
16 receives a clean claim.
17 (b) If a health care insurer does not pay or denies a health care insurance
18 claim, the insurer shall give notice to the covered person, or to the provider of the
19 medical care services or supplies if the claim was assigned or if the covered person
20 elected direct payment under AS 21.51.120(a)(2) or AS 21.54.020(a), of the basis for
21 denial or the specific information that is needed for the insurer to adjudicate the claim.
22 The health care insurer shall provide the notice required under this subsection within
23 30 calendar days after the insurer or third-party administrator under contract with the
24 insurer receives the claim.
25 (c) If a health care insurer does not provide the notice as required under (b) of
26 this section, the claim is presumed a clean claim, and interest shall accrue at a rate of
27 15 percent annually beginning on the day following the day that the notice was due
28 and continues to accrue until the date that the claim is paid.
29 (d) If a health care insurer provides the notice required under (b) of this
30 section and requests specific information that is needed to adjudicate the claim, the
31 insurer shall pay the claim not later than 15 calendar days after receipt of the

Amend #1 Language deleted

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

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

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

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

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

16 (i) In this section,

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

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

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

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

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

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

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

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

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

1 contract arising from considerations paid before that period would be less than $20
2 monthly, the company may, at its option, terminate the contract by payment in cash of
3 the then present value of the [SUCH] portion of the paid-up annuity benefit,
4 calculated on the basis of the mortality table, if any, and interest rate specified in the
5 contract for determining the paid-up annuity benefit, and by that payment shall be
6 relieved of any further obligation under the contract.
7 * **Sec. 35.** AS 21.45.305(e) is amended to read:
8 (e) For contracts **that** [WHICH] provide cash surrender benefits, **the** [SUCH]
9 cash surrender benefits available before maturity may not be less than the present
10 value as of the date of surrender of that portion of the maturity value of the paid-up
11 annuity benefit **that** [WHICH] would be provided under the contract at maturity
12 arising from considerations paid before the time of cash surrender reduced by the
13 amount appropriate to reflect any prior withdrawals from or partial surrenders of the
14 contract. The present value shall be calculated on the basis of an interest rate not more
15 than one percent higher than the interest rate specified in the contract for accumulating
16 [THE NET] considerations to determine the maturity value, **unless a higher rate is**
17 **approved by the director under AS 21.42.120,** decreased by the amount of any
18 indebtedness to the company on the contract, including interest due and accrued, and
19 increased by any existing additional amounts credited by the company to the contract.
20 In no event may any cash surrender benefit be less than the minimum nonforfeiture
21 amount at that time. The death benefit under **those** [SUCH] contracts shall be at least
22 equal to the cash surrender benefit.
23 * **Sec. 36.** AS 21.45.305(g) is repealed and reenacted to read:
24 (g) For the purpose of determining the benefits calculated under (e) and (f) of
25 this section,
26 (1) the maturity date shall be the latest date for which election is
27 permitted by the contract, but not later than the anniversary of the contract next
28 following the annuitant's 70th birthday or the 10th anniversary of the contract,
29 whichever is later;
30 (2) a surrender charge may not be imposed on or past the maturity date
31 of the contract, except that, for annuity contracts with one or more renewable

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 (c) The right of the covered person to request payment of indemnities under a
2 blanket health insurance policy directly to the provider of the services or to another
3 person may be transferred by a qualified domestic relations order to a person who is
4 not the covered person. Rights under the qualified domestic relations order do not take
5 effect until the order is received by the health care insurer. In this subsection,
6 "qualified domestic relations order" means an order or judgment in a divorce or
7 dissolution action under AS 25.24 that designates a person to determine to whom
8 indemnities for a covered person should be paid under a health insurance policy.
9 (d) This section does not prohibit a health care insurer from recovering an
10 amount mistakenly paid to a provider or a covered person.
11 * **Sec. 39.** AS 21.54 is amended by adding a new section to read:
12 **Sec. 21.54.151. Mental health benefits.** (a) Except as provided in (d) of this
13 section, a health care insurance plan sold in the large employer group market that
14 provides both medical and surgical benefits and mental health benefits shall meet the
15 following requirements:
16 (1) if the plan does not include an aggregate lifetime limit on
17 substantially all medical and surgical benefits, the plan may not provide for an
18 aggregate lifetime limit on mental health benefits;
19 (2) if the plan includes an aggregate lifetime limit on substantially all
20 medical and surgical benefits, the plan must
21 (A) include the mental health benefits within the aggregate
22 lifetime limit and may not distinguish in the application of the limit between
23 medical and surgical benefits and mental health benefits; or
24 (B) provide an aggregate lifetime limit for mental health
25 benefits that is not less than the aggregate lifetime limit for medical and
26 surgical benefits;
27 (3) if the plan includes different aggregate lifetime limits or none on
28 different categories of medical and surgical benefits, the plan must provide for
29 aggregate lifetime limits on mental health benefits consistent with federal law;
30 (4) if the plan does not include an annual limit on substantially all
31 medical and surgical benefits, the plan may not provide for an annual limit on mental

1 health benefits;
2 (5) if the plan includes an annual limit on substantially all medical and
3 surgical benefits, the plan must
4 (A) include the mental health benefits with the annual limit and
5 may not distinguish in the application of the limit between medical and
6 surgical benefits and mental health benefits; or
7 (B) provide an annual limit for mental health benefits that is
8 not less than the annual limit for medical and surgical benefits; and
9 (6) if the plan includes different annual limits or none on different
10 categories of medical and surgical benefits, the plan must provide for annual limits on
11 mental health benefits consistent with federal law.
12 (b) Except as provided otherwise in this title, a health care insurance plan is
13 not required to provide mental health benefits.
14 (c) Except as otherwise provided in this title, this section does not affect the
15 terms and conditions relating to the amount, duration, or scope of mental health
16 benefits under a health care insurance plan that provides mental health benefits,
17 including cost sharing, limits on the number of visits or days of coverage, and
18 requirements relating to medical necessity.
19 (d) This section does not apply if application of this section would result in an
20 increase in the cost under the health care insurance plan of at least one percent.
21 * **Sec. 40.** AS 21.56.120(a) is amended to read:
22 (a) A premium rate for a health care insurance plan subject to this chapter is
23 subject to the following provisions:
24 (1) the premium rate charged or offered during a rating period to small
25 employers with similar case characteristics as determined by the insurer for the same
26 or similar coverage may not vary from the applicable index rate by more than 35
27 percent of the applicable index rate;
28 (2) regarding a health care insurance plan issued before July 1, 1993, if
29 premium rates charged or offered for the same or similar coverage under a health care
30 insurance plan covering a small employer with similar case characteristics as
31 determined by the insurer exceeds the applicable index rate by more than 35 percent,

1 an increase in premium rates for a new rating period may not exceed the sum of
2 (A) a percentage change in the base premium rate measured
3 from the first day of the prior rating period to the first day of the new rating
4 period; plus
5 (B) adjustments due to changes in case characteristics or plan
6 design of the small employer, as determined by the insurer;
7 (3) the percentage increase in the premium rate charged to a small
8 employer for a new rating period may not exceed the sum of the following:
9 (A) the percentage change in the new business premium rate
10 measured from the first day of the prior rating period to the first day of the new
11 rating period; in the case of a health benefit plan into which the small employer
12 insurer is no longer enrolling new small employers, the small employer insurer
13 shall use the percentage change in the base premium rate, provided that the
14 change does not exceed, on a percentage basis, the change in the new business
15 premium rate for the most similar health care insurance plan into which the
16 small employer insurer is actively enrolling new small employers;
17 (B) any adjustment, not to exceed 15 percent annually and
18 adjusted pro rata for rating periods of less than one year, due to the claim
19 experience, health status, or duration of coverage of the employees or
20 dependents of the small employer as determined from the small employer
21 insurer's rate manual; and
22 (C) any adjustment due to change in coverage or change in the
23 case characteristics of the small employer, as determined from the small
24 employer insurer's rate manual;
25 (4) adjustments in rates for claim experience, health status, and
26 duration of coverage may not be charged to individual employees or dependents; any
27 adjustment must be applied uniformly to the rates charged for all employees and
28 dependents of the small employer;
29 (5) a premium rate for a health care insurance plan shall comply with
30 the requirements of this section [NOTWITHSTANDING AN ASSESSMENT PAID
31 OR PAYABLE BY SMALL EMPLOYER INSURERS UNDER AS 21.56.050(d)];

