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theless, possible contributors to emergency cleanup funds may include direct state appropriations, taxes or fees assessed against hazardous waste generators, or surcharges on disposal. Ultimately, these costs will be passed on to consumers of those goods whose production creates hazardous by-products.

Questions of fairness in allocating cleanup costs arise. Should present producers of chemical waste be required to finance cleanup operations for their predecessors? Should taxpayers be responsible for past dumping practices of industry? Should the chemical industry be singled out as the prime contributor to any fund [illegible]ng at an equitable distribution of financial responsibility, these issues need thorough consideration.

In cases where responsible parties can be identified, alternatives in recovering cleanup costs exist. Section 7003 of RCRA empowers the EPA to file suit against parties responsible for creating imminent health hazards. This type of provision also is found in many state laws.

STATE ACTION

Many states are wrestling with the issue of what to do with legal or illegal disposal sites that are now abandoned or no longer in use and are currently potential health problems.

The first step in combating the problem is to identify the sites. Pennsylvania recently passed legislation that requires the Department of Environmental Resources to formulate a hazardous waste management plan. This plan must include an inventory and evaluation of current hazardous waste practices within the state, including existing sites.[31] Michigan has the same type of planning requirement and is currently undertaking an inventory.

Once identified, the public health and environmental problems associated with these sites can be abated. Abatement is costly; thus the issue of responsibility for cleanup costs must be resolved. The Arkansas Resource Reclamation Act of 1979 requires the Department of Pollution Control and Ecology "to adopt and enforce regulations which would require the owners of abandoned disposal sites to undertake such actions as are reasonable to prevent environmental contamination."[32] This is an example of one approach to having the responsible party pay for cleanup of the site.

Many states have an imminent hazard provision similar to Section 7003 of RCRA which allows the EPA to file suit against the parties responsible for creating imminent health hazards,

and requires those parties to pay for cleanup of the site. Despite these provisions, if there is an emergency, remedying the situation cannot wait until liability is established in court. Money must be available immediately from the state or federal levels to respond to the problems.

There are several proposals for emergency cleanup funds at the federal level. The federal "super-fund" legislation is designed to provide funds for the immediate cleanup of dangerous hazardous waste situations and provide an incentive to industry to properly handle its waste. At the date of writing, two bills have been passed by the U.S. House of Representatives and one bill is pending in the U.S. Senate. It is not known whether a compromise bill will be passed by both houses by the end of the 1980 session.

NCSL supports federal legislation that would, among other things, establish a fund to pay for liability, compensation, cleanup, and emergency response for hazardous substances released into the environment, the cleanup of inactive sites, and compensation to victims who suffer damages. This fund should be financed primarily through fees or taxes on generators. In addition, NCSL supports a liability system that would encourage those responsible for the release of hazardous substances to clean them up and prevent additional releases. Liability should be established for damages and loss of real or personal property, including relocation costs, loss of use of natural resources, economic loss, and all out-of-pocket medical expenses due to personal injuries. NCSL supports a system that would require the states to pay 10 percent of the cost of remedial action for facilities that are privately owned and up to 50 percent where the facility is publicly owned.[33]

Several states have established funds to respond to hazardous waste releases. Kansas has established the Perpetual Care Trust Fund.[34] The fund would consist of fees collected from disposal and storage site operators. The fund could be used for repairing sites and environmental damage as a result of post-closure occurrences. Up to 20 percent of the fund's balance could be used on an emergency basis for investigation, engineering, equipment and construction related to removal, treatment or disposal of hazardous waste.

New Jersey has established the Spill Compensation Fund.[35] This fund, authorized to contain as much as $50 million, is created by taxes on the transfer of petroleum products and hazardous substances. The fund can be used for cleanup and

removal of hazardous substance discharges: "imminent and ancient spills"; costs of restoring, repairing or replacing real or personal property damaged by the discharge; costs of restoring natural resources damaged by the discharge; and compensation for tax revenues lost by state/local governments due to property damage.

Another example is the Wisconsin Hazardous Substances Spill Fund.[38] This fund is made up of an annual appropriation by the legislature and reimbursements from responsible parties. The fund can be used for abandoned or inactive site cleanup, procuring and maintaining equipment and supplies for cleanup, and training cleanup personnel.

Cleanup of abandoned or inactive sites is an expensive proposition. The EPA estimates the ultimate cost of cleaning up Love Canal may be $100 million. Although Love Canal is an egregious example of cleanup costs, even a fraction of that amount will seriously strain a state budget or a designated cleanup fund. The states and the federal government will have to cooperate to provide adequate resources.

Facility and Site Ownership Options

INTRODUCTION

Because of high entry costs, high risks and strict regulations, ownership of off-site facilities may be limited to large private firms or public entities. State legislatures are beginning to consider who should own and operate management facilities. This section will discuss the advantages and disadvantages of private and public ownership and how the state may implement the decisions.

Private Ownership—Private industry has advanced technology and business management expertise. Bond underwriters and pollution control financing authority directors have suggested that traditional financing may be difficult to obtain due to the high risks associated with waste management. Consequently, states might be faced with having to provide incentives to encourage private development. This may be especially true in states that do not produce large quantities of waste. Incentives that have been discussed include the creation of a comprehensive state hazardous waste plan, developing a siting process, and forcing generators to use approved facilities.

Providing financial inducements is another action the state might pursue. One type of financial assistance is a loan guarantee plan, where the state would guarantee to meet payments if the private firm defaulted. This financial incentive, which would make funds available to a private developer, would encourage facility construction. Another method of financial assistance is industrial development revenue bonds. These bonds have been traditionally used to help a private firm finance its own facility at lower interest rates. Another bonding method is issuance of pollution control bonds. Other forms of financial assistance include favorable tax structures and subsidies.

Public Ownership—The alternative to privately-owned management facilities involves public ownership. A state, local government or some form of public benefit corporation, may own either the facility or the land. Public ownership of the land and the facility may ensure perpetual care of the facility, reduce public opposition to its location and ensure that specific management goals are met.

Methods for financing public ownership include general obligation bonds issued by the state or local government, project revenue bonds, and state authority bonds. General obligation bonds, backed by the full faith and credit of the state, are the traditional method of financing public works projects. However, this would require the state to use a portion of its bonding capacity, forcing other projects to be postponed. Project revenue bonds are another financing vehicle available to publicly-owned facilities. These bonds are repaid solely from revenue generated by the project. State authority or commission bonds are yet another option available where state legislation enables the ownership agency to incur debt and to issue notes and bonds. These bonds are the obligation of the ownership agency, and debt services are paid out of the total pool of revenues and monies available to the agency.

If the state decides to own hazardous waste management facilities, two methods of operation are available. The state may design and operate the facility, which would provide substantial public control. The state must ensure that the agency empowered to operate the facility has the technical and financial expertise to manage the facility. The other option is to contract with a private firm to operate the facility.

Two methods are available for private operation. One, where the state designs and builds the facility and contracts for its operation, allows for extensive state control over methods of operation. The alternative to this approach is for the state to own the site and lease it to a private firm which would then develop and operate the facility.

STATE ACTION

Many states have considered the question of ownership. Some states have decided on private ownership while others have passed enabling legislation for state ownership.

Minnesota is a good example of a state that has thoroughly studied the problem and decided to encourage private ownership by attempting to provide incentives for it. The Minnesota Legislature charged the Minnesota Pollution Control Agency and the State Planning Agency with reporting on hazardous waste management options available to the state. This report pointed out that ownership was an issue that should be considered by the legislature, but made no recommendations. In the Waste Management Act of 1980, the legislature established a planning and siting program that will encourage private development as much as possible. The legislature, in the meantime, has required a report from the Department of Economic Development on private investment in hazardous waste management. Based on that report and on the interest private industry shows in the area of hazardous waste management, the legislature at a later time will decide if more public sector involvement is necessary. Meanwhile, the act does allow the state to acquire land, by condemnation if necessary, for commercial hazardous waste facilities.

New York is encouraging private development by issuing pollution control bonds. This option may be used for hazardous waste facilities as well. These bonds are issued by the Environmental Facilities Corporation (EFC) but are the sole obligation of the private company.

There are many examples of public ownership at the local and state level which have varying degrees of private/public cooperation. In California, a number of facilities are owned and operated by county governments or sanitation districts. These facilities are landfills that accept limited quantities and only certain types of wastes.

The Gulf Coast Waste Disposal Authority (GCA) in Houston, Texas, is a publicly chartered agency empowered to provide treatment facilities for public and private sources of waste.[37] The GCA is developing a hazardous waste facility that will be financed by four hazardous waste generating firms. The GCA intends to perform several tasks associated with design and operation of the facility while other tasks will be performed by private contractors.

Washington's law authorizes the Department of Ecology to acquire land on the Hanford Nuclear Reservation to develop an extremely hazardous waste disposal site or facility.[38] The legislation requires that all extremely hazardous waste be disposed of at this site. A suitable site has been acquired and the state is now doing further studies.

The EFC of New York is empowered to acquire interests in real property for the purposes of constructing and operating industrial hazardous waste treatment, storage and disposal facilities.[39] The EFC is now studying the possibility of acquiring hazardous waste management facilities.

Oregon requires that, as a condition for obtaining a permit to operate a hazardous waste site, the licensee deed to the state the hazardous waste site after closure.[40] This requirement implies that the state will assume responsibility for perpetual care of the site.

Arizona passed a bill in 1980 that provides for state acquisition of a site for a hazardous waste disposal facility.[41] The bill, effective July 1980, requires the Department of Health Services to select a site and then submit the site for legislative approval. Once the site receives approval, the department has the authority to take all action necessary to acquire and develop the site.

Chapter VII Conclusion

The specific examples of state legislative activity described in this guide demonstrate that state governments have been active in the development of innovative legislation in all areas of hazardous waste management. The degree of hazard approach adopted in California, the absolute liability section in the recently passed Pennsylvania legislation, and the comprehensive planning effort called for in the Minnesota Waste Management Act are all examples of this innovation. As time goes on, state legislatures will be developing new legislation and amending existing legislation in response to the public health and safety and environmental problems associated with improper hazardous waste management.

Notes

[1] Michigan (1979 Mich. Pub. Acts No. 64)
Florida (1979 Fla. Laws ch. 80.302)
Delaware (Del. Code Ann. tit. 7, ch. 63)
Arkansas (1979 Ark. Acts No. 406)
Massachusetts (Mass. Ann. Laws ch. 21 sec. 1 *et seq.*).

[2] 1980 Minn. Laws ch. 564, Art. IV.

[3] 1980 Ky. Acts sec. 11.

[4] L. Peery, D. Valentine and L. Wright, Senate Research Staff, *Staff Report on Issues in Hazardous Waste Management In Missouri*, Senate Energy and Environment Committee, p. 21, August 28, 1980.

[5] Cal. Health & Safety Code Div. 20, ch. 6.5, Art. 5(25150).

[6] Perry, *Staff Report on Hazardous Waste in Missouri*, p. 21.

[7] *Ibid.*

[8] 45 Fed. Reg. 33063 (May 19, 1980) (To be codified in 40 CFR 261 *et. seq.*).

[9] 45 Fed. Reg. 33063 (May 19, 1980) (To be codified in 40 CFR 261.)

[10] 1979 Utah Laws, Utah Hazardous Waste Act sec. 2(c).

[11] *Ibid.*

[12] Cal. Health & Safety Code Div. 20, ch. 6.5, Art. 2(25117)(a) and (b).

[13] Cal. Health & Safety Code Div. 20, ch. 6.5, Art. 2(25115).

[14] [illegible]sh. Rev. Code sec. 70.105.010(5) and (6) (1976).

[15] Tex. Art. 4477-7, V.T.C.S. (1978).

[16] 1979 Ark. Acts 406 sec. 4(e)(6).

[17] 45 Fed. Reg. 33154 (May 19, 1980) (To be codified in 40 CFR 265).

[18] Ill. 81st General Assembly HB 453 sec. 22.

[19] 1979 Ark. Acts 406 sec. 4.

[20] 1979 Mich. Pub. Acts No. 64 sec. 22(2).

[21] [illegible]979 Mich. Pub. Acts No. 64 sec. 41(1).

[22] *I[illegible]id.*

[23] 1979 Wis. Laws ch. 144.44(2)(b) as revised b[illegible] ch. 34, Laws of 1979.

[24] 1979 Wis. Laws ch. 144.44(3)(c) as revised by ch. 34, Laws of 1979.

[25] 1979 Ark. Acts 406 sec. 13(b).

[26] Cal. Health & Safety Code Div. 20, ch. 6.5, Art. 7(25174).

[27] 1979 Ark. Acts 406 sec. 13(a) and (b).

[28] 1979 Fla. Laws ch. 80-302 sec. 403.727(3)(a) and (b).

[29] 1980 Pa. Laws No. 1980-97 Art. VI sec. 606.

[30] 1980 Minn. Laws ch. 564.

[31] 1980 Pa. Laws No. 1980-97 Art. V sec. 507.

[32] 1979 Ark. Act 1098 sec. 7(a) and (b).

[33] *Goals For State-Federal Actions*, Policy Resolutions of the National Conference of State Legislatures 1980-1981, p. 109.

[34] 1979 Kan. Sess. Law ch. 202.

[35] 1979 N.J. Laws ch. 346.

[36] 1979 Wis. Laws ch. 144.76(6).

[37] Acts of the 61st Legislature of the State of Texas, Reg. Session, 1979, 409 as amended by 202 (1971), ch. 258 and 466 (1973), and ch. 443 (1975).

[38] Wash. Rev. Code sec. 70.104.040.

[39] N.Y. Pub. Auth. Law, Title 12, New York State Environmental Facilities Corporation, sec. 1285(c).

[40] Or. Rev. Stat. sec. 3459.590.

[41] 1980 Ariz. Sess. Laws ch. 119 (To be codified as Title 36-2801 of Ariz. Pub. Health Title).

A Legislator's Guide to Hazardous Waste Management

Appendix

Selected References

Glossary

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- "In Whose Backyard? The Problem of Siting Hazardous Waste Facilities." *State Legislatures*, April 1980, pp. 22-24, NCSL, Denver, Colorado.

Glossary

Abandoned Site
An inactive hazardous waste disposal or storage facility which cannot be easily traced to a specific owner, whose owner has gone bankrupt and subsequently cannot afford the cost of cleanup, or a location where illegal dumping has taken place.

Certificate of Need
A declaration by a state authority that a hazardous waste treatment, storage or disposal facility is essential to meet the hazardous waste management needs of the state and that the proposed facility is environmentally, technologically and politically adequate.

Cradle-to-Grave
Tracking of the source, quantity, concentration, type, etc., of hazardous waste from the instant of waste production until ultimate storage or disposal.

Disposal
The environmentally sound incineration, long-term storage, treatment, or the discharge, deposit, injection, dumping, spilling, leaking, or placing of a hazardous waste into or on land or water.

Disposal Facility
The location, equipment, or facility where hazardous wastes are disposed of, including a disposal facility associated with or adjacent to facilities generating waste.

Dump
A land site at which waste is disposed of in a manner which does not protect the environment, is susceptible to open burning, or is exposed to the elements, vermin or scavengers.

Fluidized Bed Incinerator
An incinerator in which the waste is maintained in suspension by an upward controlled flow of air.

Generator
The person who by nature of ownership, management or control, is responsible for causing or allowing to be caused, the creation of hazardous waste.

Hauler
A person who transports hazardous waste on a public road, railroad or water to a hazardous waste facility.

Incineration
The process by which waste volume is reduced by combustion in a controlled manner.

Industrial Development Revenue Bonds
Bonds which are based only on the revenues of the project or business. They are ultimately financed by money raised from the bond issued as security.

Injection
Subsurface emplacement of fluids through a bored, drilled or driven well; or through a dug well, where the depth of the well is greater than its largest surface dimension

Leachate
A liquid containing decomposed waste, bacteria and other noxious and potentially harmful materials that drains from landfills.