1 (6) a small employer insurer may use industry as a case characteristic
2 in establishing premium rates, provided that the rate factor associated with an industry
3 classification may not vary by more than 15 percent from the arithmetic average of the
4 highest and lowest rate factors associated with all industry classifications;
5 (7) a small employer insurer shall
6 (A) apply rating factors, including case characteristics,
7 consistently with respect to all small employers; rating factors must produce
8 premiums for identical groups that differ only by amounts attributable to plan
9 design and do not reflect differences due to the nature of the groups assumed to
10 select particular health care insurance plans; and
11 (B) treat all health care insurance plans issued or renewed in
12 the same calendar month as having the same rating period;
13 (8) for the purposes of this subsection, a health care insurance plan that
14 contains a restricted provider network may not be considered similar coverage to a
15 health care insurance plan that does not use a restricted provider network if the
16 restriction of benefits to network providers results in substantial differences in claim
17 costs;
18 (9) a small employer insurer may not use case characteristics, other
19 than age, sex, industry, geographic area, family composition, and group size without
20 prior approval of the director.
21 *** Sec. 41.** AS 21.56.140(a) is amended to read:
22 (a) Except as provided under AS 21.56.160, a small employer insurer shall, as
23 a condition of transacting business in this state with small employers, offer to small
24 employers all health care insurance plans the small employer insurer actively markets
25 to small employers in this state, including a basic health care insurance plan and a
26 standard health care insurance plan **<u>approved by the director</u>**.
27 *** Sec. 42.** AS 21.56.140 is amended by adding a new subsection to read:
28 (i) The director may, by order, establish benefits, cost sharing levels,
29 exclusions, and limitations for the basic and standard health care insurance plans
30 offered under (a) of this section.
31 *** Sec. 43.** AS 21.66.480(8) is amended to read:

1 (8) "title insurance limited producer" means a person, firm,
2 association, trust, corporation, cooperative, joint-stock company, or other legal entity
3 authorized in writing by a title insurance company to solicit title insurance, collect
4 premiums, determine insurability in accordance with the underwriting rules and
5 standards prescribed by the title insurance company that the licensee represents, and
6 issue policies in its behalf [; HOWEVER, THE TERM "TITLE INSURANCE
7 LIMITED PRODUCER" DOES NOT INCLUDE OFFICERS AND SALARIED
8 EMPLOYEES OF A TITLE INSURANCE COMPANY].
9 * **Sec. 44.** AS 21.90.900(17) is repealed and reenacted to read:
10 (17) "firm" means a corporation, association, partnership, limited
11 liability company, limited liability partnership, or other legal entity;
12 * **Sec. 45.** AS 21.90.900(29) is repealed and reenacted to read:
13 (29) "managing general agent" means a person who
14 (A) manages all or part of the insurance business of an insurer,
15 including the managing of a separate division, department, or underwriting
16 office; and
17 (B) acts as an agent for an insurer, whether known as a
18 managing general agent, manager, or other similar term, who, with or without
19 the authority, separately or together with affiliates, produces, directly or
20 indirectly, and underwrites an amount of gross direct written premium equal to
21 or more than five percent of the policyholder surplus as reported in the last
22 annual statement of the insurer in any one quarter or year together with the
23 following activity related to the business produced, adjusts or pays claims over
24 $10,000 a claim, or negotiates reinsurance on behalf of the insurer.
25 * **Sec. 46.** AS 25.24.160(b) is amended to read:
26 (b) If a judgment under this section distributes benefits to an alternate payee
27 under AS 14.25, AS 21.51.120(a), **AS 21.54.020(c)** [AS 21.54.020(g)], 21.54.050(c),
28 AS 22.25, AS 26.05.222 - 26.05.226, or AS 39.35, the judgment must meet the
29 requirements of a qualified domestic relations order under the definition of that phrase
30 that is applicable to those provisions.
31 * **Sec. 47.** AS 25.24.230(h) is amended to read:

1 (h) If a judgment under this section distributes benefits to an alternate payee
2 under AS 14.25, AS 21.51.120(a), <u>AS 21.54.020(c)</u> [AS 21.54.020(g)], 21.54.050(c),
3 AS 22.25, AS 26.05.222 - 26.05.226, or AS 39.35, the judgment must meet the
4 requirements of a qualified domestic relations order under the definition of that phrase
5 that is applicable to those provisions.
6 * **Sec. 48.** AS 21.07.250(4), 21.07.250(6); AS 21.27.900(10); AS 21.51.110; AS 21.56.010,
7 21.56.020, 21.56.030, 21.56.040, 21.56.050, 21.56.060, 21.56.070, 21.56.075, 21.56.080,
8 21.56.090, 21.56.100, 21.56.250(6), 21.56.250(9), 21.56.250(17), 21.56.250(19),
9 21.56.250(22), 21.56.250(24), and 21.56.250(25) are repealed.
10 * **Sec. 49.** The uncodified law of the State of Alaska is amended by adding a new section to
11 read:
12 APPLICABILITY. AS 21.45.305(g), as repealed and reenacted by sec. 36 of this Act,
13 applies to annuity contracts issued on or after January 1, 2007.
14 * **Sec. 50.** The uncodified law of the State of Alaska is amended by adding a new section to
15 read:
16 TRANSITION: SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.
17 Notwithstanding the repeal of AS 21.56.010 - 21.56.100 by sec. 48 of this Act, the Small
18 Employer Health Reinsurance Association shall continue to exist and operate for purposes of
19 winding up the affairs of the association. The association shall be governed by the board of
20 directors as it existed on June 30, 2006, and shall operate according to former AS 21.56.010 -
21 21.56.100, as they read on June 30, 2006, except that, beginning July 1, 2006, the association
22 (1) may not assume reinsurance on any new small employer groups or eligible
23 employees or dependents of small employers;
24 (2) shall terminate reinsurance on each small employer group and each
25 eligible employee or dependent of a small employer covered by the association on the first
26 plan anniversary following July 1, 2006;
27 (3) shall continue to perform and carry out the provisions of former
28 AS 21.56.010 - 21.56.100 as they read on June 30, 2006, with respect to each small employer
29 group and eligible employee and dependent reinsured by the association until all
30 administrative expenses and losses are paid;
31 (4) shall refund to small employer insurers any money remaining after all

1 administrative expenses and losses are paid in the same proportion as the last assessment
2 imposed by the association on member insurers;
3 (5) shall submit a final accounting to the director of the division of insurance
4 for review and approval; and
5 (6) shall cease to operate on order of the director of the division of insurance
6 finding that the affairs of the association have been concluded.
7 * **Sec. 51.** Sections 26 - 31 of this Act take effect immediately under AS 01.10.070(c).
8 * **Sec. 52.** Sections 25, 36, and 48 of this Act take effect January 1, 2007.
9 * **Sec. 53.** Except as provided in secs. 51 and 52 of this Act, this Act takes effect July 1,
10 2006.

Alaska State Legislature

Senator Con Bunde
Senate District P

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

Sponsor Statement
Senate Bill 289 Insurance

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

A summary of the general changes made by SB 289:

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

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

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

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

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

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

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

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

DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Division of Insurance

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

February 14, 2006

The Honorable Con Bunde
Senate Labor & Commerce
State Capital

RE: Senate Bill 289

Senator Bunde,

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

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

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

Thank you.

Sincerely,

Linda S. Hall

Linda S. Hall
Director

LB/pal102
021406

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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

MEMORANDUM February 25, 2006

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

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

FROM: Dennis C. Bailey DCB
Legislative Counsel

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

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

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

If I may be of further assistance, please advise.

DCB:lmb
06-078.lmb

Enclosure

COMMITTEE COPY

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 2/13/06 FURTHER: (Finance)

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

DATE TURNED IN TO OFFICE: 2/27/06

Labor and Commerce Committee considered SENATE BILL NO. 289

SB 289 INSURANCE

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

and recommends:

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

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

[ ] attached amendment(s)

[ ] adopt Letter of Intent by ______ Committee

[ ] further referral to ______ Committee

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

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

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
DCED	2/11/06			✓	1

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] APPROPRIATION - no fiscal note

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

SB
291

HFIN
FILE

HOUSE COMMITTEE REPORT

(11)

Date Referred to Committee: April 29, 2006 FURTHER REFERRALS:

Date of Committee Action: 5/11/06

The FINANCE Committee considered: CSSB 291(CRA)

CS FOR SENATE BILL NO. 291(CRA) MUNICIPAL HARBOR FACILITY GRANTS

"An Act relating to the municipal harbor facility grant program; and providing for an effective date."

Recommends it be replaced with [ ] HCS *or* [ ] CS *for* ________________________(______)
*For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR*______ [ ] Same Title [ ] 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
HSS
LWF
LAW
LEG
MVA
DNR
DPS
REV
DOT
UA

NEW **FISCAL NOTES**
*Assigned by Chief Clerk's Office

List by Dept(s):	*FN#	Fiscal	Indet.	Zero

PREVIOUS **FISCAL NOTES**

List by Dept(s):	FN#	Fiscal	Indet.	Zero
DOT	1			✓

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
[signature]	Hawker	*			
[signature]	FOSTER	X			
[signature]	Joule			X	
Carl E. Moses	MOSES	X			
[signature]	Kelly	X			
[signature]	Stoltze			X	
Bruce Weyhrauch	Weyhrauch	X			
Chair:					
Chair: [signature]	Chenault			X	

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSSB 291(CRA)
(S) Publish Date: 3/13/06

Revision Date/Time (Note if correction):
Title: Municipal Harbor Facility Grants
Sponsor: Senator Stedman
Requester:

Dept. Affected: DOT&PF
RDU: Administration & Support
Component: Commissioner's Office
Component No. 530

Expenditures/Revenues (Thousands of Dollars)

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

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

FUND SOURCE (Thousands of Dollars)

	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

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

Based on current information, the Department anticipates it will be able to administer this program with existing staff.

Prepared by: John Manly
Division: Commissioner's Office DOT&PF
Phone: 465-8994
Date/Time: 3/02/06 at 4:45 p.m.

Approved by: Mike Barton, commissioner
Agency: DOT&PF
Date: 3/2/2006

(Revised 9/1/2005 OMB)

ALASKA STATE LEGISLATURE

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SENATOR BERT K. STEDMAN

SPONSOR STATEMENT SB 291

"An Act relating to the municipal harbor facility grant program; and providing for an effective date."

For Alaskan coastal communities, harbors are their road to resources. Harbors are critical transportation links, hubs of waterfront commerce that many businesses depend on and protection areas for ocean going vessels.

Over the past 10 years, the Department of Transportation has transferred ownership of state harbors to 22 municipalities around Alaska's coast. In many instances the state had neglected its responsibility for conducting major preventative maintenance on those harbors. Although funds accompanied the transfers, the funds were insufficient to bring the harbors up to sate and serviceable condition. Accordingly, when local harbormasters took over the budgeting for their facilities they inherited a major financial burden that their local governments could not afford.

In 2005 the Statewide Harbormasters Association met to find a solution to the approximately $99,858,000 in needed repairs. They brought forward a proposal for a 50/50 matching grant program. That proposal is reflected in Senate Bill 291.

SB 291 establishes the Municipal Harbor Facility Grant Fund and a 50/50 capital matching funding program administered by the Department of Transportation. The bill sets out strict criteria to determine project eligibility. For example the application must be for a capital improvement project, not routine maintenance, which is considered a local responsibility, and the municipality must have the financial capability to maintain the harbor in the future. The bill prioritizes repair and major maintenance projects above other projects or new construction. Once a harbor facility receives funding under this program it will not be eligible for additional grants.

In order to access resources and continue to stimulate our economy, Alaskan harbors must be in good working order. This legislation partners the state and municipalities in this endeavor.

Contact: Kim Carnot, Aide to Senator Bert Stedman at (907) 465-3873

Alaska State Legislature

Senate Majority Web: www.akrepublicans.org

Sponsor: Senator Bert Stedman
Current Version: CSSB 291 (CRA)
Contact: Kim Carnot, 465-3873

Fact Sheet for: Senate Bill 291

Short Title: MUNICIPAL HARBOR FACILITY GRANTS

Summary:

- Establishes a capital improvement program for harbor facilities with a one time 50/50 matching grant program for municipalities.
- Funds major maintenance and capital improvements by using a portion of the watercraft fuel tax and the state's share of the fisheries business tax collected under AS 43.74.015.
- Requires the Alaska Department of Transportation and Public Facilities to administer the program.
- Prohibits a municipality from using a state grant under a different program or appropriation as its share of the 50/50 match, except for money given to the municipality under the municipal tax resources equalization, safe communities program or the municipality's share of the fisheries business tax.

Benefits:

- Creates safer and more functional harbors for coastal communities.
- Helps stimulate the economy of the entire state by improving harbors, which are the main economic engine of coastal communities.

Background:

- Alaska has more coastline than the entire contiguous United States. Harbors are critically important to Alaska. Over the past decade, the state has transferred ownership of harbors to municipalities. Unfortunately, the harbors were in poor condition at the time of transfer due to the state's failure to keep up with deferred maintenance. SB 291 helps alleviate the burden on municipalities by creating a 50/50 matching grant program to pay for major maintenance and capital improvements.