Letter of Credit
A written instrument addressed by one person to another, requesting the latter to give credit to the person in whose favor it is drawn

Manifest System
The system used for identifying the quantity, composition, origin, routing and destination of hazardous waste during its transportation from generation to disposal, treatment or storage

Midnight Dumping
The illegal dumping of hazardous waste in an environmentally unsound and uncontrolled manner

Off-Site Hazardous Waste Facility
An operation involving handling, treatment, storage or disposal of hazardous waste in one or more of the following situations
1. The hazardous waste is transported via a commercial railroad, a public road or public waters, where adjacent land is not owned by, or leased to, the producer of the waste
2. The hazardous waste site is not owned by, or leased to, the producer of the waste
3. The hazardous waste is at a site which receives hazardous waste from more than one producer

On-Site Hazardous Waste Facility
An operation involving handling, treatment, storage or disposal of hazardous waste on land owned by or leased to, a waste producer and which receives waste produced only by the producer. Also considered on-site are situations where the disposal site and the area where the hazardous waste are generated are on the same contiguous property

Sanitary Landfill
A method of disposing of refuse on land without creating nuisances or hazards to public health or safety. Careful preparation of the fill area and control of water drainage are required to assure proper landfilling. To confine the refuse to the smallest practical area and reduce it to the smallest practical volume, heavy tractor-like equipment is used to spread, compact, and usually cover the waste daily with at least six inches of compacted soil. After the area has been completely filled and covered with a final two- to three-foot layer of soil and has been allowed to settle an appropriate period of time, the reclaimed land may be turned into a recreational area such as a park or golf course. Under certain highly controlled conditions the land may be used as a plot on which some types of buildings can be constructed

Surface Impoundment
A facility or part of a facility which is a natural topographic depression, man-made excavation, or diked area formed primarily of earthen materials, which is designed to hold wastes containing free liquids (e.g., holding, storage settling and aeration pits, ponds and lagoons).

Surety Bond
A bond guaranteeing performance of a contract or obligation.

The Science and Natural Resources Program

The Solid and Hazardous Waste Management Project of the NCSL, conducted in cooperation with the EPA, is designed to familiarize state legislators and legislative staff with the legal, economic and intergovernmental problems associated with solid and hazardous waste management and provide technical assistance to state legislators and state legislative staff. This project is part of NCSL's Science and Natural Resources Program. The program offers several services to legislatures on issues and questions concerning science and technology, natural resources, and state-tribal relations. The Denver office privides *general information services*, including responses to state information requests, brief reports and newsletters, *in-depth policy research* that results in major reports and guidebooks on key issues, *conferences and seminars*, and *direct in-state technical assistance* tailored to the requests of state legislatures. In addition to solid and hazardous waste, current projects cover the specific topics of water quality, radioactive wastes, vehicle inspection and maintenance for air quality, resource information systems and state-tribal relations. The program also has projects that provide general research and information services on topics involving scientific and technical questions.

NCSL's office in Washington, D.C., *monitors* federal natural resources legislation and agency programs and then *represents* the concerns of state legislatures, as established by the NCSL State-Federal Assembly, to the federal government. Further questions concerning the program can be directed to the following staff members:

Denver

Dan R. Bucks, Science and Natural Resources Program Director
Larry Morandi, Program Manager, Natural Resources
Ron Hogan, Program Manager, Science and Technology

Washington, D.C.

Donna Wise, Natural Resources Staff Director

SB
43

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M January 28, 1981

SUBJECT: Filing Insurance Policy Forms - SB 43
(Work Order No. 12-0479)

TO: Senate Labor and Commerce Committee
ATTN: Linda Otey

FROM: Linn H. Asper
Legislative Counsel

You have asked if SB 43 as drafted, if enacted, will insure state compliance with P.L. 96-265 (42 U.S.C. Sec. 1395ss) and prevent federal intervention to regulate medicare supplemental insurance policies.

P.L. 96-265 creates a certification process for certain types of insurers, setting new standards for medicare supplemental insurance, including a requirement that such policies must be designed to pay out at least 75 percent of premiums collected in benefits. [42 U.S.C. Sec. 1395ss(c)(2)]. This is a federal requirement not directly related to state insurance laws, but if a state has not created requirements similar or identical to the federal requirements by July 1, 1982, the federal certification will come into play, superseding state regulation in this area. The State of Alaska favors state rather than federal regulation of the insurance industry in Alaska and thus wishes to obtain legislative authority to control premium-benefit ratios by enactment of SB 43.

The Division of Insurance has stated that the federal deadline of July 1, 1982 is misleading in that there is to be a federal survey of state laws existing on July 1st of this year which will be used to assess the need for federal intervention. The Division believes that changes in state law which become effective before July 1, 1982, but after July 1st of this year will not prevent the federal intervention which they seek to avoid. If the Division is correct, and I have no

reason to doubt them on this, then they do need authorizing legislation during this session to allow them to make regulations before July 1st of this year to avoid federal intervention.

It appears that SB 43 will give the Division of Insurance the authority it needs to avoid the threat of federal intervention as to medicaid supplemental insurance. It should be noted that the bill as written would allow regulation of premium-benefit ratios in all insurance policies written in the state, not just medicaid supplemental insurance. This broad authority may be desirable but it is not required by the new federal law. I also have some difficulty with the placement of the new law in AS 21.42.130, which has to do with insurance policy format, not substantive regulation of insurance rates. It might better be placed in AS 21.89 MISCELLANEOUS PROVISIONS, but its placement in AS 21.42.130 will not invalidate the law.

THIS IS REVISED IN CS TO DISABILITY INS.

To summarize, SB 43 will have the effect of supplanting federal certification procedures in the area of premium-benefit ratios in medicaid supplemental insurance, if enacted this session. It goes beyond medicaid supplemental insurance and, in fact, gives the Division of Insurance power to set premium-benefit ratios for all insurance policies.

LHA:jdn

THIS IS REVISED IN CS TO DISABILITY INSURANCE.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

POUCH D
JUNEAU, ALASKA 99811
Phone: 465-2500

January 20, 1981

Honorable Bob Mulcahy
Chairman, Senate Labor and
Commerce Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Mulcahy:

RE: Position Paper SB 43

Thank you for your request for information on SB 43.

The recent passage of Public Law 96-265 in the Federal Congress has the effect of transferring a portion of the regulation of insurance to the Federal Government unless the various states establish certain equivalent programs and do so on an extremely short time frame.

The insurance industry has traditionally been regulated by the various states, individually. This approach was reinforced in 1945 with the passage of the McCarran-Ferguson Act (15 USCA 1011-1015). There has been a fairly steady attempt to bring such regulation under a federal agency, particularly by the Federal Trade Commission, which has been resisted by the states with equal fervor. The principal argument at the federal level has been that insurance is interstate commerce and should be regulated by a federal agency. The states, on the other hand, argue that the federal bureaucracy is either unable or unwilling to recognize and be responsive to local conditions and needs. Due to Alaska's population relative to the rest of the nation, this is an argument that has a good deal of substance. In fact, Alaska has already experienced a situation that accents the State's concerns and did so at the expense of Alaska's citizens to the tune of about $36,000, and that was in 1972 dollars.

Public Law 96-265 addresses changes in the Social Security Act and includes language dealing with medicare supplemental policies. It has two requirements termed "The Baucus Amendment" which impact State regulation of insurance. The first requirement concerns adoption of minimum standards of coverage for medicare supplemental policies. The Division of Insurance has sufficient statutory authority to establish the necessary standards based on an argument that it would be a misrepresentation to offer or sell a contract of insurance that purports to be a medicare supplemental policy unless it provides the adopted minimums. This can be accomplished by regulation and work on it has commenced.

The second requirement of "The Baucus Amendment" is for cost/benefit ratio regulation. This is the area in need of a legislative solution. The Division of Insurance does not currently have rate regulatory authority over disability or accident/health kinds of insurance including medicare supplemental policies. It, in fact, wishes to avoid rate regulation of the kind now applied to property and casualty kinds of insurance as there would be a fiscal impact not commensurate with the results. However, it would be appropriate to determine a reasonable ratio of cost to benefit which could be regulated rather simply based on information supplied to the division annually, thus avoiding an elaborate and costly actuarial review process.

Under the federal legislation, the Secretary of Health, Education and Welfare is required to establish a certification program with respect to the various states that polic[illegible] issued in those states meet certain standards, unless a state has established a program to regulate the minimum standards and cost/benefit relationship as previously noted. The secretary is to base his actions on a study to be completed by July 1, 1981, so we are faced with an exceptionally short time frame to act and avoid this federal intrusion.

The proposal modifies the reasons under which the Division of Insurance may base the refusal of a filing of a contract form, to include an inappropriate relationship between the benefit provided and the cost of the coverage. This responds to the federal action concerning medicare supplemental policies. It also addresses other kinds of insurance subject to filing under AS 21.42.

We are prepared to offer testimony and/or respond to questions when this issue is heard before your committee.

Very truly yours,

Charles R. Webber
Commissioner

CRW/jarE8

Coming: Help in finding a medigap policy that makes sense

Medigap plans meeting certain voluntary standards will get an okay from Uncle Sam starting next year.

MILLIONS of senior citizens are "victims of a colossal racket" that costs them one billion dollars a year: the sale of medigap health insurance policies that are "unneeded, duplicative, and therefore essentially worthless."

That charge isn't new. It was made two years ago by the staff of the House Select Committee on Aging and its chairman, Representative Claude Pepper (D.-Fla.). *Changing Times* has reported on the problem several times, most recently in "New Guides to Picking a Medigap Policy" (Feb. 1980).

What's new is that Congress has passed a law aimed at ending the medigap rip-off.

Medigap policies are private insurance plans that supplement medicare benefits. Since medicare pays less than 40% of the health-care costs of people 65 and older, there are plenty of gaps to fill. Medicaid plugs them for those who qualify, but for other senior citizens there is a real need for private insurance.

As you are aware if you've ever considered such a policy, it's tough to judge how much protection is offered and just how the coverage would mesh with medicare benefits. Investigations have shown that the medigap business is fertile ground for unscrupulous agents pushing policies of little or no value. The Committee on Aging figures that a fourth of the four billion dollars spent annually for medigap insurance is wasted.

The new law should make choosing a supplemental policy easier and safer. It calls for a voluntary federal certification program to begin in the summer of 1982. Only plans that meet minimum standards will be awarded the government's seal of approval:

- ▶ The policy must supplement both part A and part B of medicare.
- ▶ It must be written in easy-to-understand language.
- ▶ It cannot exclude coverage of a preexisting health condition for more than six months.
- ▶ It has to permit cancellation within 30 days without financial loss.
- ▶ It must offer reasonable economic benefit in relation to the premium charged.

The question of what is a reasonable economic benefit will be answered in part by the policy's loss ratio—the percentage of premium income returned to policyholders in benefits. The higher the loss ratio, the smaller the portion of each premium dollar that goes for profits, agents' commissions and other expenses. The federal standards set 75% as the minimum loss ratio for group medigap policies; for individual policies the minimum ratio will be 60%.

Clearly, some medigap policies now sold cannot pass the test. The Committee on Aging reports, for example, that some individual policies pay out less than 30 cents of each premium dollar in benefits. In contrast, Blue Cross/Blue Shield group plans—which account for about half of the nearly 20,000,000 policies purchased each year to supplement medicare—average a loss ratio of about 90%.

Because the federal program will be voluntary, insurance companies won't be required to submit their medigap plans for government scrutiny. Plans that don't meet the minimum standards won't be banned, but it is expected that the potential marketing advantage of winning the government's okay will encourage companies to seek certification, and that passing the federal test will become a benchmark for medigap policies. (In states that impose equal or higher standards than those in the federal law, the state's requirements will apply.) The Department of Health and Human Services (HHS) will design an emblem for display on federally approved policies.

In addition to establishing the certification program, the new law takes aim at medigap abuses by making it a federal crime for agents to use certain sales practices. It will be illegal, for example, to knowingly sell a policy that duplicates coverage an individual already has from medicare or another private policy. It will also be a crime to claim falsely that a policy has been okayed by the government or for a company to offer a mail-order medigap policy in a state unless the policy has been approved by the state's insurance office.

You still have to compare

Federal certification won't mean all insurance plans will be identical. Approved policies will undoubtedly differ on specific coverages offered and premiums charged. As with any other insurance, you'll have to compare carefully to get the medigap policy that best fits your needs.

There's help coming in that area, too. HHS is setting up a nationwide counseling service to help people evaluate medigap policies. Although counselors won't recommend individual policies, they will analyze plans and help buyers compare policies on such points as whether coverage duplicates medicare, which gaps are filled and which aren't, and exactly what benefits are offered.

Although HHS is uncertain when this service will be widely available, your local social security office or an area senior citizens organization may be able to tell you whether it will be offered in your area.

You can compare medigap policies yourself by getting copies of the HHS "Medicare/Private Insurance Checklist." This four-page work sheet gives the limits of medicare coverage and gives you space to chart the terms and benefits of supplemental policies you are considering. You can get copies of the checklist free from the office that handles your medicare. ☐

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

POUCH D
JUNEAU, ALASKA 99811
Phone: 465-2500

February 10, 1981

Honorable Bob Mulcahy, Chairman
Senate Labor and Commerce Committee
Pouch V
Juneau, Alaska 99811

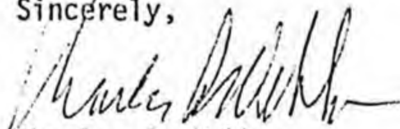
Dear Senator Mulcahy:

Re: Senate Bill 43

On Monday, February 9, 1981, Don Koch of this department appeared before your committee in support of SB 43. A representative of the Health Insurance Association of America (HIAA) also appeared and presented that association's views on SB 43 which were partly in conflict with Mr. Koch's testimony and position. Your committee suggested that it would be appropriate for this department and HIAA to attempt a compromise solution to conflicts.

With the assistance of Mr. Mike Thomas, HIAA's representative, we have worked out a resolution of our differences and ask that you offer the enclosed revision as a substitute to SB 43. It accomplishes the desires of this department in a manner acceptable to HIAA. We sincerely appreciate the reception that you and your committee have given this proposal.

Sincerely,



Charles R. Webber
Commissioner

CRW/va121G7
Enclosure

08-H2LH

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February 10, 1981

The Honorable Robert Mulcahy
Chair, Senate Commerce & Labor Committee
Alaska State Senate
Pouch "V", Mail Stop 3100
Juneau, Alaska 99811

Re: Senate Bill 43

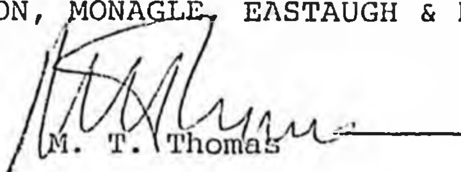
Dear Senator Mulcahy:

I have reviewed Commissioner Webber's letter of February 10, 1981, and the enclosed proposal for a committee substitute. The proposed language will, we believe, adequately and appropriately deal with the director's concerns, and we urge its adoption.

Thank you for your consideration on this bill.

Very truly yours,

ROBERTSON, MONAGLE, EASTAUGH & BRADLEY



M. T. Thomas

MTT/dh

Wednesday
January 21, 1981

Part V

Department of Health and Human Services

Health Care Financing Administration

Medicare Program; Medigap—Certification of Medicare Supplemental Health Insurance Policies

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 403

Medicare program; Medigap—Certification of Medicare Supplemental Health Insurance Policies

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed Rule.

SUMMARY: This proposal would establish a program of certification, by the Secretary, of Medicare supplemental health insurance policies (so-called Medigap policies) voluntarily submitted by insurers for review. It would implement, in part, section 507 of the Social Security Disability Amendments of 1980. HCFA will administer the certification program.

The voluntary certification program would go into effect July 1, 1982, and would apply only to policies issued in those States that do not have in effect a program for regulating Medigap policies equal to or more stringent than the one to be described in these regulations. A Supplemental Health Insurance Panel, consisting of the Secretary or a designee and four State Commissioners or Superintendents of Insurance appointed by the President, will determine the adequacy of a State's program in relation to the standards contained in the regulations.

These regulations would: (1) set standards for policies voluntarily submitted to HCFA for certification, (2) establish procedures for the certification program, and (3) promulgate the statutory requirements that the Supplemental Health Insurance Panel would use to approve State regulatory programs.

DATE: To assure consideration, comments should be received by: March 23, 1981.

ADDRESS: Address comments in writing to: Administrator, Health Care Financing Administration, Department of Health and Human Services, P.O. Box 17073, Baltimore, Maryland 21235. If you prefer, you may deliver your comments to Room 309-G Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C., or to Room 709, East High Rise Building, 6401 Security Boulevard, Baltimore, Maryland.

Please refer to BPP-91-P. Agencies and organizations are requested to submit comments in duplicate. Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309-G of the Department's office at 200 Independence Ave., S.W., Washington, D.C. 20201 on Monday through Friday of each week from 8:30 to 5:00 p.m. (202-245-7890).

FOR FURTHER INFORMATION CONTACT: Thomas Hoyer, 301-594-9690.

SUPPLEMENTARY INFORMATION: Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments and will respond to them in the preamble to that rule.