THE
FOLLOWING
DOCUMENT(S)
ARE
POOR
ORIGINAL
COPIES

Alaska Association of Harbormasters and Port Administrators Deferred Maintenance Funding Summary							
List of Communities That Have Accepted Harbor Ownership from the State of Alaska							
Location	Facility	Sale Date/Type	*State Funds Already Provided	Cost Est Provided	Funds Required	Contact	Phone Number
Chenega	Oil Spill Response & Seaplane Float	10/8/1998 Bill of Sale	$ 315,000		$678,000	Olen Harris	562-1444
Cold Bay	Dock	6/10/1992 Bill of Sale	n/a	Eng Est 5/4/05	$500,000	Bob Juettner	274-7555
Cordova	Small Boat Harbor	8/03/2003 Bill of Sale	$ 4,876,000	Est 1/31/2006		Dale Muma	424-6400
Craig	Dock North Cove Small Boat Harbor South Cove Small Boat Harbor	12/19/2001 Bill of Sale 6/30/1992 Comm's Deed 9/14/1995 Comm's Deed	$ 581,000	Quote 2/1/2006	$175,000	Michael Kampnich	826-3404
Homer	Small Boat Harbor	4/30/1999 Bill of Sale	$ 3,605,400	Est 10/2005	$3,300,000	Steve Dean	235-3160
Juneau	Aurora Small Boat Harbor Don Statter Small Boat Harbor Douglas Dock Douglas Small Boat Harbor Harris Small Boat Harbor Taku Small Boat Harbor North Douglas Launch Ramp	4/2/2003 Bill of Sale	$ 7,119,000	Eng Report 3/04	$17,100,000	John Stone	586-0294
Ketchikan	Bar Harbor North Bar Harbor South City Float Ryus Float Thomas Basin Small Boat Harbor	8/11/2004 Bill of Sale 5/15/2002 Bill of Sale 1/1/1999 Bill of Sale 8/11/2004 Bill of Sale 8/11/2004 Bill of Sale	$ 7,876,000	Est 9/1/05	$13,450,000	Chris Brewton	228-5632
King Cove	Old Harbor	3/25/1995 Bill of Sale	$ 352,000	Eng Est 2/3/06	$4,592,000	David Bash	497-2237
Klawock	Small Boat Harbor Dock	3/28/2003 Bill of Sale 5/16/1986 Quit Claim Deed	$ 896,000		$200,000	John Morris	755-2261
Kodiak	City Float St. Herman's Small Boat Harbor St. Paul Small Boat Harbor Channel Transient Float	3/12/1999 Bill of Sale	$ 7,775,500	Eng Rep 2/02 Update Est 2/06	$14,900,000	Marty Owen	486-8080
Old Harbor	Dock Float	5/20/1993 Bill of Sale 5/20/1993 Bill of Sale	$ 154,000		$1,000,000	Jim Nestic	286-2204
Pelican	Small Boat Harbor & Seaplane Float	9/06/2001 Bill of Sale	$ 1,451,142	1/30/2006	$1,040,000	Patty Phillips	735-2202
Petersburg	North Harbor Middle Small Boat Harbor South Small Boat Harbor	12/06/2005 Bill of Sale 6/03/2003 Bill of Sale	$ 2,500,000 $ 3,729,000	Eng Est 2/6/06	$4,000,000 $2,500,000	Jim Stromdahl	772-4688
Sand Point	Small Boat Harbor	12/2/1992 Bill of Sale	n/a		$2,100,000	Richard Kochuten, Sr	383-2696
Seldovia	Small Boat Harbor	5/18/2004 Bill of Sale	$ 2,628,000		$3,400,000	Ronda Haynes	234-7643
Seward	Small Boat Harbor	2/25/1[illegible] Bill of Sale	$ 3,134,200	Eng Est 2/6/06	$7,693,000	Scott Ransom	224-3138
Sitka	Crescent Harbor (A-D, 1-4) Crescent Harbor (E-F, 5-7) Sealing Cove Small Boat Harbor Thomsen Small Boat Harbor - Old ANB Float	11/09/2001 Bill of Sale 08/30/2004 Bill of Sale 08/30/2004 Bill of Sale 08/30/2004 Bill of Sale 6/18/1992 Comm's Deed	$ 6,468,000	Est 2/1/06	$4,500,000	Ray Majeski	747-1439
Skagway	Small Boat Harbor	10/21/2004 Bill of Sale	$ 1,068,852	Est 1/1/06	$ 2,575,000	Mattew O'Boyle	983-2628
Tatitlek	Oil Spill Response and Ferry Dock	10/8/1998 Bill of Sale	$ 315,000		$270,000	Olen Harris	562-1444
Valdez	Small Boat Harbor	12/01/2003 Bill of Sale	$ 3,013,300	Est 2/1/06	$2,500,000	Alan Sorum	835-4981
Whittier	Passenger Loading Dock Small Boat Harbor	5/15/2002 Bill of Sale 8/02/2004 Bill of Sale	$ 2,479,000		$4,890,000	Mark Earnest	472-2327x111
Wrangell	Fish & Game Float Inner Small Boat Harbor Reliance Small Boat Harbor Shoemaker Bay Harbor Standard Oil Float	8/20/2003 Bill of Sale	$ 3,492,000	Eng Est 2/2/06	$6,200,000	Greg Meissner	874-3736
Yakutat	Small Boat Harbor and Seaplane Float	8/8/2005 Bill of Sale	$ 326,000	Eng Rep 12/04	$ 2,295,000	Erving Grass	784-3323
Total State Funding Provided			***$64,154,394***				
Funding Needed to Complete Repairs					***$99,858,000***		

Spreadsheet prepared by Alan Sorum on 25 March 2005. Contact: (907) 835-4981
***Revised by John Stone on Feb. 6, 2006 to show verified cost estimates, 907-586-0294**

Alaska Association of Harbormasters
And Port Administrators
617 Katlian Ave., Sitka, AK 99835
Phone: (907) 747-4877 Fax: (907) 747-6278

Senate Community and Regional Affairs Committee
March 6, 2006
SB 291
Testimony by John Stone
President, AAHPA

Mr. Chair and members of the Senate Community and Regional Affairs Committee, my name is John Stone. I am the president of the Alaska Association of Harbormasters and Port Administrators.

The Alaska Association of Harbormasters is an organization comprised of the senior managers from 27 community harbor systems. These include Anchorage, Bethel, Bristol Bay Borough/Naknek, Cordova, Craig, Dillingham, Haines, Homer, Hoonah, Juneau, Kenai, Ketchikan, King Cove, Kodiak, Nome, Pelican, Petersburg, Port MacKenzie, Sand Point, Seward, Sitka, Skagway, Unalaska/Dutch Harbor, Valdez, Whittier, Wrangell, and Yakutat. The Association's goal is simple: to make Alaska's harbors they best they can be.

First, let me say that the Association fully supports SB 291 and appreciates the Committee taking the lead on this important state and community issue. During the past several years, the Association has attempted to bring the dilapidated condition of Alaska's harbor infrastructure to the attention of the Legislature. We appreciated the opportunity to speak to the Fish Caucus last session to discuss this statewide problem. We are also very encouraged that the Alaska Department of Transportation fully supports this bill.

Most of Alaska's harbor infrastructure was built by the Alaska Department of Transportation and Public Facilities in the 1960's and 1970's. Largely, this infrastructure is at the end its useful life making complete replacement of it necessary. We believe the financial resources needed to replace these facilities before the end of their lives requires the collective effort of the State and local harbor jurisdictions.

Testimony of John Stone, President of AAHPA, on SB-291
Before the Senate Community and Regional Affairs Committee
March 6, 2006

The State's policy for many years was to enter into agreements with the cities and municipalities for the operation of the harbor systems with the State retaining title to the physical harbor improvements. The cities and municipalities established enterprise funds and assessed fees to users in an amount necessary to finance the operating cost of the facilities. This arrangement has worked very well from an operations standpoint. Unfortunately, neither party addressed facility replacement; the locals because they did not hold title to the improvements and the State because funding was not available.

In the 1990's, the State developed a new policy whereby the title of the physical improvements would be turned over to the local harbor jurisdictions along with some funding to help with facility replacement. Although the policy is sound, the program suffered from the fact that the funding provided with the transfer of title was only a fraction of the funding needed to replace the infrastructure that was transferred.

As the transfers have gone forward, local harbor jurisdictions developed facility replacement schedules and began looking at fees to cover facility replacement costs. It became clear that harbor fees needed to increase several-fold in short order. It also became clear that fees alone are not sufficient to recapitalize the transferred harbor infrastructure before it is lost.

Local harbor jurisdictions have indeed stepped up to the plate. Many of us are looking to finance revenue bonds with fee increases in order to replace transferred infrastructure. The Association believes this presents a good opportunity for a match funding program with the State. Many local governments, the State Chamber, the Alaska Municipal League, and our Association have adopted resolutions in support of this harbor match funding program.

We ask for this match program because we believe it is a good investment for the State. My colleagues at the Association will expand upon this point. Suffice to say that our harbors substantially contribute to the State's economy and are the lifeblood of many communities.

In summary, we thank the Chair and Committee for its consideration of SB 291. The Alaska Association of Harbormasters and Port Administrators strongly supports this bill. The dilemma facing us is that we have a tremendous amount of harbor

infrastructure that is at the end of its useful life. This infrastructure has been put into our hands. We are scrambling to find ways to replace it before it is lost. We are also substantially increasing fees to help with replacement costs. We have learned that fees are not the total answer. This bill provides much needed help with these replacements by matching our local investments. This bill also achieves the policy goal of the harbor transfers, whereby the local communities become responsible for the operation, maintenance, and replacement of the harbor improvements, because it gives us the capability to replace the transferred infrastructure before it is lost.

Thank-you.

Headquarters:
217 2nd Street, Suite 201
Juneau, Alaska 99801
(907) 586-2323 FAX 463-5515
www.alaskachamber.com

Regional Office:
601 W. 5th Ave., Suite 700
Anchorage, Alaska 99501
(907) 278-2722 FAX 278-6643

March 6, 2006

Senator Bert Stedman, Chair
Community & Regional Affairs Committee
State Capital
Juneau, AK 99801-1182

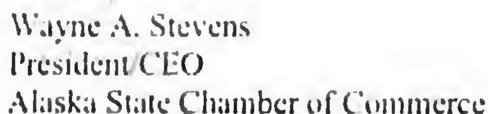
The Honorable Chairman and Members of the Senate Community & Regional Affairs Committee,

The Alaska State Chamber of Commerce strongly supports SB 291. Supporting Alaska's Harbor Infrastructure has been one of the State Chamber's legislative priorities for a number of years. Without adequate harbor infrastructure, commercial fishermen and sport anglers have little opportunity to grow their uniquely Alaskan businesses.

Whether to help our commercial fishermen offload their catch, or to provide safe ramping for Alaska's burgeoning tourist activities, our harbors are in need of repair and expansion to increase our opportunities for commerce. The State of Alaska has an obligation to provide adequate harbor facilities in many parts of the state; our harbors are the transportation corridors for Alaska's maritime roadways. Without adequate harbor infrastructure, Alaska will continue to be limited in its growth of maritime commerce.

SB 291 attempts to address many of Alaska's harbor funding problems by creating the municipal harbor grant fund through the collection of fuel tax revenues and fisheries business taxes. While SB 291 makes headway in fixing many of Alaska's harbors, the State Chamber feels that the taxes collected will not provide adequate revenues to address Alaska's aging harbor infrastructure. The Chamber feels that additional appropriations may be necessary or additional bonding utilizing tax revenues might ultimately provide adequate revenues to address the funding necessary to help our harbors.

Yours in economic prosperity,



Wayne A. Stevens
President/CEO
Alaska State Chamber of Commerce

Alaska State Chamber of Commerce
2006 Position
State and Federal Funding Dock and Harbor Maintenance and Development Projects throughout Alaska

Request that the State of Alaska fund and assist in acquiring federal funding for existing and future harbor and dock development projects in an effort to stimulate economic growth in Alaskan communities. The Alaska State Chamber of Commerce further urges the State of Alaska to make funding available to repair and improve existing facilities to serviceable standards consistent with DOT regulations as part of their mandated transferal of ownership of these harbors to communities.

Cordova District Fishermen United

P.O. Box 939
Cordova, Alaska 99574
(907) 424-3447 FAX (907) 424-3430

February 22, 2006

RECEIVED 2/27/06

Senator Bert Stedman
State Capitol, Room 30
Juneau, AK 99801-1182

RE: Support SB 291– Municipal Harbor Facilities Grant Fund

Dear Senator Stedman,

Cordova District Fishermen United (CDFU) supports SB 291 that will create a program to achieve capital improvements for harbor facilities through a one-time 50/50 match grant to municipalities.

The transfer of harbor management and funding from the state of Alaska to local communities has proven to be extremely costly to those communities that have been willing to assume this responsibility. This is in part due to deferred maintenance and the rising cost of repairs

For Alaska's coastal communities, harbors maintenance & facilities are critical for the fishing industry as well as residents & visitors. It is imperative that these harbors be in a good state of repair, both for functionality & safety of its users.

CDFU supports the creation of a program that will fund capital improvements as well as major maintenance or harbor facilities made possible through SB 291.

Sincerely,

Diane Platt

Diane Platt
Executive Director

City of Pelican

RECEIVED

BOX 737 · PELICAN ALASKA 99832 · PHONE 735-2202/2203 · FAX 735-2258 · E-MAIL cityhall@pelicancity.net · WEBSITE www.pelicancity.net

CITY OF PELICAN
RESOLUTION 2006-2

A RESOLUTION TO PROVIDE MATCHING MAINTENANCE AND REPAIR FUNDS TO LOCAL GOVERNMENT OWNED HARBORS

WHEREAS, the State of Alaska built and owned many of the harbor facilities in Alaska's communities; and,

WHEREAS, under State of Alaska ownership, the maintenance and repair of the harbor facilities was minimal; and,

WHEREAS, when transferring ownership of the harbor facilities to the local governments, the State of Alaska provided insufficient funds to restore the harbor facilities to "good" condition; and,

WHEREAS, local governments are willing to assume financial responsibility of their ownership roles; and,

WHEREAS, local governments are realizing that ownership of harbors means that moorage rates to the public must be increased several fold to restore the harbors to good condition; and,

WHEREAS, increased moorage fees is a disincentive for using the Pelican Boat Harbor, and,

WHEREAS, local governments seek financial assistance from the Legislature to improve Alaska's harbor facilities; and

WHEREAS, local governments request the Legislature to provide a 50% match funding program for the maintenance and repair of the transferred harbors

NOW, THEREFORE BE IT RESOLVED that the City of Pelican requests that the State of Alaska Legislature provide capital matching funds to local governments who have accepted ownership of the harbors for the purpose of helping local governments to fund deferred port and harbor maintenance projects.

RESOLUTION 2006-2
PAGE 2

PASSED, APPROVED AND ADOPTED this 3RD day of JANUARY, 2006.

Signed: Patricia Phillips
Patricia Phillips, Mayor

Attest:

Betty L. Bean
Betty L. Bean, City Clerk/Treasurer

RESOLUTION # 1791

A RESOLUTION REQUESTING THE STATE LEGISLATURE PROVIDE MATCHING MAINTENANCE AND REPAIR FUNDS TO LOCAL GOVERNMENT OWNED HARBORS

Offered by: Anderson
Supported by: Sarff

Whereas, the State of Alaska built and owned many of the harbor facilities in Alaska's communities and under State of Alaska ownership the maintenance and repair of the harbor facilities was minimal; and

Whereas, when transferring ownership of the harbor facilities to the local governments the State of Alaska provided insufficient funds to restore the harbor facilities to "good" condition; and

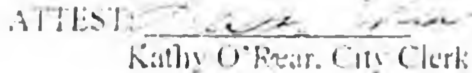
Whereas, local governments are willing to assume financial responsibility of their ownership roles, but have realized that ownership requires moorage rates to the public be increased substantially to restore the harbors to "good" condition; and

Whereas, local governments are not able to implement the dramatic moorage increases needed to restore the facilities and must seek financial assistance from the Legislature.

THEREFORE, BE IT RESOLVED by the Petersburg City Council – in order to prevent Alaska's harbor facilities from decaying and disappearing, the State of Alaska Legislature is requested to provide a 50% capital matching fund program to local governments who have accepted ownership of the previously State owned harbors for the purpose of helping the local governments fund deferred port and harbor maintenance projects.

PASSED AND APPROVED by the Petersburg City Council February 6, 2006.

Ted Smith, Mayor

ATTEST: 
Kathy O'Rear, City Clerk

CERTIFIED COPY

CITY OF VALDEZ, ALASKA

RESOLUTION NO. 05-15

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF VALDEZ, ALASKA, URGING THE LEGISLATURE TO PROVIDE MAINTENANCE AND REPAIR FUNDS TO LOCAL GOVERNMENT OWNED HARBORS

WHEREAS, the State of Alaska built and owned many of the harbor facilities in Alaska's communities; and,

WHEREAS, under State of Alaska ownership, the maintenance and repair of the harbor facilities was minimal; and,

WHEREAS, when transferring ownership of the harbor facilities to the local governments, the State of Alaska provided insufficient funds to restore the harbor facilities to "good" condition; and,

WHEREAS, local governments are willing to assume financial responsibility of their ownership roles;

WHEREAS, local governments are realizing that ownership of harbors means that moorage rates to the public must be increased several fold to restore the harbors to good condition; and,

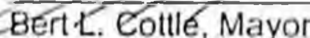
WHEREAS, many local governments may not be able to implement such dramatic moorage increases without financial assistance; and

WHEREAS, local governments seek financial assistance from the Legislature to prevent Alaska's harbor facilities from disappearing.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF VALDEZ, ALASKA, that the State of Alaska Legislature is urged to provide capital funds to local governments who have accepted ownership of the harbors for the purpose of helping local governments transition to their ownership roles.

PASSED AND APPROVED BY THE CITY COUNCIL OF THE CITY OF VALDEZ, ALASKA, this 22nd day of February, 2005.

CITY OF VALDEZ, ALASKA



Bert L. Cottle, Mayor

ATTEST:

Sheri L. Pierce, CMC/AAE, City Clerk

ALASKA ASSOCIATION OF HARBORMASTERS AND PORT ADMINISTRATORS

Resolution Number 2005-01

A resolution of the Alaska Association of Harbormasters and Port Administrators for the Legislature to provide matching maintenance and repair funds to local government owned harbors.