Medicare Program

Medicare is a Federal health insurance program, provided for under title XVIII of the Social Security Act, for people 65 and older and some people under 65 who are disabled. The Medicare program consists of two parts, a Hospital Insurance Program (Part A) and a Supplementary Medical Insurance Program (Part B).

Part A, Hospital Insurance, covers hospital, skilled nursing facility (SNF) and home health care, as well as certain therapy services. It is oriented towards acute care, and its coverage provisions are based on the concept of a benefit period or "spell of illness", a period that begins when an individual receives inpatient hospital or SNF services and ends when that individual has been out of the hospital or SNF for 60 consecutive days. In each benefit period, individuals are entitled to up to 90 days of inpatient hospital care, up to 100 days of post-hospital SNF care, and up to 100 post hospital home health visits. If the full 90 days of hospital benefits are exhausted during a spell of illness, a beneficiary may draw on 60 additional lifetime reserve days.

Part B, the Supplementary Medical Insurance Program, provides coverage for physicians' services, medical and other health services (a wide range of services including diagnostic tests and X-rays, outpatient hospital services, durable medical equipment, ambulance service, prosthetic devices, physical therapy, etc.), and up to 100 home health visits per year.

Both parts of Medicare contain cost sharing provisions, that is, deductible and coinsurance. The law requires that, under Part A, the inpatient hospital deductibles and hospital and SNF coinsurance amounts be adjusted annually to reflect the rising costs of health care (Section 1813(b)(2) of the Act). Under Part A, there is currently an annual hospital deductible of $180, a daily co-payment of $45 for the 61st through the 90th day of care, and $90 a day for each lifetime reserve day. In a SNF, there is a $22.50 co-payment for care from the 21st through the 100th day.

Under Part B, medical insurance generally pays 80 percent of "reasonable charges", and the beneficiary pays 20 percent coinsurance. (Under Title XVIII, the "reasonable charge" is the amount of the actual charge of a physician or supplier that can be recognized for payment under Medicare.) Since actual charges generally exceed the "reasonable charges", beneficiaries are also responsible for the difference, unless the physician or supplier accepts "assignment" of a beneficiary's claim. In addition, the beneficiary must pay an annual $60 deductible.

There are a number of items and services that are not covered under either of Medicare's two insurance programs. These items and services include: custodial nursing home care, custodial home care, most prescription drugs, dental care, eyeglasses and eye examinations, immunizations, most foot care, and homemaker services. Beneficiaries must pay the full cost of these services out-of-pocket or obtain additional insurance protection to pay the costs.

Medicare Supplemental Health Insurance Policies—Nature and Problems

The Medicare program was never designed to cover the total cost of providing medical care for its beneficiaries. It has been estimated that Medicare paid for about 44 percent of all health care costs for its beneficiaries in 1978. The remaining 56 percent included the cost of noncovered services and cost-sharing provisions of the Medicare program. Since the enactment of the Medicare program, various insurance organizations, both profit and nonprofit, have developed and marketed health insurance policies aimed at paying health care expenses not covered by the Medicare program. In 1978, about 15 million of the 23 million Medicare beneficiaries spent $4 billion for approximately 19 million policies to supplement Medicare. These policies are commonly referred to as "Medigap" policies and principally include Medicare supplement policies, indemnity policies and specified disease policies.

Medicare supplement policies are designed to fill specific gaps in the Medicare benefit structure. These policies typically offer coverage of some or all of Medicare's deductible and coinsurance amounts and sometimes include coverage of services not covered under Medicare. There are many varieties of supplement policies with premiums and benefit structures

designed to meet the needs of people with a variety of incomes. A characteristic of most of these policies, however, is that they base their payments on Medicare's coverage and reimbursement structures. They seldom pay more than the 20 percent coinsurance amount of the "reasonable charge" recognized by Medicare. They rarely pay any of the difference between the "reasonable charge" and the actual amount that a physician or supplier of services might charge. Furthermore, they frequently do not cover a broader range of services than are covered under Medicare. The premiums for these policies are usually adjusted annually to compensate for increases in Medicare's deductible and coinsurance amounts.

Indemnity policies usually have fixed premiums and pay a predetermined amount of money when certain conditions are present or certain health care services are furnished. An indemnity policy, for example, might pay a fixed amount for each day of hospital or nursing home care, for each medical or surgical procedure required, or for a given diagnosis. The amount of benefits is usually predetermined and is not tied to the beneficiary's actual health care expenses. Indemnity benefits are usually payable without regard to other coverage.

Specified disease policies, popularly known as "dread disease policies", will pay certain specified amounts once a positive diagnosis (e.g., cancer) has been medically confirmed. As with indemnity policies, the benefits paid under specified disease policies are often fixed and are not usually tied to the beneficiary's actual expenses.

In May, 1972, the Senate Judiciary Committee, Subcommittee on Anti-Trust and Monopoly, held hearings related to the sale of Medigap policies. Since then more than a dozen other investigations and studies by congressional committees, the Federal Trade Commission, the news media, and various other individuals and agencies have revealed and confirmed certain problems with Medigap insurance. Some of the problems relate to the nature of the policies, and some of them relate to the manner in which they are sold:

1. There is such a wide variety of Medigap policies that it is difficult, if not impossible, for a beneficiary to compare them and effectively assess their relative benefits and costs.

2. The policies themselves are often written in complicated language that obscures the extent of their coverage or the nature of their exclusions. For example, many policies contain clauses which limit or exclude payment for services received in connection with medical conditions which were known to exist at the time the policy was sold. These pre-existing condition clauses can negate coverge described in other portions of the policy.

3. Medicare beneficiaries often misunderstand the coverage available under Medicare. This, when coupled with misunderstanding of coverage of the supplemental policies, may lead individuals to purchase coverage that duplicates Medicare coverage or coverage that exists under another supplemental policy, while at the same time leaving significant gaps in coverage.

4. It is also virtually impossible for Medicare beneficiaries to determine the value of the policy's benefits in relationship to the premiums paid. This relationship, known as the loss ratio, is a way of determining how much of the aggregate premium income from a policy an insurance organization spends on aggregate benefits. Many group policies return 80 to 90 cents, or more, on the premium dollar, while some individual policies return less than 25 cents. In general, Medigap policies as a class often return less money in benefits than most other health insurance policies. ("Medigap: State Responses to Problems with Health Insurance for the Elderly", T. Van Ellet; Intergovernmental Health Policy Project, The George Washington University, Washington, D.C.; October 30, 1979 (hereafter, "Medigap" by Van Ellet), p. 10.)

5. Financial incentives, including very large sales commissions, have led some insurance agents to persuade policyholders to terminate a good policy in order to subscribe to a new one. The practice is costly to the beneficiaries and often leaves them without protection for a period of time because the new policy usually has a waiting period for pre-existing conditions. In other cases, a beneficiary is persuaded to purchase additional insurance policies to increase coverage when, in fact, the additional policy duplicates rather than supplements existing protection.

6. Elderly beneficiaries tend to rely on insurance agents for information about the Medicare program and the coverage available under the Medigap policies they are offered, and they are particularly vulnerable to misrepresentation and other abuses. Evidence of fraud, forgery, and intimidation has also been uncovered.

Regulation of Medigap Policies

The McCarran-Ferguson Act of 1945 (15 U.S.C. 1011 et seq.) permitted individual States to regulate the insurance business, and the States have been traditionally responsible for regulating Medigap policies. States have general laws which affect the entire field of insurance, and a number of States have enacted, or have final approval pending of, laws and regulations specific to Medicare supplemental insurance. Despite the current level of activity among the States, however, studies have shown that the scope of regulation varies from State to State and that enforcement of existing regulations is also uneven. (See "Medigap" by Van Ellet.)

There have been several significant initiatives in recent years to address the problems associated with Medigap policies. The National Association of Insurance Commissioners (NAIC), an association of the chief insurance regulatory officials of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands, has played a major role in the effort. The NAIC, in collaboration with HCFA, developed a "Guide to Health Insurance for People with Medicare". Over 6 million copies of the pamphlet have thus far been distributed through social security offices, insurance companies, State insurance departments, and senior citizen interest groups. More important, however, the NAIC also amended its model standards for individual accident and sickness insurance policies so they can be used by States specifically to regulate Medigap policies. The amended model, adopted by the NAIC on June 6, 1979, contains minimum standards that Medigap policies would be required to meet (Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act, as it applies to Medicare Supplemental policies: "NAIC Model Standards"). Standards address such issues as minimum coverage requirements, limits on exclusions of coverage because of pre-existing conditions, disclosure requirements, and refund requirements.

As a result of the abuses associated with Medigap policies, Congress enacted section 507 of Pub. L. 96-265 (the Social Security Disability Amendments of 1980). That section of the law established a voluntary certification program for Medicare supplemental health insurance policies (section 1882 of the Social Security Act (42 U.S.C. 1395ss)). The intent of the legislation is to establish a program that enables Medicare beneficiaries to identify Medigap policies for purchase that are represented accurately both by sales agents and promotional literature, do not duplicate Medicare or other health insurance coverage, and provide fairly priced minimum protection against

health care expenses that are not paid for by Medicare.

In the debate that preceded enactment of Pub. L. 96-265, and in the law itself, Congress recognized the progress already made by the States in the area of Medigap regulation. Further, it recognized and accepted the traditional role of the States in regulating insurance. Its intention in developing Medigap legislation was to provide the States and insurance companies with an incentive to speed up their activities to improve the regulation and quality of Medigap policies. At the same time, Congress established an alternative mechanism of certification that could be implemented at the national level for policies issued in States that choose not to establish minimum regulatory programs by July 1, 1982.

While the law relies on improve State and Federal regulation of Medigap policies as a major means of identifying and curbing abuses in the sale of Medigap policies, it also places strong reliance on consumer education as a force in improving the general quality . Medigap policy offerings. The presumption is that beneficiaries, assisted by information provided by HHS, the States, insurance companies and other sources, will become better informed, more aggressive purchasers of Medigap insurance and that insurance organizations will therefore improve the quality of the policies they offer for sale in order to retain their competitive position in the market.

The basic provisions of the Medigap legislation addressed in these regulations are as follows:

1. The statute mandates that the Secretary of HHS establish a program of review and certification of Medigap policies that meet or exceed requirements specified in the statute and regulations. The Secretary's program is voluntary in that it provides for review of only those policies that are voluntarily submitted by insurers (section 1882(a) of the Act). It goes into effect July 1, 1982. (The Secretary has determined that HCFA will administer the voluntary program.)

2. Medigap policies must meet the NAIC Model Standards in order to be certified in the Secretary's program. (A summary of the NAIC Model Standards applicable to Medigap policies is presented below.) However, Congress structured the voluntary program so that it would apply the NAIC Model Standards to group policies as well as individual policies and also established minimum loss ratio requirements for each category of policy (section 1882(c) of the Act).

The NAIC has standards applicable to a variety of policies, including Medicare supplement policies, indemnity policies, and specified disease policies. However, it is important to note that the NAIC Model Standards that Congress incorporated by reference into P.L. 96-265 specifically address only "Medicare supplement policies". Consequently, the focus of the voluntary certification program is on those policies and does not address the certification of, or minimum standards for, "specified disease policies" or "indemnity policies".

3. The Secretary's voluntary certification program will apply only in those States that have not implemented, under State law, a regulatory program that applies standards equal to or more stringent than the NAIC Model Standards and the loss ratio requirements as specified in the statute (section 1882 (b) and (i) of the Act). Regarding the NAIC standards and loss ratio requirements, Congress clearly did not intend to encourage States to limit their regulatory programs to the minimum level specified in the law. On the contrary, the intent of Congress was to encourage States to implement regulatory programs that they determine are appropriate to their needs and to assure States that those programs meeting or exceeding specified minimum standards would be approved by a panel, as specified below. (See Conference Committee Report on Social Security Disability Amendments of 1980, H.R. 3236, Report No. 96-944, pp. 76-77.)

4. The statute also provides for a Supplemental Health Insurance Panel that will determine whether or not State regulatory programs for Medigap policies meet the requirements of the law. The Panel will consist of the Secretary or a designee, who will serve as chairperson, and four State Commissioners or Superintendents of Insurance, to be appointed by the President (section 1882(b) of the Act).

5. The Secretary will authorize the use of an emblem by an insurer to indicate that a policy has been certified as meeting the standards of the voluntary certification program (section 1882(a) of the Act).

The statute contains provisions other than those addressed in these regulations. These include Federal criminal penalties designed to assist States and the Federal government in dealing with abuses identified in the various studies and investigations of Medigap policies (section 1882(d) of the Act). These penalties basically apply to cases in which false statements or misrepresentations are made about a policy's certification or about the extent and nature of the policy's coverage for the purpose of obtaining certification. They also apply to cases of misrepresentation by an insurance agent as an employee or agent of the Federal government (e.g., of the Medicare program) and to cases in which an individual sells a policy that is known to be duplicative of Medicare coverage or other health insurance the individual has. There is also a penalty governing the use of the mails for the delivery of advertisement of Medicare supplemental health insurance policies that have not been approved for sale in a State.

Section 1832(f) of the Act requires the Secretary to undertake a comprehensive study of the comparative effectiveness of various State regulatory approaches in (a) limiting marketing and agent abuse, (b) assuring the dissemination of information to Medicare beneficiaries (and to other consumers) that is necessary for informed purchase of Medigap policies, (c) promoting policies that provide reasonable economic benefits for the insured, (d) reducing the purchase of unnecessary duplicative coverage, (e) improving price competition, and (f) establishing effective State regulatory programs.

At the same time, the Secretary's study must address the need for standards for, or certification of, health insurance policies other than Medicare supplemental health insurance policies sold to Medicare beneficiaries. In order to carry out this study, HCFA needs to collect information concerning policy provisions, premium cost, premium volume and number of policyholders per policy on a State by State basis, loss ratio per policy, consumer knowledge of Medicare and other private health insurance coverage, and consumer purchasing behavior. This study would be used to collect baseline data for the later evaluation of the impact of the Federal voluntary certification program. Suggestions on how to obtain this information would be appreciated. Ideas on how to identify all health insurance products and the companies that sell them to Medicare beneficiaries, and ideas on comparing insurance policies, e.g., a scoring system, and establishing some method for comparing loss ratios would also be welcome.

The Secretary is also required to submit to Congress, no later than July 1, 1982, and at least every two years thereafter, a report evaluating the effectiveness of the certification procedures and the criminal penalties established under the law (section 1882(f) (2) of the Act). The report must include an analysis of the impact that

the certification program and the penalties have on the types, market share, value, and cost of policies certified by the Secretary. The report will also address whether the certification program and the criminal penalties should be continued or changed. We invite suggestions and comments regarding the potential sources of information for the report, the types of information that would be most appropriate, and the organizations or individuals that should be consulted.

Finally, section 1882(e) requires that the Secretary furnish all Medicare beneficiaries information that will enable them to make informed purchases of Medigap policies. Prior to the enactment of this provision, HCFA's Office of Beneficiary Service began distributing informational materials and conducting training classes for, and distributing training materials to, individuals who have contact with Medicare beneficiaries on the State and local levels. Those individuals will be in a position to inform beneficiaries of the problems inherent in the selection of Medigap insurance and of the certification program.

Provisions of the Regulations

State Regulation of Health Insurance Policies

Congress specifically stated that nothing in the statute should be construed so as to affect the right of any State to regulate Medicare supplemental health insurance policies that are marketed within its borders (section 1882(i) of the Act). This same provision would be contained in the regulations. In practice, for example, a policy certified in one State, either by that State or under the voluntary program, could be barred from sale in a second State, if the policy fails to meet the more stringent requirements of the second State.

Medicare Supplemental Health Insurance Policy

These regulations would define a Medicare supplemental health insurance policy, in accordance with section 1882(g) (1) of the Act, as a health insurance policy or other health benefit plan that a private entity offers to a Medicare beneficiary to supplement Medicare. Under the definition, the policy would provide payment for expenses that are not reimbursed under the Medicare program because of deductibles, coinsurance, noncoverage, or other limitations.

The term "Medicare supplemental health insurance policy" (Medigap policy) would include individual as well as group policies. In accordance with section 1882(c) of the Act, policies issued as a result of solicitation of individuals through the mail or by mass media advertising (including both print and broadcasting advertising) would be considered individual policies. The term "policy" would include a certificate issued under a policy (section 1882(g)(1) of the Act). However, in accordance with section 1882(g) of the Act, group health insurance policies of employers and labor organizations would not come under the provisions of these regulations. These policies were exempted for a number of reasons: they are usually sold without regard to age; they are not often sold specifically to supplement Medicare; and abuses commonly associated with Medigap policies have not generally been found to occur with respect to them. In fact, many of these policies have proven to be the best Medicare supplement available to retired workers.