Whereas, the State of Alaska built and owned many of the harbor facilities in Alaska's communities; and,

Whereas, under State of Alaska ownership, the maintenance and repair of the harbor facilities was minimal; and,

Whereas, when transferring ownership of the harbor facilities to the local governments, the State of Alaska provided insufficient funds to restore the harbor facilities to "good" condition; and,

Whereas, local governments are willing to assume financial responsibility of their ownership roles;

Whereas, local governments are realizing that ownership of harbors means that moorage rates to the public must be increased several fold to restore the harbors to good condition; and,

Whereas, many local governments may not be able to implement such dramatic moorage increases without financial assistance; and

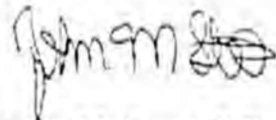
Whereas, local governments seek financial assistance from the Legislature to prevent Alaska's harbor facilities from disappearing; and

Whereas, local governments request the Legislature to provide 50% match funding program for the maintenance and repair of the transferred harbors.

THFREFORE, BE IT RESOLVED by the Alaska Association of Harbormasters and Port Administrators that it requests that the State of Alaska Legislature provide capital matching funds to local governments who have accepted ownership of the harbors for the purpose of helping local governments to fund deferred port and harbor maintenance projects.

Section 1. This resolution shall take effect immediately upon its adoption.

PASSED AND APPROVED by the Alaska Association of Harbormasters and Port Administrators, this 12nd day of October, 2005.



John M. Stone, P.E., President
Alaska Association of Harbormasters and Port Administrators

SB
291

SFIN

FILE

REPORTED OUT
APR 27 2006
SENATE FINANCE COMMITTEE

SENATE FINANCE COMMITTEE REPORT

DATE: 3/13/06

FURTHER:

DATE TURNED IN TO OFFICE: 4/27/06

Finance Committee considered SENATE BILL NO. 291

SB 291 MUNICIPAL HARBOR FACILITY GRANTS

"An Act relating to the municipal harbor facility grant program; and providing for an effective date."

and recommends:

[ ] be replaced with ______ CS ______________ (________)

[✓] adopt previous ______ CS SB 291 (CRA)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by ______________ Committee

[ ] further referral to ______________ Committee

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

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

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Ind.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Ind.	Zero	FN#
DOTPF	3/2/06			✓	1

[ ] APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	Do Pass	Do Not Pass	No Rec	Amend
[signature]		✓		
[signature]	✓			
[signature]	✓			
[signature]			✓	
COCHAIR: [signature]			✓	
COCHAIR: [signature]	✓			

REPORTED OUT
APR 27 2006
SENATE FINANCE COMMITTEE

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: CSSB 291(CRA)
(S) Publish Date: 3/13/06

Revision Date/Time (Note if correction):
Title: Municipal Harbor Facility Grants
Sponsor: Senator Stedman
Requester:

Dept. Affected: DOT&PF
RDU: Administration & Support
Component: Commissioner's Office
Component No. 530

Expenditures/Revenues (Thousands of Dollars)

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

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

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2006) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

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

Based on current information, the Department anticipates it will be able to administer this program with existing staff.

Prepared by: John Manly
Phone: 465-8994
Division: Commissioner's Office DOT&PF
Date/Time: 3/02/06 at 4:45 pm
Approved by: Mike Barton, commissioner
Date: 3/2/2006
Agency: DOT&PF

(Revised 6/7/2005 OMB)

COMMITTEE COPY

SENATE FINANCE COMMITTEE

4 /27 / 2006 COMMITTEE ACTION

Bill Number	SB 291 (CRA)
Amendment	
Motion	to report from Committee
Motion by	Wilken
Objection by	Bunde & Green
Removed	
Second Objection by	

Committee Member	Y	N
Senator Dyson	✓	
Senator Hoffman	✓	
Senator Olson	✓	
Senator Stedman		
Senator Bunde		✓
Co-Chair Wilken	✓	
Co-Chair Green	✓	

Tally	
Yea	5
Nay	1
Absent	1

MOTION PASSED

ALASKA STATE LEGISLATURE

SESSION
State Capitol, Rm 30
Juneau, Alaska 99801-1182
(907) 465-3873 Phone
(907) 465-3922 Fax
(877) 463-3873 Toll Free
Senator_Bert_Stedman@legis.state.ak.us

INTERIM
50 Front Street
Ketchikan, AK 99901-6442
Phone (907) 225-8088
Fax (907) 225-0713

SENATOR BERT K. STEDMAN

SPONSOR STATEMENT SB 291

"An Act relating to the municipal harbor facility grant program; and providing for an effective date."

For Alaskan coastal communities, harbors are their road to resources. Harbors are critical transportation links, hubs of waterfront commerce that many businesses depend on and protection areas for ocean going vessels.

Over the past 10 years, the Department of Transportation has transferred ownership of state harbors to 22 municipalities around Alaska's coast. In many instances the state had neglected its responsibility for conducting major preventative maintenance on those harbors. Although funds accompanied the transfers, the funds were insufficient to bring the harbors up to safe and serviceable condition. Accordingly, when local harbormasters took over the budgeting for their facilities they inherited a major financial burden that their local governments could not afford.

In 2005 the Statewide Harbormasters Association met to find a solution to the approximately $99,858,000 in needed repairs. They brought forward a proposal for a 50/50 matching grant program. That proposal is reflected in Senate Bill 291.

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In order to access resources and continue to stimulate our economy, Alaskan harbors must be in good working order. This legislation partners the state and municipalities in this endeavor.

Contact: Kim Carnot, Aide to Senator Bert Stedman at (907) 465-3873

Alaska Association of Harbormasters and Port Administrators Deferred Maintenance Funding Summary