Congress also intended that group health insurance policies of trade, professional, and occupational associations be exempted (Conference Committee Report on H.R. 3236, Report No. 96–944, p. 77). A policy would be exempt, however, only if the association—

1. Is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation;
2. Has been maintained in good faith for a purpose other than the obtaining of insurance; and
3. Has been in existence at least two years before the date of its initial offering of a Medigap policy to its members.

General Requirements

In order to be certified under the voluntary or a State program, a policy must meet standards specified in section 1882(c) of the Act. It would have to meet the NAIC standards and the loss ratio standards, as provided for below. These standards would have to be met or exceeded either in a single policy or, in the case of policies of nonprofit hospital and medical service associations, in two or more policies issued in conjunction with one another.

NAIC Model Standards

Medigap policies must meet the NAIC model standards in order to be certified in either the voluntary program or an approved State program. (See section 1882(c)(1) of the Act.) These proposed regulations, however, would differ from the NAIC standards in specified instances:

1. The NAIC standards address only individual policies. However, the statute clearly addresses both individual and group policies, thereby establishing that Congress intended both individual and group policies to meet requirements prescribed by the NAIC standards (including the standards relating to minimum benefit provisions, pre-existing condition limitations, full disclosure, and cancellation clauses).
2. The NAIC standards define a Medigap policy as one offered to an individual eligible for Medicare by reason of age. The statute, however, defines a Medicare supplemental health insurance policy as one offered to an individual entitled to Medicare, without regard to age (section 1882(g) of the Act). Therefore, in these regulations, a certified Medigap policy for any Medicare beneficiary would be required to comply with the standards prescribed by the statute.
3. The NAIC standards provide optional loss ratio guidelines for individual policies only. These regulations would mandate the loss ratio standards for individual and group policies contained in the statute (section 1882(c) of the Act), as discussed below.

Loss Ratios

The proposed regulations would require that Medicare supplemental policies meet the loss ratio standards mandated in section 1882(c) of the Act. Policies would be expected to return to policyholders in the form of aggregate benefits provided under the policy at least 75 percent of the aggregate amount of premiums in the case of group policies and 60 percent in the case of individual policies. These regulations would specify the formula for determining loss ratios and the components and assumptions used in applying that formula. In addition, under the voluntary certification program insurers would be required to submit supporting information to HCFA that identifies the data incorporated into that formula. We believe that such specificity is necessary in the regulations to assure that policies meet the loss ratio standards of the law and that loss ratio calculations are done "in accordance with accepted actuarial principles and practices", as mandated in section 1882(c)(2) of the Act. Accordingly, insurers would be required to submit the following, together with the policy and the loss ratio computation:

1. The scale of premiums for the loss ratio calculation period.
2. A description of all assumptions made in the development of the loss ratio,
3. The formula used to calculate gross premiums.

4. The expected level of earned premiums in the loss ratio calculation period.

5. The expected level of incurred claims in the loss ratio calculation period.

We would also require that a qualified actuary sign an actuarial certification, a declaration that the expected loss ratio for a given policy is based on actuarial assumptions that are appropriate and reasonable, taking into account actual policy experience, if any, and reasonable expectations. For purposes of these regulations, a "qualified actuary" would mean a member in good standing of the American Academy of Actuaries, or a person who has otherwise demonstrated his or her actuarial competence to the satisfaction of the Commissioner or Superintendent of Insurance of the domiciliary State of the insurer.

Note.—These regulations address only the specifications of the loss ratio calculation and supporting information that would be required when the insurer submits a policy to HCFA in order to obtain initial certification. For a certified policy to maintain its certification, the insurer must submit material, including an updated loss ratio, at least on an annual basis to HCFA. The law clearly envisions that the Secretary's evaluation of that material would extend to the actual experience of the policy in previous years. Therefore, for purposes of those subsequent submittals, HCFA would require both a loss ratio that addresses anticipated experience and data on actual claims and premiums for that policy. We intend to publish proposed regulations, at a later date, regarding the specific data that HCFA would require.

In dealing with the issue of loss ratio specifications, HCFA has recognized that it is necessary to establish the formula for loss ratio calculations and to define carefully its direct and indirect components. The definitions have been included because of HCFA's recognition that "accepted actuarial principles and practices" permit a wide range of discretion to the actuary in selecting among the techniques and data at his or her disposal.

The loss ratio formula has been stated specifically in the regulations as a simple ratio of benefits to premiums. In the ratio, "benefits" would be computed by adding the present value, on the initial calculation date, of expected incurred benefits in the loss ratio calculation period to the present value, on the initial calculation date, of the total policy reserve at the last day of the loss ratio calculation period. The total policy reserve on the initial calculation date would then be subtracted. "Premiums" would be composed of the present value, on the initial calculation date, of expected earned premiums for the loss ratio calculation period. For purposes of the formula, "present values" could be an aggregate, computed by the insurer for a period not to exceed 12 consecutive months, of expected earned premiums and incurred benefits.

In developing definitions of the various direct and indirect loss ratio components, HCFA recognizes, as indicated above, that "accepted actuarial principles and practices" encompass a range of choices that are made by the actuary on the basis of his or her professional judgment as to appropriate data and techniques available. To avoid widely varying professional interpretations, HCFA has provided definitions for the components. These definitions specify the actuarial concepts that HCFA, on the basis of its consultations with actuaries internally and in the insurance industry, believes are appropriate for developing loss ratios for purposes of these regulations.

In addition to the formula and definitions discussed above, it will also be necessary for HCFA to specify other requirements relating to types of computations, assumptions, and data to be considered in developing loss ratios for purposes of these regulations. HCFA believes that these specifications will be necessary to assist actuaries in the development of loss ratios that are consistent will the intent of the law and regulations. These further issues are discussed in the next section of this preamble, which invites comments specifically on a number of the issues now under development.

We believe that the approach to loss ratio requirements taken in these regulations will assure that the requirements of the law are met, will provide for consistent application of the loss ratio threshold standards to all policies submitted for review, and enable comparison among policies on the basis of loss ratios. Once the system is fully articulated and in place, HCFA believes that different actuaries, considering the same Medigap policy and taking into account the principles and concepts described in these regulations, would be able independently to achieve comparable loss ratios.

Solicitation of Comments Specific to Loss Ratios

As we have noted above, some of the specifications for loss ratio determinations are not yet complete. HCFA is studying the practices of various States and is consulting insurance and actuarial groups and other professionals in the field to develop these specifications. We intend to take into consideration the data acquired in that study and through those consultations, and also the comments to this proposed rule, when we prepare the final rule. In addition, we will provide for a further comment period for the loss ratio specifications in the final regulations. We invite comments on all aspects of the loss ratio proposal; however, we are especially interested in comments on the following:

1. In determining premiums and benefits, the insurer must provide for various factors, as appropriate. Two of those are: (a) the expected future change in the distribution by age and sex of the insured group; and (b) the expected wearing off of the impact, in the early period(s) after a policy is issued, of the process the company used to select the insured and of clauses that temporarily exclude pre-existing conditions from coverage. These factors will influence claims. For example, the company that screens and selects the insured (excluding, for example, those with certain health conditions) will have fewer claims to pay in the early years of a policy than the company that guarantees acceptance to all applicants. (The insured in the former instance will most likely be healthier, at lower risk.) We believe that the insuring organization, in calculating the benefits of a policy, should provide for the impact of these factors on claims beyond the loss ratio calculation period.

2. Assumptions regarding a variety of factors, such as lapse of policies, interest, mortality, and morbidity, are integral components of a loss ratio formula. We will address them in final regulations, but we invite comments and suggestions now for our consideration.

3. These proposed regulations would require the insurer to submit supporting data for loss ratios (e.g., scale of gross premiums, a description of assumptions, formula used to calculate gross premiums, and expected level of earned premiums and incurred claims). We invite comments on that supporting data and recommendations regarding other or additional data that would be appropriate.

The Supplemental Health Insurance Panel

Establishment of the Supplemental Health Insurance Panel is authorized by section 1882(b) of the Act. The Panel will consist of the Secretary or a designee, who serves as chairperson, and four State Commissioners or Superintendents of Insurance appointed by the President. HCFA published a notice in the Federal Register on August 5, 1980 (45 FR 51923) inviting interested

parties to recommend, by September 4, 1980, State Commissioners and Superintendents of Insurance to serve on the Panel. The President is required by section 1882(b)(2) of the Act to make appointments to the Panel no later than December 31, 1980.

The principal function of the Panel is to assess State regulatory programs for Medigap policies and to determine if those programs meet minimum requirements. If the Panel approves a program as meeting the requirements of the law, that State has an "approved program". The decisions of the Panel are binding on HCFA; that is, HCFA can implement the voluntary program only in those States that do not have approved programs. The Secretary shall report to Congress, no later than January 1, 1982, the Panel's initial determinations as to which States cannot be expected to have implemented an approved program by July 1, 1982. (See section 1882(i)(2)(B) of the Act and Conference Committee Report on H.R. 3236, Report No. 96-944, p. 76.) Finally, the Panel could maintain oversight to assure that States satisfactorily implement their regulatory programs once the Panel has approved them.

The Panel is an independent component within HHS and will be responsible for establishing and implementing its own operating procedures. While those procedures are beyond the scope of these regulations, we are taking this opportunity to identify some of the questions and issues that will be before the Panel, and we invite comments and suggestions.

1. What criteria should the Panel use to determine whether or not a State has established and implemented a satisfactory program for the regulation of Medigap policies?

2. Determinations of the Panel are binding on States and on HCFA. Should the Panel establish procedures so that States might seek review of its determinations before they become effective? If so, what should they be?

3. How should the Panel communicate its determinations to affected parties, principally the State Commissioners and Superintendents of Insurance and the insurance industry? Should notices in the Federal Register be used for this purpose? What other means could be used?

Emblem

Section 1882(a) of the Act provides for an emblem, a graphic symbol the Secretary uses to indicate that a policy has been certified as meeting the requirements of the voluntary certification program. We would authorize the insurer to imprint the emblem on certified policies. (However, where a State prohibits the display of such symbols, insurers could not use the emblem.) We are currently in the process of designing the emblem.

We will also empower States with approved programs for regulating Medigap policies to authorize insurers to use the emblem on policies issued in their States.

As a safeguard to beneficiaries, we would require that an insurer could use the emblem only if the insurer agrees to inform the policyholder in writing within 60 days after his or her policy loses its certification.

States With Approved Regulatory Programs

HCFA would not review or certify policies issued in a State with an approved program for the regulation of Medigap policies. Those policies are presmued to meet the standards of the law and would be deemed certified. For a State to have an "approved program", the Panel must determine that the State has established, under State law, a regulatory program that applies standards equal to or more stringent than the NAIC standards and loss ratio requirements, specified in section 1882(c) of the Act, to each Medicare supplemental health insurance policy issued in that State. (See section 1882(b) of the Act.) For purposes of these regulations, "policy issued in that State" would mean—.

1. A group policy, if the holder of the master policy resides in that State; and

2. An individual policy, if a holder of that policy resides in that State. (See section 1882(g)(2)(c) of the Act.)

The Voluntary Certification Program

The Secretary has determined that HCFA will administer the voluntary certification program. Under these regulations, the procedures of that program would be as follows:

1. We would review policies that insurers voluntarily submit. However, we would review and certify only those policies issued in a State that does not have approved regulatory program for all Medicare supplemental health insurance policies issued in that State.

2. The insurer would be required to submit the following material to HCFA for review:

a. A copy of the policy and an outline of the policy's coverage, in the form prescribed by the NAIC model standards.

b. A statement that the information submitted for certification is accurate and complete and does not misrepresent any material fact. We would require that the president of the insurance company, or a designee, sign this statement. We believe that this requirement is necessary to assure that the material is accurate and that it has been submitted by an authorized representative of the insuring organization.

c. An actuarial certification, as specified in the regulations.

d. A statement that the policy meets the requirements of the State in which the policy is issued and of the States in which the policy will be marketed as a certified policy.

e. A list of the States in which the insurer is authorized to market the policy.

f. A statement that the insurer agrees to inform the policyholder in writing if HCFA decertifies that policy.

3. We would certify policies that meet or exceed the NAIC standards and loss ratio requirements specified in regulations.

4. We would certify a policy only if the insurer agrees to notify the policyholder in writing within 60 days of decertification, if the policy was identified as a "certified policy" at the time of sale and later decertified.

5. We would continue to recognize the State's role in regulating insurance policies marketed within its borders. Therefore, we would not certify a policy for sale in a State unless it meets both the requirements of these regulations and requirements of the State in which it is issued and of the States in which the policy will be marketed as a certified policy.

6. A policy that continues to meet the standards would retain its certification if the insurer files with HCFA, no later than June 30 of each year, updated versions of the documents listed in item 2 above. Submittal by this date is required by the statute (Section 1882 (a)).

Insurers would be encouraged to file the above material as early as possible, between January 1 and June 30, to facilitate annual review. The first annual submission of material for a newly certified policy would be due no later than June 30 of the calendar year following HCFA's certification of that policy.

Although the statute mandates that the insurer file material annually, no later than Jyne 30, the insurer could be required in some cases to submit the material before that date. To obtain certification of a policy, the insurer must calculate a loss ratio for an identified period, called the "loss ratio calculation period". For the policy to retain its certification beyond the last date of that period, the insurer would have to submit a complete packet of material, including an updated loss ratio determination.

Accordingly, the regulations would require that the insurer submit the necessary documents no later than June 30 or the last date of the loss ratio calculation period, whichever occurs earlier.

7. We would decertify a policy if the policy fails to meet the standards specified in regulations or if the insurer fails to file material, as specified above.

8. We would authorize insurers to imprint the Secretary's emblem on certified policies. We would also monitor insurers to assure that they notify policyholders when a policy bearing the emblem loses its certification.

9. We would inform each State of all policies certified or decertified under the voluntary program.

Appeal of HCFA Determinations

These regulations would provide opportunity for an administrative review, if HCFA determines not to certify, or to decertify, a policy under the voluntary program.

1. *Notice to the insurer.* If HCFA determines not to certify, or to decertify, a policy, HCFA would send a notice informing the insurer of the following:

a. The reasons for the determination.

b. That the insurer has 30 days from the date of the notice to appeal, in writing, HCFA's determination and to submit additional information to HCFA for review.

c. That if the insurer appeals, HCFA will conduct an administrative review, as provided for below.

d. That in a case involving decertification, the decertification will go into effect in 30 days from the date of the notice, unless the insurer appeals. Should the insurer appeal, the policy would retain its certification, pending the results of the administrative review.

2. *Administrative review.*

a. A HCFA official, not involved in the original determination, would conduct an independent review of the material, including any additional information the insurer provides.

b. The administrative review would be initiated within 90 days of the date of the initial notice to the insurer of the decision to decertify, or not to certify, a policy.

c. Within 15 days of completion of the review, HCFA would inform the insurer of the results of that review, with an explanation of the final determination. In a decertification case a final decision to decertify would go into effect 15 days after the date of the notice to the insurer of the final determination.

We believe that these procedures afford a reasonable opportunity for the insurers to contest an adverse determination on certification, without undue administrative burden either on HCFA or the insurer.

Transfer of Policies From a State Program to the Voluntary Program

These regulations would provide for the orderly transfer of Medigap policies deemed certified under an approved State program to the voluntary program, if the Panel determines that the State no longer has an approved program. If the Panel determines that a State ceases to have an approved regulatory program for Medigap policies, all policies issued in that State immediately lose their deemed certification and automatically come under the aegis of the voluntary program. Policies that have certification status from the State on the day that the determination of the Panel is effective would be presumed to meet the requirements of, and would be certified under, the HCFA progam until the earlier of the following:

1. Six months after the effective date of the Panel's determination.

2. The expiration date of the certification received under the State program.

If the insurer wishes to have a policy retain its certification beyond the date specified above, the insurer would be required to submit the policy to HCFA for review and certification. The insurer is encouraged to submit the policy as soon as possible to enable HCFA to review the material and make a determination while the policy still retains its certification.

These regulations would not address the transition that would occur when policies certified under the HCFA program become subject to an approved State regulatory program. When the Panel determines the State has an approved program, all Medigap policies issued in that State come under the authority of that State's program. We anticipate that the State would provide for the orderly transfer of policies from HCFA's certification program to its own regulatory program to avoid unnecessary difficulties for beneficiaries as well as insurers. We recommend that States begin to develop procedures for the transfer of policies from the HCFA program to their own programs.