List of Communities That Have Accepted Harbor Ownership from the State of Alaska

Location	Facility	Sale Date/Type	*State Funds Already Provided	Cost Est Provided	Funds Required	Contact	Phone Number
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Cold Bay	Dock	6/30/1992 Bill of Sale	n/a	Eng Est 5/4/05	$500,000	Bob Juettner	274-7555
Cordova	Small Boat Harbor	8/03/2003 Bill of Sale	$ 4,876,000	Est 1/31/2006		Dale Muma	424-6400
Craig	Dock North Cove Small Boat Harbor South Cove Small Boat Harbor	12/19/2001 Bill of Sale 6/30/1992 Comm's Deed 9/14/1995 Comm's Deed	$ 581,000	Quote 2/1/2006	$175,000	Michael Kampnich	826-3404
Homer	Small Boat Harbor	4/30/1999 Bill of Sale	$ 3,605,400	Est 10/2005	$3,300,000	Steve Dean	235-3160
Juneau	Aurora Small Boat Harbor Don Statter Small Boat Harbor Douglas Dock Douglas Small Boat Harbor Harris Small Boat Harbor Taku Small Boat Harbor North Douglas Launch Ramp	4/2/2003 Bill of Sale	$ 7,119,000	Eng Report 3/04	$17,100,000	John Stone	586-0294
Ketchikan	Bar Harbor North Bar Harbor South City Float Ryus Float Thomas Basin Small Boat Harbor	8/11/2004 Bill of Sale 5/15/2002 Bill of Sale 1/1/1999 Bill of Sale 8/11/2004 Bill of Sale 8/11/2004 Bill of Sale	$ 7,876,000	Est 9/1/05	$13,450,000	Clair Brewton	228-5632
King Cove	Old Harbor	3/25/1995 Bill of Sale	$ 352,000	Eng Est 2/3	$4,592,000	David Bath	497-2237
Klawock	Small Boat Harbor Dock	3/28/2003 Bill of Sale 5/16/1986 Quit Claim Deed	$ 896,000		$200,000	John Morris	755-2261
Kodiak	City Float St. Herman's Small Boat Harbor St. Paul Small Boat Harbor Channel Transient Float	3/12/1999 Bill of Sale	$ 7,775,500	Eng Rep 2/02 Update Est 2/06	$14,900,000	Marty Owen	486-8080
Old Harbor	Dock Float	5/20/1993 Bill of Sale 5/20/1993 Bill of Sale	$ 154,000		$1,000,000	Jim Nestic	286-2204
Pelican	Small Boat Harbor & Seaplane Float	9/06/2001 Bill of Sale	$ 1,451,142	1/30/2006	$1,040,000	Patty Phillips	735-2202
Petersburg	North Harbor Middle Small Boat Harbor South Small Boat Harbor	12/06/2005 Bill of Sale 6/03/2003 Bill of Sale	$ 2,500,000 $ 3,729,000	Eng Est 2/6/06	$4,000,000 $2,500,000	Jim Stromdahl	772-4688
Sand Point	Small Boat Harbor	12/2/1992 Bill of Sale	n/a		$2,100,000	Richard Kochuten, Sr.	383-2696
Seldovia	Small Boat Harbor	5/16/2004 Bill of Sale	$ 2,628,000		$3,400,000	Ronda Haynes	234-7643
Seward	Small Boat Harbor	2/25/1999 Bill of Sale	$ 1,134,200	Eng Est 2/6/06	$7,093,000	Scott Ransom	224-3138
Sitka	Crescent Harbor (A-D, 1-4) Crescent Harbor (E-F, 5-7) Sealing Cove Small Boat Harbor Thomsen Small Boat Harbor - Old ANB Float	11/09/2001 Bill of Sale 08/30/2004 Bill of Sale 08/30/2004 Bill of Sale 08/30/2004 Bill of Sale 6/18/1992 Comm's Deed	$ 6,460,000	Est 2/1/06	$4,500,000	Ray Majeski	747-3439
Skagway	Small Boat Harbor	10/21/2004 Bill of Sale	$ 1,068,852	Est 1/1/06	$ 2,575,000	Matthew O'Boyle	983-2628
Tatitlek	Oil Spill Response and Ferry Dock	10/8/1998 Bill of Sale	$ 315,000		$270,000	Olen Harris	562-1444
Valdez	Small Boat Harbor	12/03/2003 Bill of Sale	$ 3,013,300	Est 2/1/06	$2,500,000	Alan Sorum	835-4981
Whittier	Passenger Loading Dock Small Boat Harbor	5/15/2002 Bill of Sale 8/02/2004 Bill of Sale	$ 2,479,000		$4,890,000	Mark Earnest	472-2327x113
Wrangell	Fish & Game Float Inner Small Boat Harbor Reliance Small Boat Harbor Shoemaker Bay Harbor Standard Oil Float	8/20/2003 Bill of Sale	$ 3,492,000	Eng Est 2/2/06	$6,200,000	Greg Meissner	874-3736
Yakutat	Small Boat Harbor and Seaplane Float	8/8/2005 Bill of Sale	$ 526,000	Eng Rep 12/04	$ 2,295,000	Irving Gray	784-3323
Total State Funding Provided			***$64,354,394***				
Funding Needed to Complete Repairs					***$99,858,000***		

Spreadsheet prepared by Alan Sorum on 25 March 2005. Contact: (907) 835-4981
***Revised by John Stone on Feb. 6, 2006 to show verified cost estimates, 907-586-0294**

AAHPA is requesting a 50% match grant program.
(e.g., State Funding request of approximately $48 million, local match requirement of $48 million)

Alaska Association of Harbormasters And Port Administrators
617 Katlian Ave., Sitka, AK 99835
Phone: (907) 747-4877 Fax: (907) 747-6278

Senate Community and Regional Affairs Committee
March 6, 2006
SB 291
Testimony by John Stone
President, AAHPA

Mr. Chair and members of the Senate Community and Regional Affairs Committee, my name is John Stone. I am the president of the Alaska Association of Harbormasters and Port Administrators.

The Alaska Association of Harbormasters is an organization comprised of the senior managers from 27 community harbor systems. These include Anchorage, Bethel, Bristol Bay Borough/Naknek, Cordova, Craig, Dillingham, Haines, Homer, Hoonah, Juneau, Kenai, Ketchikan, King Cove, Kodiak, Nome, Pelican, Petersburg, Port MacKenzie, Sand Point, Seward, Sitka, Skagway, Unalaska/Dutch Harbor, Valdez, Whittier, Wrangell, and Yakutat. The Association's goal is simple: to make Alaska's harbors they best they can be.

First, let me say that the Association fully supports SB 291 and appreciates the Committee taking the lead on this important state and community issue. During the past several years, the Association has attempted to bring the dilapidated condition of Alaska's harbor infrastructure to the attention of the Legislature. We appreciated the opportunity to speak to the Fish Caucus last session to discuss this statewide problem. We are also very encouraged that the Alaska Department of Transportation fully supports this bill.

Most of Alaska's harbor infrastructure was built by the Alaska Department of Transportation and Public Facilities in the 1960's and 1970's. Largely, this infrastructure is at the end its useful life making complete replacement of it necessary. We believe the financial resources needed to replace these facilities before the end of their lives requires the collective effort of the State and local harbor jurisdictions.

Testimony of John Stone, President of AAHPA, on SB-291
Before the Senate Community and Regional Affairs Committee
March 6, 2006

The State's policy for many years was to enter into agreements with the cities and municipalities for the operation of the harbor systems with the State retaining title to the physical harbor improvements. The cities and municipalities established enterprise funds and assessed fees to users in an amount necessary to finance the operating cost of the facilities. This arrangement has worked very well from an operations standpoint. Unfortunately, neither party addressed facility replacement; the locals because they did not hold title to the improvements and the State because funding was not available.

In the 1990's, the State developed a new policy whereby the title of the physical improvements would be turned over to the local harbor jurisdictions along with some funding to help with facility replacement. Although the policy is sound, the program suffered from the fact that the funding provided with the transfer of title was only a fraction of the funding needed to replace the infrastructure that was transferred.

As the transfers have gone forward, local harbor jurisdictions developed facility replacement schedules and began looking at fees to cover facility replacement costs. It became clear that harbor fees needed to increase several-fold in short order. It also became clear that fees alone are not sufficient to recapitalize the transferred harbor infrastructure before it is lost.

Local harbor jurisdictions have indeed stepped up to the plate. Many of us are looking to finance revenue bonds with fee increases in order to replace transferred infrastructure. The Association believes this presents a good opportunity for a match funding program with the State. Many local governments, the State Chamber, the Alaska Municipal League, and our Association have adopted resolutions in support of this harbor match funding program.

We ask for this match program because we believe it is a good investment for the State. My colleagues at the Association will expand upon this point. Suffice to say that our harbors substantially contribute to the State's economy and are the lifeblood of many communities.

In summary, we thank the Chair and Committee for its consideration of SB 291. The Alaska Association of Harbormasters and Port Administrators strongly supports this bill. The dilemma facing us is that we have a tremendous amount of harbor

infrastructure that is at the end of its useful life. This infrastructure has been put into our hands. We are scrambling to find ways to replace it before it is lost. We are also substantially increasing fees to help with replacement costs. We have learned that fees are not the total answer. This bill provides much needed help with these replacements by matching our local investments. This bill also achieves the policy goal of the harbor transfers, whereby the local communities become responsible for the operation, maintenance, and replacement of the harbor improvements, because it gives us the capability to replace the transferred infrastructure before it is lost.

Thank-you.

Headquarters:
217 2nd Street, Suite 201
Juneau, Alaska 99801
(907) 586-2323 FAX 463-5515
www.alaskachamber.com

Regional Office:
601 W. 5th Ave., Suite 700
Anchorage, Alaska 99501
(907) 278-2722 FAX 278-6643

ALASKA ★ STATE ★ CHAMBER OF COMMERCE

March 6, 2006

Senator Bert Stedman, Chair
Community & Regional Affairs Committee
State Capital
Juneau, AK 99801-1182

The Honorable Chairman and Members of the Senate Community & Regional Affairs Committee,

The Alaska State Chamber of Commerce strongly supports SB 291. Supporting Alaska's Harbor Infrastructure has been one of the State Chamber's legislative priorities for a number of years. Without adequate harbor infrastructure, commercial fishermen and sport anglers have little opportunity to grow their uniquely Alaskan businesses.

Whether to help our commercial fishermen offload their catch, or to provide safe ramping for Alaska's burgeoning tourist activities, our harbors are in need of repair and expansion to increase our opportunities for commerce. The State of Alaska has an obligation to provide adequate harbor facilities in many parts of the state; our harbors are the transportation corridors for Alaska's maritime roadways. Without adequate harbor infrastructure, Alaska will continue to be limited in its growth of maritime commerce.