Effective Dates

Final regulations would be effective 60 days after publication, except for the following:

1. The effective date of certification of a policy would be July 1, 1982 or later. That is also the first date that a certified policy could bear the emblem (section 1882(i) of the Act). The effective date for the use of the emblem is based on Congressional concern that insurers not be given an unfair competitive advantage in its use, specifically insurers with policies in force that already meet or exceed the standards specified in the statute. Congress intended to give insurers adequate lead time to review their policies and to make changes, as appropriate, in order to be certified under the voluntary program or to meet the requirements of an approved State program. In addition, States that wish to establish approved programs would have time to review and amend State laws and regulations. Finally, this also affords reasonable time for the Panel to assess State programs, so that HCFA would know those States in which the voluntary program would be operative.

2. HCFA cannot begin to certify policies until the Panel's determinations, as to which States have established programs that meet the requirements of the statute, become effective. Section 1882(i) of the Act specifies that the Panel's initial determinations must be submitted to Congress no later than January 1, 1982 and that they become effective 60 days later. In counting those 60 days, "days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation." (See section 1882(i)(2)(B) of the Act.)

In order to facilitate the start of the voluntary program and to enable companies to display the emblem on approved policies on July 1, 1982, HCFA would begin reviewing policies issued in States found not to have satisfactory programs as soon as the initial determinations of the Panel are sent to Congress. HCFA's certification of those policies, however, would not become effective before July 1, 1982. Moreover, if the Panel should reverse an earlier negative determination, by approving the State's regulatory program, any policy that HCFA reviewed, and that is issued in that State, would immediately come under the State program.

The Department is required to submit section 403.245 of the regulations to the Office of Management and Budget (OMB) for review and approval. This section deals with the submission of information by an insuring organization in order to obtain and maintain certification under the voluntary program. The Department will submit this section to OMB.

Economic Impact

The Department has analyzed the economic impact of these proposals and does not believe that they are "major" within the meaning of Executive Order

12044. For example, these proposals would not create a cost impact of $100 million or more within the next five years.

Direct administrative costs to beneficiaries, the insurance industry, States, and Federal government are unlikely to exceed several million dollars annually, compared to current costs approaching $4 billion annually for Medigap policies and approximately $122 million for State insurance regulation (covering all insurance, not just Medigap). The insurance companies would not be required to submit data to HCFA which they would not ordinarily have prepared either for internal use or State review; or both. However, some States do not now review policy content in detail; and these proposals may have consequential impact in insurance commissions in those States. Also, although we have sought to minimize administrative burdens, further improvements may be possible. We request comments on any aspect of administrative requirements in these proposals for which burden could be reduced further.

The proposed rule would create improved information for consumers. Nothing in the proposal imposes entry restrictions, licensing restrictions, or other forms of "command and control" government regulation. In addition, certification is voluntary. Accordingly, we do not believe that these proposals have direct regulatory impact on the insurance industry. Clearly, however, they will result in a market response over time as newly informed consumers purchase better policies and the insurance industry adjusts its policies to meet consumer expectations. We have no quantitative basis for projecting these responses at this time, but expect them to involve an increased proportion of the $4 billion spent to Medigap policies to be returned to consumers in the form of benefits, with offsetting reductions in administrative cost such as selling expenses. There should be no adverse impact, except insofar as companies unable or unwilling to adjust to a more competitive market lose market share. The study required by law in 1982 will address this issue, but we welcome comments at this time.

NAIC Model Standards

For the reader's information, we present here a summary of the basic requirements of the NAIC model standards, as applicable to Medigap policies. Complete copies of the text may be obtained from The National Association of Insurance Commissioners 350 Bishops Way, Brookfield, Wisconsin 53004; Attention: Dana Horenberger, Publications Coordinator.

1. *General Provisions:*

a. "Medicare Supplement Coverage" means a policy of accident and sickness insurance (1) that is designed primarily to supplement Medicare, or is advertised, marketed or otherwise purported to be a supplement to Medicare, and (2) that meets the requirements of these standards.

b. The terms "Medicare Supplement", "Medigap", and words of similar import must not be used to characterize a policy, unless the policy is issued in compliance with these standards.

c. A policy issued as a "Medicare Supplement Coverage" must not include limitations or exclusions that are more restrictive than those of Medicare for any type of care covered under the policy.

Note.—The drafters of the NAIC Model Standards intended that nonprofit hospital and medical service associations be subject to these standards. In States where such hospital and medical service associations are prohibited from issuing single subscriber contracts that include all of the benefits required by these standards, the issuing entity must meet the following requirements: Subscriber contracts (1) must include as much of those benefits as are permitted, and (2) must be issued in conjunction with another contract that includes at least the remainder of the minimum benefits required. In that event, the combination of contracts will be considered to meet these standards.

2. *General Coverage Provisions:* These are minimum standards and do not preclude policies from including additional benefits.

a. "Medicare benefit period" means the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A, Medicare hospital insurance.

b. "Medicare eligible expenses" means health care expenses of the kinds covered by Medicare, to the extent that these expenses are recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as are applicable to Medicare claims.

c. Except as provided for in paragraphs d and e of this section, policies must not contain waivers to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions.

d. Pre-existing condition limitations must not exclude coverage, for more than 6 months after the effective date of coverage under the policy, of a condition for which medical advice was given by or treatment was recommended by or received from, a physician within 6 months before the effective date of the coverage.

e. Coverage must not be subject to any exclusions, limitations, or reductions that are inconsistent with the exclusions, limitations or reductions permissible under Medicare. A policy may, however, stipulate that coverage is not provided for any expenses to the extent of any benefit available to the insured person under Medicare.

f. Coverage must not indemnify against expenses resulting from sickness on a different basis from losses resulting from accidents.

g. Coverage must provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be changed to correspond with such changes.

3. *Minimum Benefit Provisions:* Medicare supplemental coverage must provide at least the following:

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

b. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime inpatient reserve days.

c. Upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days.

d. Coverage of 20 percent of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year.

4. *Disclosure Provisions:*

a. All policies, except single premium nonrenewable policies and those resulting from direct response solicitation, must have a refund notice prominently printed on, or attached to, the first page of the policy. That notice must state that the policyholder has the right to return the policy within ten days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. With respect to policies issued as a result of a direct response

solicitation (that is, issued as result of solicitation through the news media or the mail), the policy must have a notice prominently printed on, or attached to, the first page of the policy stating in substance that the policyholder has the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

b. All insurers must provide an appropriate outline of coverage for a Medicare supplement policy. The insurers must deliver the outline to the applicant at the time application is made; and, except for a direct response policy, the insurer must obtain verification of receipt of that outline. The items included in the outline must appear in the sequence prescribed below. (The coverage outline that follows is taken verbatim from the NAIC Model Standards.)

(Company Name) Medicare Supplement Coverage Outline of Coverage

(1) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you Read Your Policy Carefully!

(2) Medicare Supplement Coverage—Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to other limitations which may be set forth in the policy. The policy does not provide benefits for Custodial Care such as helping in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if such coverage is provided).

(3) (a) (for agents:) Neither (insert company's name) nor its agents are connected with Medicare.

(b) (for direct response:) (insert company's name) is not connected with Medicare.

(4) (A brief summary of the major benefit gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare Supplement Coverage in the following order:)

Service	Benefit	Medicare pays	This policy pays	you pay
Hospitalization: Semiprivate room and board general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic X-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	First 60 days	All but $(180)	$	$
	61st to 90th day	All but $(45) a day		
	91st to 150 day	All but $(90) a day		
	Beyond 150 days	Nothing		
Posthospital skilled nursing care: In a facility approved by Medicare, you must have been in a hospital for at least 3 days and enter the facility within 14 days after hospital discharge.	First 20 days	100% of costs		
	Additional 80 days	All but $(22.50) a day		
	Beyond 100 days	Nothing		
Medical expense	Physican's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and ambulance.	80% of reasonable charge (after $(60) deductible.		

(5) (A statement that the policy does or does not cover the following):

(a) Private duty nursing.

(b) Skilled nursing home care costs (beyond what is covered by Medicare).

(c) Custodial nursing home care costs.

(d) Intermediate nursing home care costs.

(e) Home health care (above number of visits covered by Medicare).

(f) Physician charges (above Medicare's reasonable charge).

(g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay).

(h) Care received outside of U.S.A.

(i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.

(6) (A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (4) above, including conspicuous statements:)

(a) (That the chart summarizing Medicare benefits only briefly describes such benefits.)

(b) (That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.)

(7) (A description of policy provisions respecting renewability or continuation of coverage, including any reservation of right to change premium.)

(8) (The amount of premium for this policy.)

42 CFR Chapter IV, Subchapter A, is amended by adding a new Part 403 and Subpart B to read as follows:

PART 403—SPECIAL PROGRAMS AND PROJECTS

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Subpart B—Certification of Medicare Supplemental Health Insurance Policies

Sec.
403.200 Basis and scope.

General Provisions

403.208 State regulation of insurance policies.

Sec.
403.212 Medicare supplemental health insurance policy.
403.215 General standards for certified Medicare supplemental health insurance policies.
403.218 NAIC model standards.
403.221 Loss ratio standards.
403.224 Calculation of expected loss ratios: General provisions.
403.225 Calculation of expected loss ratios: Date and time frame provisions.
403.227 Actuarial certification.
403.230 Supplemental health insurance panel.
403.234 Emblem.

State Regulatory Programs

403.240 State with an approved regulatory program.
403.242 Certification of policies.

Voluntary Certification Programs

403.245 Requirements for obtaining certification.
403.248 Review and certification of policies.
403.251 Submittal of material to retain certification.
403.255 Decertification of policies.
403.258 Termination of a State program: Transfer of policies.
403.260 Administrative review of HCFA determinations.

Authority: Sections 1102, 1871, and 1882 of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395ss).

§ 403.200 Basis and scope.

This subpart implements, in part, section 1882 of the Social Security Act, which provides for voluntary certification, by the Secretary of Health and Human Services, of Medicare supplemental health insurance policies. The intent of the legislation is to establish a program that enables Medicare beneficiaries to identify Medicare supplemental health insurance policies that do not duplicate Medicare coverage and that provide adequate, fairly priced protection against health care expenses that are not covered by Medicare. This subpart sets forth the standards and procedures HCFA will use to implement the certification program.

General Provisions

§ 403.208 State regulation of insurance policies.

The provisions of this subpart do not affect the right of a State to regulate policies marketed in that State.

§ 403.212 Medicare supplemental health insurance policy.

(a) Except as specified in paragraph (c) of this section, "Medicare supplemental health insurance policy" (policy) means a health insurance policy or other health benefit plan—

(1) That a private entity offers to a Medicare beneficiary; and

(2) That provides payment for expenses incurred for services and items that are not reimbursed under the Medicare program because of deductibles, coinsurance, or other limitations under Medicare.

(b) Medicare supplemental health insurance policy includes the following:

(1) An individual policy. For purposes of this section, "individual policy" includes any policy issued as a result of solicitation of individuals—

(i) Through the mail; or

(ii) By mass media advertising.

(2) A group policy.

(3) A certificate issued under a policy.

(c) Medicare supplemental health insurance policy does not include any of the following health insurance policies or health benefit plans:

(1) A policy or plan of one or more employers for employees, former employees, or any combination thereof.

(2) A policy or plan of one or more labor organizations for members, former members, or any combination thereof.

(3) A policy or plan of the trustees of a fund established by one or more labor organizations, one or more employers, or any combination, for any one or combination of the following:

(i) Employees.

(ii) Former employees.

(iii) Members.

(iv) Former members.

(4) A policy or plan of a professional trade or occupational association, if the association—

(i) Is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation;

(ii) Has been maintained in good faith for a purpose other than obtaining insurance; and

(iii) Has been in existence for at least two years before the date of its initial offering of a Medicare supplemental health insurance policy to its members.

§ 403.215 General standards for certified medicare supplemental health insurance policies.

(a) A policy that meets the requirements of this subpart will be either—

(1) Deemed certified in a State with an approved regulatory program, as provided for in § 403.242; or

(2) Certified under the voluntary certification program, as provided for in § 403.248.

(b) To be certified under paragraph (a) of this section, a policy must meet—

(1) The NAIC model standards of § 403.218;

(2) The loss ratio standards of § 403.221; and

(3) For purposes of paragraph (a)(2), any State requirements applicable to a policy—

(i) Issued in that State; or

(ii) Marketed in that State as a certified policy.

(c) The standards specified in §§ 403.218 and 403.221—

(1) May be met in two or more policies issued in conjuction with one another in the case of—

(i) A nonprofit hospital association; and

(ii) A medical service association; and

(2) Must be met in a single policy in all other cases.

§ 403.218 NAIC model standards.

(a) "NAIC model standards" means the National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act, as amended and adopted by NAIC on June 6, 1979, as it applies to Medicare supplemental policies.

(b) The policy must meet or exceed the NAIC model standards, except that—

(1) The policy must meet the NAIC model standards, regardless of the Medicare beneficiary's age; and

(2) The policy must meet the loss ratio standards specified in § 403.221.

§ 403.221 Loss ratio standards.

(a) The policy must be expected to return to the policyholders, in the form of aggregate benefits provided under the policy—

(1) A least 75 percent of the aggregate amount of premiums in the case of group policies; and

(2) At least 60 percent of the aggregate amount of premiums in the case of individual policies.

(b) The insuring organization must calculate loss ratios according to the provisions of §§ 403.224 and 403.225.

§ 403.224 Calculation of expected loss ratios: General provisions.

(a) *Basic formula.*

(1) The expected loss ratio is calculated by determining the ratio of benefits to premiums.

(2) To calculate the amount of "benefits"—

(i) Add the present values on the initial calculation date of—

(A) Expected incurred benefits in the loss ratio calculation period, to—

(B) The total policy reserve at the last day of the loss ratio calculation period; and

(ii) Subtract the total policy reserve on the initial calculation date from the sum of these values.

(3) To calculate the amount of "premiums", calculate the present value on the initial calculation date of expected earned premiums for the loss ratio calculation period.

(b) *Provisions for calculating "benefits".*

(1) "Total policy reserve" means the sum of—

(i) Additional reserve; and

(ii) The reserve for future contingent benefits.

(2) "Additional reserve" means the amount calculated on a net level reserve basis, using appropriate values to account for lapse, mortality, morbidity, and interest, that on the valuation date represents—

(i) The present value of expected incurred benefits over the loss ratio calculation period; less—

(ii) The present value of expected net premiums over the loss ratio calculation period.

(3) "Net premium" means the level portion of the gross premium used in calculating the additional reserve. On the day the policy is issued, the present value of the series of those portions equals the present value of the expected

incurred claims over the period that the gross premiums are computed to provide coverage.

(4) "Reserve for future contingent benefits" means the amounts, not elsewhere included, that provide for the extension of benefits after insurance coverage terminates. These benefits—

(i) Are predicated on a health condition existing on the date coverage ends;

(ii) Accrue after the date coverage ends; and

(iii) Are payable after the valuation date.

(c) *Provisions for calculating "premiums".*

(1) "Earned premium for a given period means—

(i) Written premiums for the period; plus—

(ii) The total premium reserve at the beginning of the period; less—

(iii) The total premium reserve at the end of the period.

(2) "Written premiums in a given period" means—

(i) Premiums collected in that period; plus—

(ii) Premiums due and uncollected at the end of that period; less—

(iii) Premiums due and uncollected at the beginning of that period.

(3) "Total premium reserve" means the sum of—

(i) The unearned premium reserve;

(ii) The advance premium reserve; and

(iii) The reserve for rate credits.

(4) "Unearned premium reserve" means the portion of gross premiums due that provide for days of insurance coverage after the valuation date.

(5) "Advance premium reserve" means premiums received by the insuring organization that are due after the valuation date.

(6) "Reserve for rate credits" means rate credits on a group policy that—

(i) Accrue by the valuation date of the policy; and

(ii) Are paid or credited after the valuation date.

§ 403.225 Calculation of expected loss ratios: Date and time frame provisions.

(a) "Application date" means the day the insuring organization sends the policy to HCFA for review.

(b) "Initial calculation date" means the first date of the period that the insuring organization uses to calculate the policy's expected loss ratio.

(1) The initial calculation date may be before, the same as, or after the application date; except—

(2) The initial calculation date must not be earlier than January 1 of the calendar year of the application date.

(c) "Loss ratio calculation period" means the period beginning with the initial calculation date and ending with the last day of the period for which the insuring organization calculates the policy's scale of premiums.

(d) To calculate "present values", the insuring organization may use approximations that aggregate, for a period not to exceed 12 months—

(1) Expected earned premiums, and

(2) Expected incurred benefits.

§ 403.227 Actuarial certification.

(a) For purposes of certification requests submitted under § 403.245(b), "actuarial certification" means a signed declaration in which a qualified actuary states that the assumptions used in calculating the expected loss ratio are appropriate and reasonable, taking into account actual policy experience, if any, and reasonable expectations.

(b) "Qualified actuary" means—

(1) A member in good standing of the American Academy of Actuaries; or

(2) A person who has otherwise demonstrated his or her actuarial competence to the satisfaction of the Commissioner or Superintendent of Insurance of the domiciliary State of the insuring organization.

§ 403.230 Supplemental health insurance panel.

(a) *Membership.* The Supplemental Health Insurance Panel (Panel) consists of—

(1) The Secretary or a designee, who serves as chairperson, and

(2) Four State Commissioners or Superintendents of Insurance appointed by the President.

(b) *Functions.*

(1) The Panel determines whether or not a State regulatory program for Medicare supplemental health insurance policies meets and continues to meet minimum requirements, as specified under § 403.240.

(2) The Secretary, as chairperson of the Panel, informs the State Commissioners and Superintendents of Insurance of all determinations made under paragraph (b)(1) of this section.

§ 403.234 Emblem.

(a) The emblem is a graphic symbol, approved by HHS, that indicates that a policy meets the certification requirements of this subpart.

(b) Unless prohibited by the State in which the policy is marketed, the insuring organization may display the emblem on policies certified under the voluntary certification program.

(c) If a policy is issued in a State with an approved regulatory program, the State in which the policy is marketed may authorize the insuring organization to display the emblem on that policy.

(d) In the case of a policy displaying the emblem, the insuring organization must notify each holder of the policy within 60 days in writing, if—

(1) HCFA decertifies the policy, as specified in §§ 403.255, 403.258(b)(3), and 403.260(b)(5) and (c)(4); or

(2) The State with an approved regulatory program determines that the policy ceases to meet State requirements.

State Regulatory Programs

§ 403.240 State with an approved regulatory program.

(a) A State has an approved regulatory program if the Panel determines that the State has in effect under State law a regulatory program that provides for the application of standards, with respect to each Medicare supplemental health insurance policy issued in that State, that are equal to or more stringent than those specified in § 403.215.

(b) "Policy issued in that State" means—

(1) A group policy, if the holder of the master policy resides in that State; and

(2) An individual policy, if a holder of that policy resides in that State.

§ 403.242 Certification of policies.

If a State has an approved regulatory program, a policy issued in that State is deemed certified.

Voluntary Certification Program

§ 403.245 Requirements for obtaining certification.

(a) A policy must meet the standards specified in § 403.215 to be certified by HCFA.

(b) An insuring organization requesting certification of a policy must submit the following to HCFA for review:

(1) A copy of the policy.

(2) A copy of the outline of coverage, in the form prescribed by the NAIC model standards.

(3) A statement that the policy meets the requirements specified in paragraph (a) of this section.

(4) A copy of the calculations for the expected loss ratio.

(5) Supporting data used in calculating the expected loss ratio. That data must include—

(i) The scale of premiums for the loss ratio calculation period;

(ii) A description of all assumptions;

(iii) The formula used to calculate gross premiums;

(iv) The expected level of earned premiums in the loss ratio calculation period; and

(v) The expected level of incurred claims in the loss ratio calculation period.

(6) An actuarial certification, as specified in § 403.227, of the loss ratio computations.

(7) A list of States in which the insuring organization is authorized to market the policy.

(8) A statement that the insuring organization will notify the policyholders in writing within 60 days of decertification, if the policy is identified as a certified policy at the time of sale and later decertified.

(9) A signed statement in which the president of the insuring organization, or a designee, attests that the information submitted to HCFA for review is accurate and complete and does not misrepresent any material fact.

§ 403.248 Review and certification of policies.

(a) HCFA will review policies that the insuring organization voluntarily submits, except that HCFA will not review a policy issued in a State with an approved regulatory program under § 403.240.

(b) If the requirements specified in § 403.245 are met, HCFA will—

(1) Certify the policy; and

(2) Authorize the insuring organization to imprint the emblem on the policy, as provided for in § 403.234.

(c) HCFA will inform all State Commissioners and Superintendents of Insurance of Policies that it certifies.

§ 403.251 Submittal of material to retain certification.

(a) HCFA certification for policies that continue to meet the standards will remain in effect, if the insuring organization files the material specified in § 403.245(b) no later than the date specified in paragraph (b) or (c) of this section.

(b) Except as specified in paragraph (c) of this section, the insuring organization must file the material with HCFA no later than June 30 of each year. The first time the insuring organization must file the material is no later than June 30 of the calendar year that follows the year in which HCFA—

(1) Certifies a new policy; or

(2) Certifies a policy that has been decertified, as provided in § 403.255.

(c) If the loss ratio calculation period, used to calculate the expected loss ratio for the last actuarial certification submitted to HCFA, ends before the June 30 date of paragraph (b) of this section, the insuring organization must file the material with HCFA no later than the last day of that rate calculation period.

§ 403.255 Decertification of policies.

(a) HCFA will decertify a policy, if—

(1) The policy fails to meet the requirements specified in § 403.245(a); or

(2) The insuring organization fails to meet the requirements for submittal of material specified in § 403.251.

(b) If HCFA decertifies a policy, HCFA will inform the insuring organization and all State Commissioners and Superintendents of Insurance of its determination.

(c) HCFA will monitor the insuring organization to assure that the insuring organization notifies each policyholder in writing when his or her policy is decertified.

§ 403.258 Termination of a State program: Transfer of policies.

(a) When the Panel determines that a State no longer has an approved regulatory program, policies issued in that State are transferred to the jurisdiction of the voluntary certification program.

(b) If the policy was certified under a State regulatory program, but is transferred to the voluntary program, the following provisions apply:

(1) HCFA will waive the requirements specified in § 403.245(b) for submittal of certain information by the insuring organization to obtain initial certification.

(2) HCFA will certify the policy. That certification will be in effect—

(i) Until the expiration date of the certification the policy received under the State program; but

(ii) Not for more than 6 months.

(3) If the insuring organization wishes certification to continue beyond the date specified in paragraph (b) (2) of this section, the insuring organization must submit the material specified lin § 403.245(b) before that date.

(i) If HCFA certifies the policy on or before the date specified in paragraph (b) (2), the new certification will become effective on the date the determination is made.

(ii) If HCFA does not certify the policy on or before the date specified in paragraph (b) (2) of this section, that policy is decertified.

§ 403.260 Administrative review of HCFA determinations.

(a) This section provides for administrative review of a HCFA determination—

(1) Not to certify a policy; or

(2) To decertify a policy.

(b) HCFA will send a notice to the insuring organization containing the following information:

(1) That HCFA has made a determination—

(i) Not to certify a policy; or

(ii) To decertify a policy.

(2) The reasons for the determination.

(3) That the insuring organization has 30 days from the date of the notice to—

(i) Request, in writing, an administrative review of the HCFA determination; and

(ii) Submit additional information to HCFA for review.

(4) That, if the insuring organization requests an administrative review, HCFA will conduct the review, as provided for in paragraph (c) of this section.

(5) That, in a case involving decertification, the decertification will go into effect 30 days from the date of the notice, unless the insuring organization requests an administrative review. If the insuring organization requests an administrative review, the policy retains its certification until HCFA makes a final determination.

(c) If the insuring organization requests an administrative review, HCFA will conduct the review as follows:

(1) A HCFA official, not involved in the initial HCFA determination, will initiate an administrative review within 90 days of the date of the notice provided for in paragraph (c) of this section.

(2) The official will consider—

(i) The original material submitted to HCFA for review, as specified in §§ 403.245(b) or 403.251; and

(ii) Any additional information, that the insuring organization submits to HCFA.

(3) Within 15 days after the administrative review is completed, HCFA will inform the insuring organization in writing of the final decision, with an explanation of the final decision.

(4) If the final decision is to decertify a policy, the decertification will go into effect 15 days after the date of HCFA's notice to inform the insuring organization of the final decision.

(Secs. 1102, 1871, and 1882 of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395ss))

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance Program; No. 13.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 5, 1980.

Howard Newman,

Administrator, Health Care Financing Administration.

Approved: January 9, 1981.

Patricia Roberts Harris,

Secretary.

[FR Doc. 81-1775 Filed 1-19-81; 8:45 am]

BILLING CODE 4110-35-M

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SB 43
Title An Act relating to insurance policy form filings
Requested by Governor Date Dec. 10, 1980

II. FISCAL DETAIL
Agency Affected Division of Insurance
Program Category Affected Public Protection
BRU, Program, or Subprogram(s) Affected Division of Insurance
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES	0	0				
200 TRAVEL	0	0				
300 CONTRACTUAL	0	0				
400 COMMODITIES	0	0				
500 EQUIPMENT	0	0				
600 LAND & STRUCTURES	0	0				
700 GRANTS, CLAIMS, ETC.	0	0				
TOTAL	0	0				

FUNDING (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND	0	0				
FEDERAL FUNDS	0	0				
OTHER (Specify Fund Source)	0	0				

POSITIONS

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
FULL TIME	0	0				
PART TIME	0	0				
TEMPORARY	0	0				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

IV. DATE Dec. 10, 1980
PREPARED BY John George, Div. of Insurance
AGENCY Commerce and Economic Development
PHONE 2515

Original: Legislative Finance

3643

January 12, 1981

President of the Senate
Alaska State Legislature
Pouch V
Juneau, AK 99811

Dear Mr. President:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill which amends AS 21.42.130 by allowing the director of insurance to disapprove a form filed under AS 21.42.120 when the insurance benefits do not bear a reasonable relationship to the premiums charged. Regulations establishing appropriate cost/benefit ratios will be adopted to provide guidelines for the exercise of this power.

This amendment is a response to Public Law 96-265 which empowered the federal government to certify programs for medicare supplemental policies in states that fail to establish equivalent programs of certification. This bill will provide a mechanism for the director of insurance to certify supplemental medicare policies and avoid federal regulation of this area.

Sincerely,

S/JSH

Jay S. Hammond
Governor

to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. Forms for use in property, marine (other than wet marine and transportation coverages), casualty and surety insurance coverages the filing required by this section may be made by rating organizations on behalf of its members and subscribers; but this provision does not prohibit a member or subscriber from filing the forms on its own behalf.

(b) Each filing shall be made not less than 30 days in advance of delivery. At the expiration of the 30 days the form filed shall be considered approved unless before the 30-day period it has been affirmatively approved or disapproved by order of the director. Approval of the form by the director constitutes a waiver of the unexpired portion of the waiting period. The director may extend by not more than an additional 30 days the period within which he may affirmatively approve or disapprove the form, by giving notice of the extension before expiration of the initial 30-day period. At the expiration of the extended period, and in the absence of a prior affirmative approval or disapproval, the form shall be considered approved. The director may at any time, after notice and for cause shown, withdraw the approval.

(c) An order of the director disapproving the form or withdrawing a previous approval shall state the grounds and the particulars in such detail as reasonably to inform the insurer thereof.

(d) The director may, by order, exempt from the requirements of this section for as long as he considers proper an insurance document or form or type thereof as specified in the order, to which, in his opinion, this section may not practicably be applied, or the filing and approval of which are, in his opinion, not desirable or necessary for the protection of the public.

(e) This section applies also to a form used by domestic insurers for delivery in a jurisdiction outside this state, if the insurance supervisory official of the jurisdiction informs the director that the form is not subject to approval or disapproval by the official, and upon the director's order requiring the form to be submitted to him for the purpose. The applicable same standards shall apply to these forms as apply to forms for domestic use. (§ 1 ch 120 SLA 1966)

Sec. 21.42.130. Grounds for disapproval. The director shall disapprove a form filed under § 120 of this chapter or withdraw a previous approval thereof, only if the form

(1) is in any respect in violation of or does not comply with this title;

(2) contains or incorporates by reference, where incorporation is permissible, an inconsistent, ambiguous, or misleading clause,

or exception and condition which deceptively affects the risk purported to be assumed in the general coverage of the contract;

(3) has a title, heading, or other indication of its provisions which is misleading;

(4) is printed or otherwise reproduced in a manner which renders a provision of the form substantially illegible. (§ 1 ch 120 SLA 1966)

Sec. 21.42.140. Standard provisions. (a) Insurance contracts shall contain the standard or uniform provisions which are required by the applicable provisions of this title pertaining to contracts of particular kinds of insurance. The director may waive the required use of a particular provision in a particular insurance policy form if

(1) he finds the provision unnecessary for the protection of the insured and inconsistent with the purposes of the policy; and

(2) the policy is otherwise approved by him.

(b) No policy may contain a provision inconsistent with a standard or uniform provision used or required to be used, but the director may approve a substitute provision which is, in his opinion, not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.

(c) In lieu of the provisions required by this title for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used when approved by the director.

(d) A provision required by this title to be contained in a policy cannot be waived by agreement between the insurer and another person. (§ 1 ch 120 SLA 1966)

Am. Jur., ALR and C.J.S. references.—29 Am. Jur., Insurance, §§ 186 to 188.

Departure from standard policy as affecting enforcibility of policy provision against insurer, 113 ALR 773.

44 C.J.S. Insurance §§ 249 to 261.

Sec. 21.42.150. Policy must contain entire contract. The policy, when issued, shall contain the entire contract between the parties, and neither the insurer nor its agent or representative, nor a person insured by the policy, may make an agreement as to the insurance which is not expressed in the policy. This section does not prohibit the modification of a policy, after issuance, by written rider or endorsement issued by the insurer. (§ 1 ch 120 SLA 1966)

Sec. 21.42.160. Contents of policies in general. (a) Each policy shall specify

(1) the names of the parties of the contract;

(2) the subject of the insurance;

(3) the risks insured against;

(4) the society has a board of directors charged with the responsibility for managing its affairs in the interim between meetings of its supreme legislative or governing body, subject to control by the body and having powers and duties delegated to it in the constitution or laws of the society;

(5) the board of directors is elected by the supreme legislative or governing body, except in case of filling a vacancy in the interim between meetings of the body;

(6) the officers are elected either by the supreme legislative or governing body or by the board of directors; and

(7) the members, officers, representatives or delegates may not vote by proxy. (§ 1 ch 120 SLA 1966)

Sec. 21.84.590. Other provisions applicable. In addition to the provisions contained in this chapter, other chapters and provisions of this title shall apply to fraternal benefit societies, to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications thereof, as follows:

(1) AS 21.03

(2) AS 21.06, with the exception of AS 21.06.250

(3) The following sections of AS 21.09:

(A) AS 21.09.050

(B) AS 21.09.100

(4) AS 21.33.010

(5) AS 21.36

(6) AS 21.42.290

(7) AS 21.69.370

(8) AS 21.69.640

(9) AS 21.78. (§ 1 ch 120 SLA 1966)

Chapter 87. Hospital and Medical Service Corporations.

Section
10. Scope of chapter
20. Purpose and interpretation
30. Provisions exclusive
40. Incorporation—Certificate of authority required
50. Same—Law applicable; approval of articles of incorporation; amendment
60. Name of corporation
70. Qualifications for certificate of authority
80. Application for certificate of authority
90. Issuance or refusal of certificate of authority
100. Continuance or expiration of certificate of authority
110. Suspension or revocation of certificate of authority
120. Services and benefits which may be provided, medical service corporations
130. Services and benefits which may be provided, hospital service corporations
140. Medical service agreements
150. Hospital service agreements
160. Subscriber's contracts
170. Service agreements and subscriber's contracts must provide substantial service benefits
180. Filing and approval of agreements and contracts
190. Charges and rates
200. Reserves
210. Surplus fund
220. Investments

Chapter 89. Miscellaneous Provisions.

Section
20. Required motor vehicle coverage
30. Payment
40. Eye care under health and accident insurance

Section
50. Arson information

Sec. 21.89.020. Required motor vehicle coverage. (a) An automobile liability policy which insures an owner or operator of a motor vehicle against loss resulting from his liability for bodily injury or death, or for property injury or destruction, or both, which is sold in this state after January 1, 1969, by an insurance carrier authorized to transact business in this state, shall contain limits in at least the amount prescribed for a motor vehicle liability policy in AS 28.20.440(b)(2), and meet the requirements of AS 28.20.440(b)(3) unless waived as provided in that paragraph.

(b) This section may not be construed to apply only to automobile liability policies obtained to satisfy a requirement of AS 28.20. (§ 1 ch 105 SLA 1968)

Cross reference. — As to motor vehicle liability policy, see AS 28.20.440.