SB 291 attempts to address many of Alaska's harbor funding problems by creating the municipal harbor grant fund through the collection of fuel tax revenues and fisheries business taxes. While SB 291 makes headway in fixing many of Alaska's harbors, the State Chamber feels that the taxes collected will not provide adequate revenues to address Alaska's aging harbor infrastructure. The Chamber feels that additional appropriations may be necessary or additional bonding utilizing tax revenues might ultimately provide adequate revenues to address the funding necessary to help our harbors.

Yours in economic prosperity,

Wayne A. Stevens
President/CEO
Alaska State Chamber of Commerce

Alaska State Chamber of Commerce
2006 Position
State and Federal Funding Dock and Harbor Maintenance and Development Projects throughout Alaska

Request that the State of Alaska fund and assist in acquiring federal funding for existing and future harbor and dock development projects in an effort to stimulate economic growth in Alaskan communities. The Alaska State Chamber of Commerce further urges the State of Alaska to make funding available to repair and improve existing facilities to serviceable standards consistent with DOT regulations as part of their mandated transferal of ownership of these harbors to communities.

Cordova District Fishermen United

P.O. Box 939
Cordova, Alaska 99574
(907) 424-3447 FAX (907) 424-3430

RECEIVED 2/27/06

February 22, 2006

Senator Bert Stedman
State Capitol, Room 30
Juneau, AK 99801-1182

RE: Support SB 291 – Municipal Harbor Facilities Grant Fund

Dear Senator Stedman,

Cordova District Fishermen United (CDFU) supports SB 291 that will create a program to achieve capital improvements for harbor facilities through a one-time 50/50 match grant to municipalities.

The transfer of harbor management and funding from the state of Alaska to local communities has proven to be extremely costly to those communities that have been willing to assume this responsibility. This is in part due to deferred maintenance and the rising cost of repairs

For Alaska's coastal communities, harbors maintenance & facilities are critical for the fishing industry as well as residents & visitors. It is imperative that these harbors be in a good state of repair, both for functionality & safety of its users.

CDFU supports the creation of a program that will fund capital improvements as well as major maintenance or harbor facilities made possible through SB 291.

Sincerely,

Diane Platt

Diane Platt
Executive Director

City of Pelican

RECEIVED

BOX 737 · PELICAN, ALASKA 99832 · PHONE 735-2202/2203 · FAX 735-2258 · E-MAIL cityhall@pelicancity.net WEBSITE www.pelicancity.net

CITY OF PELICAN
RESOLUTION 2006-2

A RESOLUTION TO PROVIDE MATCHING MAINTENANCE AND REPAIR FUNDS TO LOCAL GOVERNMENT OWNED HARBORS

WHEREAS, the State of Alaska built and owned many of the harbor facilities in Alaska's communities; and,

WHEREAS, under State of Alaska ownership, the maintenance and repair of the harbor facilities was minimal; and,

WHEREAS, when transferring ownership of the harbor facilities to the local governments, the State of Alaska provided insufficient funds to restore the harbor facilities to "good" condition, and,

WHEREAS, local governments are willing to assume financial responsibility of their ownership roles; and,

WHEREAS, local governments are realizing that ownership of harbors means that moorage rates to the public must be increased several fold to restore the harbors to good condition; and,

WHEREAS, increased moorage fees is a disincentive for using the Pelican Boat Harbor, and,

WHEREAS, local governments seek financial assistance from the Legislature to improve Alaska's harbor facilities; and

WHEREAS, local governments request the Legislature to provide a 50% match funding program for the maintenance and repair of the transferred harbors.

NOW, THEREFORE BE IT RESOLVED that the City of Pelican requests that the State of Alaska Legislature provide capital matching funds to local governments who have accepted ownership of the harbors for the purpose of helping local governments to fund deferred port and harbor maintenance projects.

RESOLUTION 2006-2
PAGE 2

PASSED, APPROVED AND ADOPTED this 3RD **day of** JANUARY**,**
2006.

Signed: Patricia Phillips
Patricia Phillips, Mayor

Attest:

Betty L Bean
Betty L. Bean, City Clerk/Treasurer

RESOLUTION # 1791

A RESOLUTION REQUESTING THE STATE LEGISLATURE PROVIDE MATCHING MAINTENANCE AND REPAIR FUNDS TO LOCAL GOVERNMENT OWNED HARBORS

Offered by: Anderson
Supported by: Sarff

Whereas, the State of Alaska built and owned many of the harbor facilities in Alaska's communities and under State of Alaska ownership the maintenance and repair of the harbor facilities was minimal; and

Whereas, when transferring ownership of the harbor facilities to the local governments the State of Alaska provided insufficient funds to restore the harbor facilities to "good" condition; and

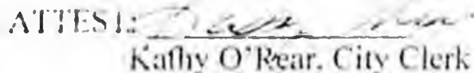
Whereas, local governments are willing to assume financial responsibility of their ownership roles, but have realized that ownership requires moorage rates to the public be increased substantially to restore the harbors to "good" condition; and

Whereas, local governments are not able to implement the dramatic moorage increases needed to restore the facilities and must seek financial assistance from the Legislature.

THEREFORE, BE IT RESOLVED by the Petersburg City Council – in order to prevent Alaska's harbor facilities from decaying and disappearing, the State of Alaska Legislature is requested to provide a 50% capital matching fund program to local governments who have accepted ownership of the previously State owned harbors for the purpose of helping the local governments fund deferred port and harbor maintenance projects.

PASSED AND APPROVED by the Petersburg City Council February 6, 2006.

Ted Smith, Mayor

ATTEST: 
Kathy O'Rear, City Clerk

CERTIFIED COPY

CITY OF VALDEZ, ALASKA

RESOLUTION NO. 05-15

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF VALDEZ, ALASKA, URGING THE LEGISLATURE TO PROVIDE MAINTENANCE AND REPAIR FUNDS TO LOCAL GOVERNMENT OWNED HARBORS

WHEREAS, the State of Alaska built and owned many of the harbor facilities in Alaska's communities; and,

WHEREAS, under State of Alaska ownership, the maintenance and repair of the harbor facilities was minimal; and,

WHEREAS, when transferring ownership of the harbor facilities to the local governments, the State of Alaska provided insufficient funds to restore the harbor facilities to "good" condition; and,

WHEREAS, local governments are willing to assume financial responsibility of their ownership roles;

WHEREAS, local governments are realizing that ownership of harbors means that moorage rates to the public must be increased several fold to restore the harbors to good condition; and,

WHEREAS, many local governments may not be able to implement such dramatic moorage increases without financial assistance; and

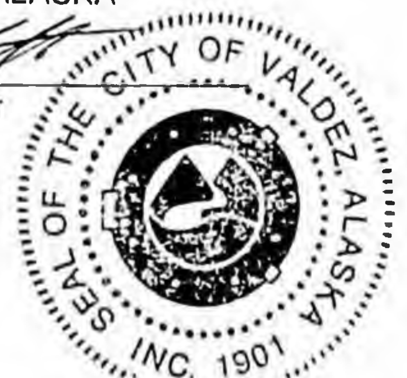
WHEREAS, local governments seek financial assistance from the Legislature to prevent Alaska's harbor facilities from disappearing.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF VALDEZ, ALASKA, that the State of Alaska Legislature is urged to provide capital funds to local governments who have accepted ownership of the harbors for the purpose of helping local governments transition to their ownership roles.

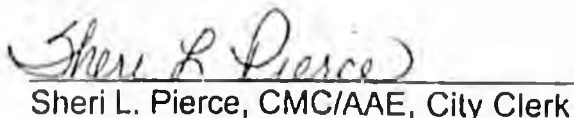
PASSED AND APPROVED BY THE CITY COUNCIL OF THE CITY OF VALDEZ, ALASKA, this 22nd day of February, 2005.

CITY OF VALDEZ, ALASKA

Bert L. Cottle, Mayor



ATTEST:



Sheri L. Pierce, CMC/AAE, City Clerk