Legislative committee report. — For legislative committee report on ch. 105, SLA 1968 (HB 236), see House Journal (1967), p. 370.

This section does not require stacking in the single policy context. This conclusion follows from the fact that uninsured motorists insurance may be waived in Alaska. Curran v. Fireman's Fund Ins. Co., 393 F. Supp. 712 (D. Alas. 1975).

Insured was allowed to "stack" the uninsured motorists coverage provided him in a single multivehicle policy where the insured, under the interpretation of the contract propounded by the insurer, would receive absolutely no additional coverage for his premium dollars paid for uninsured motorists coverage on the vehicles other than the one involved in the accident and where the only possible interpretation of the contract was that the uninsured motorists premiums paid in connection with the other vehicles were meant to increase the amount of coverage, the limits of liability clause notwithstanding. Curran v. Fireman's Fund Ins. Co., 393 F. Supp. 712 (D. Alas. 1975).

A policy provision which "waives" uninsured motorist coverage in the event the insured has other available insurance does not directly contravene this section. Werley v. United Servs. Auto. Ass'n, Sup. Ct. Op. No. 799 (File Nos. 1454, 1455), 498 P.2d 112 (1972).

Sec. 21.89.030. Payment. No insurance company doing business in this state may pay a judgment or settlement of a claim in this state for a loss incurred in this state with an instrument other than a negotiable bank check payable on demand and bearing even date with the date of writing. (§ 1 ch 172 SLA 1968)

Revisor's note. — Both chapters 105 and 172, SLA 1968, added a new section designated 21.89.020. This section has been renumbered.

Legislative committee report. — For legislative committee report on ch. 172, SLA 1968 (CSHB 365), see House Journal (1968), p. 246.

SB
69

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House CS for CS for SS for SB 69 (Judiciary)
Title An Act relating to the operation of motor vehicles and to the
Requested by Senator Stimson Date 4-6-82

II. FISCAL DETAIL
Agency Affected Department of Public Safety
Program Category Affected Life and Property Protection
BRU, Program, Or Subprogram(s) Affected Driver/Vehicle Services
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		9.4	18.7	28.0	28.0	28.0
400 COMMODITIES		.2	.3	.4	.4	.4
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		9.6	19.0	28.4	28.4	28.4

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		9.6	19.0	28.4	28.4	28.4
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

It is estimated an additional 6,080 individuals will be required to maintain proof of financial responsibility for the future in FY 83. Those individuals, plus 6,000 more in FY 84, for a total of 12,080, and an additional 6,000 in FY 85, for a total of 18,080. In FY 86, it is estimated the number of individuals required to file the proof for the first time will be approximately the same as those no longer required to file because their three years have elapsed, therefore, no additional increase.

It has been our experience an average of one notice per individual, each year, will have to be mailed out due to notification from an insurance company that an individual's insurance is being cancelled for non-payment of premium, failure to renew, etc. For legal purposes our notice must be sent via certified mail, return receipt requested, at the cost of $1.55 each.

FY83 6,080 x $1.55 = $9,424;
FY84 12,080 x $1.55 = $18,724
FY85 18,080 x $1.55 = $28,024

Commodities: Miscellaneous office supplies, including paper, envelopes, etc.

IV. DATE April 6, 1982 PREPARED BY Bill Brown
AGENCY Public Safety/Motor Vehicles
PHONE 465-4335

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/81)

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M   March 16, 1982

SUBJECT: Proposed HCS CSSSSB 69 (Judiciary)

TO: Senator Terry Stimson

FROM: Linn H. Asper
Legislative Counsel

You have requested a sectional analysis of the above referenced committee substitute that you reqested in draft for the House Judiciary Committee:

* Section 1: Allows a court to assign a driver who accumulates of 6 or more points in 12 months or 9 or more points in 24 months to attend a driver improvement course. If the driver fails to successfully complete the course, his operator's license may be suspended.

* Sec. 2: Requires a driver whose license is suspended for point accumulation to provide proof of future financial responsiblity (insurance coverage) before the license is reinstated. Accumulation of fewer points than those necessary to suspend a drivers license may require the driver to provide proof of future financial responsiblity or face suspension.

* Sec. 3: Requires a peace officer who investigates an accident to put persons involved in the accident on notice of the provisions of the motor vehicle safey responsiblity act regarding suspension of a drivers license.

* Sec. 4: Makes proof of future financial responsiblity a further condition for the termination of a suspension order under AS 28.20 after an agreement is reached between the parties to an accident.

* Sec. 5: Amends the general provisions of AS 28.20 on duration of suspension to require posting of proof of future

financial responsiblity before a suspensior can be terminated.

* Sec. 6: Requires that security deposited under AS 28.20 remain on deposit for two years rather than one year, as is now the case.

* Sec. 7: Requires proof of financial responsibility for the future whenever a license is suspended, revoked, limited or canceled, before a new license can be granted. Makes the former permissive language mandatory and extends the scope of the section.

* Sec. 8: Requires a reinstatement fee of $50 when a person's license is reinstated.

* Sec. 9: Repeals the provision of the law that allowed an affidavit procedure to terminate a period of suspension. The changes in * Sec. 5 make this provision obsolete.

LHA:ljb

(2) when, following default and suspension, the person in default pays the balance of the agreed amount; or

(3) one year elapses following the effective date of the suspension and evidence satisfactory to the department is filed with it that during the period no action at law upon the agreement is pending. (§ 14 ch 163 SLA 1959)

Sec. 28.20.130. Payment upon judgment. The payment of a judgment arising out of an accident, or the payment upon judgment of an amount equal to the maximum amount which could be required for deposit under this chapter, for the purposes of this chapter, releases the judgment debtor from the liability evidenced by the judgment. (§ 15 ch 163 SLA 1959; am § 12 ch 2 SLA 1964)

Cross reference. — See Editor's note to AS 04.15.030.

Sec. 28.20.140. Termination of security requirement. If satisfied as to the existence of a fact which under §§ 100 -- 130 of this chapter entitles a person to be relieved from the security requirements, the department shall not require the deposit of security and shall terminate a previous order of suspension in respect to the person, and shall immediately return the deposit to the person or his personal representative. (§ 16 ch 163 SLA 1959)

Sec. 28.20.150. Duration of suspension. (a) Unless a suspension is terminated under other provisions of this chapter, an order of suspension by the department remains in effect until terminated and no license may be renewed or issued to a person whose license is suspended until

(1) the person deposits or there is deposited on his behalf the security required under this chapter; or

(2) one year elapses following the date of suspension and evidence satisfactory to the department is filed with it that during the period no action for damages arising out of the accident resulting in the suspension has been instituted.

(b) An affidavit of the applicant that no action at law for damages arising out of the accident has been filed against him or, if filed, that it is not pending is prima facie evidence of that fact. The department may take whatever steps are necessary to verify the statement set forth in the affidavit. (§ 17 ch 163 SLA 1959)

Sec. 28.20.160. Application to nonresidents, unlicensed drivers, unregistered vehicles and accidents in other states. (a) If a driver or owner of a vehicle subject to registration under the laws of this state involved in an accident in this state does not have a license or registration in this state, then the driver may not be licensed, nor may the owner register a vehicle in this state until he complies with the

April 17, 1981 465-4322

The Honorable Terry Stimson
Alaska State Senate
Pouch V
Juneau, AK 99811

Dear Senator Stimson:

The purpose of this letter is to express my position on Senate Bill 69 and corresponding substitutes to date.

I respectfully submit that the Bill in its present substitute form (SCCCS 69, H&SS) is discriminatory in that it places requirements on some errant Alaskan drivers while others are exempt.

To administer the requirements or non requirements defined in the aforementioned substitute would be cumbersome at best without the end result justifying the means.

As the driver improvement course now stands, it is a voluntary one unless ordered by the Court as part of the sentence process. If individuals with points accessed against them wish to reduce those points, the prerogative to do so is with them when the availability of such a course is present. The voluntary method appears to be effective within the parameter of a driver/accident ratio which is the intent of the course in the first place.

To place additional regulations on all Alaskans that in part or in whole do not materially effect the state-wide driver/accident ratio is not fully warranted.

Admittedly Senator, I do have some concerns about over-regulating the public and will make myself available as spokesman for this Department to testify on the Bill if you or any of your colleagues so desire.

Sincerely,

William R. Nix
Commissioner

Department of Public Safety
Administrative Services
Juneau, Alaska

APR 22 1981

cc: Senator Bill Ray
Keith Specking, Legislative Aide, Governor's Office
Walter Lawson, Administrative Services, DPS
Ron Lehr, Budget & Management

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. House CS for CS for SS for SB 69 (Judiciary)
Title An Act relating to the operation of motor vehicles and to the
Requested by Senator Stimson Date 4-6-82

II. FISCAL DETAIL
Agency Affected Department of Public Safety
Program Category Affected Life and Property Protection
BRU, Program, Or Subprogram(s) Affected Driver/Vehicle Services
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		9.4	18.7	28.0	28.0	28.0
400 COMMODITIES		.2	.3	.4	.4	.4
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		9.6	19.0	28.4	28.4	28.4

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		9.6	19.0	28.4	28.4	28.4
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

It is estimated an additional 6,080 individuals will be required to maintain proof of financial responsibility for the future in FY 83. Those individuals, plus 6,000 more in FY 84, for a total of 12,080, and an additional 6,000 in FY 85, for a total of 18,080. In FY 86, it is estimated the number of individuals required to file the proof for the first time will be approximately the same as those no longer required to file because their three years have elapsed, therefore, no additional increase.

It has been our experience an average of one notice per individual, each year, will have to be mailed out due to notification from an insurance company that an individual's insurance is being cancelled for non-payment of premium, failure to renew, etc. For legal purposes our notice must be sent via certified mail, return receipt requested, at the cost of $1.55 each.

FY83 6,080 x $1.55 = $9,424;
FY84 12,080 x $1.55 = $18,724
FY85 18,080 x $1.55 = $28,024

Commodities: Miscellaneous office supplies, including paper, envelopes, etc.

IV. DATE April 6, 1982 PREPARED BY Bill Brown
AGENCY Public Safety/Motor Vehicles
PHONE 465-4335

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF [illegible]
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. CS SS SB 69 (Judiciary)
Title An Act relating to potential consequences of the assessment of driver's
Requested by House Judiciary Date 4-2-82

II. FISCAL DETAIL
Agency Affected Department of Public Safety
Program Category Affected Life and Property Protection
BRU, Program, Or Subprogram(s) Affected Driver/Vehicle Services
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		4.5	4.9	5.3	5.8	6.3
400 COMMODITIES		.1	.1	.1	.1	.2
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS,CLAIMS,ETC.						
TOTAL		4.6	5.0	5.4	5.9	6.5

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND		4.6	5.0	5.4	5.9	6.5
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instruction, Section III)

300 - Contractual: When proof of financial responsibility for the future is required, such as in proposed AS 28.15.255(a), it has been our experience an average of one notice per individual, each year, must be mailed out due to notification from an insurance company an individual's insurance has been cancelled for non-payment, failure to renew, etc. For legal purposes this notice must be sent via certified mail, return receipt requested, at the cost of $1.55 each. The additional number of drivers we would require proof of financial responsibility for the future from is approximately 2,880. 2,880 x $1.55 = $4,464.

400 - Commodities: Miscellaneous office supplies, including paper, envelopes, etc. $100.

IV. DATE 4-5-82 PREPARED BY Bill Brown
AGENCY Public Safety - Motor Vehicles
PHONE 465-4335

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/81)

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ALASKA CODE REVISION COMMISSION

ALASKA STATE LEGISLATURE
POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
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MEMORANDUM

TO: Representative Fred Brown, Chairman
House Judiciary Committee

FROM: Dickerson Regan, Consultant
Alaska Code Revision Commission

DATE: March 3, 1981

RE: SB 80--Oath, affirmation, acknowledgment, notarization and verification.

I am informed SB 80 is scheduled for consideration by the House Judiciary Committee Wednesday, March 4.

The Alaska Code Revision Commission discussed the referenced bill at its meeting February 24th. It suggests that the Committee propose minor amendments to the bill to restore uniform wording in places where stylistic editing and retyping in the Legislative Affairs Agency had resulted in more than stylistic changes. (The change of "any other" to "a" is the only change noted at the time of the meeting. The other changes are of the same type and are offered for the Committee's consideration):

Page 4, line 4: Following "or" delete "a" and insert "any other" in its place.

Page 4, line 8: Following "or" delete "a" and insert "any other" in its place.

Page 4, line 10: Following "United State." insert "or his dependents".

Page 4, line 11: Following "United States" delete ", a" and insert "or his dependents, any other" in its place.

Page 4, line 12: Following "United States" delete the comma.

Page 4, line 13: Following "(5)" delete "a" and insert "any other" in its place.

Page 4, line 19: Following "if" delete "appropriate" and insert "any" in its place.

Page 4, line 20: Following "a" delete "person" and insert "holder of that rank or title" in its place.

Page 7, line 3: Following "acknowledging" delete "is" and insert "was" in its place.

The proposed changes are in the part of the bill taken from the Uniform Recognition of Acknowledgments Act. They would return this section of the bill to the general form in which it was drafted by the commission, which is also the general form of the Uniform Recognition of Acknowledgments Act.

The term "a" was substituted for "any other" when the bill was retyped in the Legislative Affairs Agency. Although the term "a" is preferred to the term "any" in Alaska's drafting style, substituting "a" for "any other" in each of the places noted above has created a redundancy. In each instance it is comparable to listing three categories of apples:

(1) a red apple
(2) a yellow apple
(3) an apple

when the intent is to spell out two specific kinds and a third category--any <u>other</u> kind.

Although probably is has no substantive effect, changing the "a" back to "any other" would clear up the redundancy problem.

Another change that was made when the bill was retyped in Legislative Affairs resulted from an effort to eliminate a mid-sentence colon (p. 4, lines 10, 11, 12). Although the colon is in the commission's draft bill and in the uniform act, it is not favored drafting form and it is appropriate to try to avoid its use. In the resulting form of 050 in the bill, however, it is not clear that "or his dependents" is intended to modify all three categories that precede it. The proposed amendment would make this clear but would continue the elimination of the colon in mid-sentence since that is a desirable stylistic change.

The proposed change in 060 of the bill (p. 4, lines 19-20) would also change the bill back to its form before it was retyped. The original wording "if any", is more definite than "if appropriate" and should be used. Substitution, during retyping, of "a person" for "a holder of that rank or title" leaves confusion between subsections (a) and (d). In the uniform act and the commission's

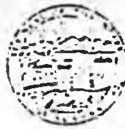
draft bill, (a) sets out what is sufficient proof that a holder of an office (within specified categories) can perform a notarial act; (d) creates a rebuttable presumption (i.e., prima facie evidence) that the person who performed the notarial act had the title he designated and his signature is genuine. The form of the uniform act seems preferable, using the term "person" only in (d).

The final amendment to the bill proposed above (090, p. 7, line 3) is just to return all of 090(4) to the past tense. The retyped form of the bill seems comparable to saying, "He knew the person then acknowledging is George Washington." The uniform act and the commission's draft bill would keep it all in the past tense.

Each amendment proposed in this memorandum would restore uniform language where editorial change made during retyping were somewhat more than stylistic changes.

The commission would appreciate consideration of these suggestions by the Judiciary Committee.

CODE REVISION COMMISSION



ALASKA STATE LEGISLATURE

MEMORANDUM

TO: Chairman, Alaska Legislative Council

FROM: John W. Abbott, Chairman John W. Abbott
Alaska Code Revision Commission

DATE: January 9, 1981

RE: Bill on oath, affirmation, acknowledgment, notarization and verification

Pursuant to the authority granted in AS 24.20.075(c), the Alaska Code Revision Commission has prepared the attached bill on oath, affirmation, acknowledgment, notarization and verification and asks that it be introduced in the legislature.

The need for statutory treatment of these subjects became apparent during the commission's consideration of the state's recording law. The terms are frequently encountered in Alaska Statutes, but neither a clear definition nor recommended forms are provided. The enclosed bill would take care of the deficiency.

Much of the attached bill is the Uniform Recognition of Acknowledgments Act, drafted by the National Conference of Commissioners on Uniform State Laws. The history of this Act and the Uniform Acknowledgments Act is set out in the attached comments. The last Alaska uniform legislation in this general area was enacted in 1915.

This bill was submitted to the council on February 21, 1980.

JWA:dr:chw

cc: Hon. Jay S. Hammond, Governor
Hon. Jay A. Rabinowitz, Chief Justice
Myrton R. Charney, Executive Director
Legislative Affairs Agency

Enclosures

COMMENTARY TO ACCOMPANY

BILL ON

OATH, AFFIRMATION, ACKNOWLEDGMENT,

NOTARIZATION AND VERIFICATION

For general background, following is a brief history of uniform laws on acknowledgment. It is followed by a section analysis of the attached bill.

General Background

Although acknowledgments have long been recognized as an ideal subject for uniformity among the states, Alaska has lagged far behind in this area.

In 1892 the Conference of Commissioners on Uniform State Laws adopted an Act for the acknowledgment and execution of written instruments, the Uniform Acknowledgment Act. It was generally revised in 1939 and was further revised in 1942, 1949 and 1960. Alaska has never adopted it.

In 1914 the Conference adopted an Act for the acknowledgment of written instruments taken outside the United States, the Uniform Foreign Acknowledgments Act, which was enacted in Alaska as ch. 66, SLA 1915 and now is codified as AS 40.10. Although the Uniform Foreign Acknowledgments Act was withdrawn by the Conference in 1943, it still is retained in Alaska law.

In 1968 the conference brought out a new act called the "Uniform Recognition of Acknowledgments Act". The act covers most of the same ground as the "Uniform Acknowledgment Act", dealing both with in-state and out-of-state acknowledgments.

When the conference put out its most recent "Summaries of Uniform Acts Currently Recommended for Adoption", it listed the "Recognition" Act for adoption but categorized the "Uniform Acknowledgment Act" as "being revised or considered for revision at this time".

There is reason to believe the two uniform acts will merge into one, using the general format of the 1968 "Recognition" Act.

Organization of the bill

In this bill the overlapping subject matter of the two uniform acts is covered by a section on who can acknowledge in the state (see Sec. 010) coupled with adoption of the entire "Recognition" Act (see Sec. 050 - 130).

The sections between 020 - 040 extend the subject matter of the bill beyond acknowledgments, serve to perpetuate existing "under penalty of perjury" certification of certain documents and clarify what is an acceptable form of "notarization" and "verification", terms that are used throughout Alaska Statutes.

Section analysis

Sec. 010 lists who can acknowledge in Alaska. To the persons who can take an acknowledgment in Alaska is added a commissioned officer. This category is not in the "Uniform Acknowledgment Act" but is in the "Recogni ion" Act.

Sec. 020 is an existing section (AS 09.65.020) which permits substitution of a signature "under penalty of perjury" for an oath given before a notary in some limited circumstances.

Sections 030 and 040 are definitions of notarization and verification based upon the common meanings of the terms.

Sections 050 - 130 are the Uniform Recognition of Acknowledgments Act. Sec. 050 recognizes foreign acknowledgments and covers the general area covered by the 1914 Uniform Foreign Acknowledgments Act, AS 40.10, which would be superceded by this uniform act section.

Sec. 060(a), (b) and (c) provide what will suffice to prove the authority of a designated office holder to take an acknowledgment. A final sentence in (a) reading "Further proof of his authority is not required" is omitted in this bill because it is surplusage. No substantive effect is intended by the omission. (d) of the subsection distinguishes proof of the authority of the holder of the office from proof of the genuineness of the signature and the genuineness of the claim that the person is an officer.

Form requirements, which are generally minimal, are covered by section 070 and 080.

Sec. 090 defines what is meant by the short-form phrase "acknowledged before me". The general treatment is the same as the treatment of statutory short forms of deeds under AS 34.15.040.

Sec. 100 provides the statutory short form for acknowledgments made by persons acting in various capacities.

Sections 110 - 130 are the savings clause, uniformity, and

title sections expected in uniform acts.

Bill sections 2, 3 and 4 near the end of the bill are technical amendments to correct references and avoid duplication in the real property title.

The repeal of AS 09.65.010 - 09.65.020 at the end of the draft is needed to remove the subject matter of oaths to this new chapter.

Repeal of AS 34.15.170 is to avoid duplication with AS 09.63.060 in section 1 of the bill. (The section being repealed is erroneously titled; it covers authentication, not acknowledgment.) Repeal of AS 34.15.190 is to avoid retention of a section on acknowledgment by married persons that is no longer necessary. Repeal of AS 34.15.200 is to avoid dup[illegible] with AS 09.63.070 in section 1 of the bill; for notaries the section is also duplicated by existing AS 44.50.070. In a separate bill on recording the commission is proposing more far reaching amendments and repeals in these and other sections of AS 34.15. However, the treatment of AS 34.15 here is minimal, encompassing only what is necessary in order to make this bill a complete unit not dependant upon passage of any other bill.

The repeal of AS 40.10 is a repeal of the 1914 version of the Uniform Foreign Acknowledgments Act which is superceded by this bill.

AS 44.53 also is repealed. It is a chapter permitting the governor to appoint commissioners to serve as Alaska notaries in other states. The chapter is not necessary when foreign acknowledgments are recognized, as they are under existing AS 40.10 and would be under this bill. The governor's office can find no record of commissioners having been appointed under AS 44.53.

than $200. A new or an additional undertaking may be ordered by the court upon proof that the original undertaking is insufficient in amount or security. (§ 5.12 ch 101 SLA 1962; am § 1 ch 3 SLA 1971)

This section is substantive. Ware v. City of Anchorage, Sup. Ct. Op. No. 477 (File No. 882), 439 P.2d 793 (1968).

It creates new right and new liability.—This section creates a new right in the resident defendant and a new liability in the nonresident plaintiff which are separate and apart from, and go beyond, the procedure of computing and assessing costs and attorney's fees. Ware v. City of Anchorage, Sup Ct. Op. No. 477 (File No. 882), 439 P.2d 793 (1968).

ALR and C.J.S. references.—Waiver of statute or court rule declaring nonresident plaintiff to give security for cost, 8 ALR 1510.

Statute regarding security for cost as mandatory or permitting exercise of discretion, 84 ALR 252.

Nonresident's duty to furnish security for costs as affected by joinder or addition of resident, 158 ALR 737.

20 C.J.S. Costs § 125 et seq.

Chapter 65. Miscellaneous Provisions.

Section
10. Officers authorized to administer oaths or affirmations
12. Certification of documents
20. Successive actions
30. Corporate sureties
40. Parties exempt from giving bond
50. Death or disability of a party
60. Defense not prejudiced by assignment
70. Suits against incorporated units of local government
80. Suits by incorporated units of local government
90. Civil liability for emergency aid
100. Civil liability for examination or treatment of minors

Sec. 09.65.010. Officers authorized to administer oaths or affirmations. Every justice, judge, magistrate, clerk of a court, notary public, United States postmaster, and the commanding officer of a vessel of the United States Coast Guard may administer oaths or affirmations. (§ 3.09 ch 101 SLA 1962)

ALR and C.J.S. references. — Disqualification of official empowered to administer oath, where he is attorney for person taking oath, 74 ALR 771.

67 C.J.S. Oaths and Affirmations § 5.

Sec. 09.65.012. Certification of documents. (a) A matter required or authorized to be supported, evidenced, established, or proved by the sworn statement, declaration, verification, certificate, oath, or affidavit, in writing of the person making it (other than a deposition, an acknowledgement, or an oath of office, or an oath required to be taken before a specified official other than a notary public), may be supported, evidenced, established, or proved, by the person certifying in writing "under penalty of perjury" that the matter is true and accurate. The certification shall state the date and place of execution, the fact that no notary public or other official empowered to administer oaths is available, and the following:

"I certify under penalty of perjury that the foregoing is true and accurate."

(b) A person who wilfully and falsely executes a certification under penalty of perjury is guilty of perjury. (§ 1 ch 58 SLA 1970)

Legislative committee report.—For report on ch. 58, SLA 1970 (HCSSB 481), see 1970 House Journal, p. 716.

Sec. 09.65.020. Successive actions. Successive actions may be maintained upon the same contract or transaction when a new cause of action arises under the contract. (§ 5.01 ch 101 SLA 1962)

Cross reference. — See Civ. R. 8; 13(e).

Sec. 09.65.030. Corporate sureties. When, by the laws of the state or by a charter, ordinance, rule, or regulation of a political subdivision, municipality, public corporation, or by a board, body, organization, court, or judge, a recognizance, stipulation, bond, undertaking, or bail in an action, suit, proceeding, or matter conditioned for the faithful performance of an act or duty or for the doing of an act or thing is permitted or required to be given with one or more sureties, it is sufficient compliance if the instrument is executed by a corporation which has complied with the laws of the state and is authorized by law to act as surety upon instruments and in proceedings, actions, suits, and matters as set out in this section. (§ 5.02 ch 101 SLA 1962)

Cross reference.—See Civ. R. 80(a).

Sec. 09.65.040. Parties exempt from giving bond. In an action or proceeding in a court in which the state is a party or in which the state is interested, no bond or undertaking is required of the state or an officer of the state. (§ 5.03 ch 101 SLA 1962)

Sec. 09.65.050. Death or disability of a party. In case of the death or disability of a party to an action, the court may at any time within two years after the death or disability, on motion, allow the action to be continued by or against his personal representatives or successor in interest. (§ 5.06 ch 101 SLA 1962)

The substitution of a new party is generally effected by motion, which should ordinarily be made by the party in interest. Nome & Sinook Co. v. Ames Mercantile Co., 187 F. 928 (9th Cir. 1911).

Case continues from point where original party left off.—As a general rule, the substituted party takes up the prosecution or defense at the point where the original party left off, and the pleadings already filed inure to the benefit of the new party. Nome & Sinook Co. v. Ames Mercantile Co., 187 F. 928 (9th Cir. 1911).

Better practice is to direct substituted party to file supplemental pleading. — The substitution having been allowed, probably the better practice would be for the court to direct the substituted party to file a supplemental complaint, showing the transfer and his right to continue the action, or for such party to obtain leave to file such a complaint; but the mere omission to file such a com-

include a lease. Smalley v. Juneau Clinic Bldg. Corp., Sup. Ct. Op. No. 766 (File Nos. 1310, 1311), 493 P.2d 1296 (1972).

Hence, this section applies to a lease for a term of years. Smalley v. Juneau Clinic Bldg. Corp., Sup. Ct. Op. No. 766 (File Nos. 1310, 1311), 493 P.2d 1296 (1972).

A lease is not void as between the parties to it by reason of noncompliance with the acknowledgment statute. Smalley v. Juneau Clinic Bldg. Corp., Sup. Ct. Op. No. 766 (File Nos. 1310, 1311), 493 P.2d 1296 (1972).

Failure to comply with the mandatory acknowledgment requirement of subsection (a) of this section, while affecting recordation and admissibility, does not have the effect of making the conveyance void as between the parties. Smalley v. Juneau Clinic Bldg. Corp., Sup. Ct. Op. No. 766 (File Nos. 1310, 1311), 493 P.2d 1296 (1972).

But recordation thereof is precluded. — Failure to comply with the acknowledgment requirement does not make an instrument invalid as between the parties to it, but rather only precludes its recordation and thus its effectiveness as against third persons. Smalley v. Juneau Clinic Bldg. Corp., Sup. Ct. Op. No. 766 (File Nos. 1310, 1311), 493 P.2d 1296 (1972).

And admissibility affected. — Under AS 34.15.260 an unacknowledged conveyance cannot be recorded and may not be read in evidence without further proof of the conveyance. Smalley v. Juneau Clinic Bldg. Corp., Sup. Ct. Op. No. 766 (File Nos. 1310, 1311), 493 P.2d 1296 (1972).

But action may not be maintained on defectively executed lease. — See same catchline in note to AS 34.15.010.

Cited in Waskey v. Chambers, 224 U.S. 564, 32 S. Ct. 597, 56 L. Ed. 885 (1912).

Am. Jur. and ALR references. — 1 Am. Jur., Acknowledgments, § 1 et seq.; 16 Am. Jur., Deeds, § 89 et seq.

Signing deed with lead pencil, 8 ALR 1339.

Sec. 34.15.160. Conveyances executed outside the state. If a conveyance is executed in a state, territory, or district of the United States, the conveyance may be executed according to the laws of that state, territory, or district, and the execution of the conveyance may be acknowledged before a judge of a court of record, justice of the peace, notary public, or other officer authorized by the laws of that state, territory, or district to take the acknowledgment of conveyances or before a commissioner appointed for that purpose. (§ 22-3-10 ACLA 1949; am § 2 ch 12 SLA 1966)

Quoted in Alaska Exploration Co. v. Northern Mining & Trading Co., 152 F. 145 (9th Cir. 1907).

Sec. 34.15.170. Certificate of acknowledgment. (a) In a case provided for in § 160 of this chapter, the conveyance shall have attached to it a certificate of the clerk or other certifying officer of a court of record of the county or district where the acknowledgment is taken, under the seal of his office, that

(1) the person whose name is subscribed to the certificate of acknowledgment is, at the date of the certificate, the officer he is represented to be in the certificate;

(2) he believes the signature of the person subscribed to the certificate is genuine;

(3) the conveyance is executed and acknowledged according to the laws of the state, territory, or district.

(b) The provisions of (a) of this section do not apply where the acknowledgment is taken before

(1) a commissioner appointed for that purpose;

(2) a notary public certified under his notarial seal; or

(3) the clerk of a court of record certified under the seal of the court. (§ 22-3-11 ACLA 1949; am § 3 ch 12 SLA 1966)

Am. Jur. and ALR references. — 1 Am. Jur., Acknowledgments, § 70 et seq.

Certificate of acknowledgment, 29 ALR 921; 72 ALR 1290.

Sec. 34.15.180. Execution and acknowledgment of conveyance in foreign country. If a conveyance is executed in a foreign country it may be executed according to the laws of that country and the execution of it acknowledged as provided in AS 40.10.010 — 40.10.050. (§ 22-3-12 ACLA 1949; am § 18 ch 70 SLA 1964; am § 4 ch 12 SLA 1966)

Sec. 34.15.190. Acknowledgment by a married person. The acknowledgment of a married person to a convenience of real property in this state is taken in the same manner as if the person were unmarried. (§ 22-3-13 ACLA 1949; am § 104 ch 127 SLA 1974)

Effect of amendment. — The 1974 amendment substituted "married person" for "married woman" and "the person" for "she."

Sec. 34.15.200. Officer's knowledge of grantor's identity. No acknowledgment of an executed conveyance may be taken by an officer unless he knows or has satisfactory evidence that the person making the acknowledgment is the individual described in and executing the conveyance. (§ 22-3-15 ACLA 1949)

Compliance presumed. — It is presumed that the officer taking the acknowledgment complied with this section. Coates v. Smith, 81 Ore. 556, 160 P. 517 (1916), construing the Oregon statute.

Quoted in Rolando v. Zesch, 7 Alaska 437 (1926).

Am. Jur. and ALR references. — 1 Am. Jur., Acknowledgments, § 110 et seq.

Showing in certificate as to officer's knowledge of identity, 29 ALR 1006; 72 ALR 1300.

Sec. 34.15.210. Proof by subscribing witness. (a) Proof of the execution of a conveyance may be made before an officer authorized to take acknowledgment of conveyances, and shall be made by a subscribing witness, who shall state his own place of residence and that he knows the person described in and executing the conveyance.

(b) This proof may not be taken unless the officer is personally acquainted with the subscribing witness or has satisfactory evidence that he is the same person who is a subscribing witness to the instrument. (§ 22-3-16 ACLA 1949; am § 5 ch 12 SLA 1966)

Notary must certify as to identity of subscribing witness. — Where there is no certificate by the notary that he is acquainted with subscribing witness or that he had any evidence that such person was the subscribing witness, the recordation of the instrument is not authorized. Nelson v. Lord, 4 Alaska 174 (1910).

Cited in Morency v. Floyd, 2 Alaska 194 (1904).

Am. Jur. reference. — 16 Am. Jur., Deeds, § 101 et seq.

Sec. 34.15.220. Proof of conveyance by handwriting. When a grantor is dead, out of the state, or refuses to acknowledge his

Chapter 10. Uniform Foreign Acknowledgment Act.

Section
10. Officers before whom deeds or other instruments acknowledged
20. Certificate of acknowledgement
30. Certificate in form required for acknowledgment inside state
40. Construction of chapter
50. Short title

Sec. 40.10.010. Officers before whom deeds or other instruments acknowledged. All deeds or other instruments requiring acknowledgment, if acknowledged without the United States, shall be acknowledged before an ambassador, minister, envoy or charge d'affaires of the United States, in the country to which he is accredited, or before one of the following officers commissioned or accredited to act at the place where the acknowledgment is taken, and having an official seal, viz: any consular officer of the United States, a notary public, or a commissioner or other agent of this state having power to take acknowledgments to deeds. (§ 23-2-1 ACLA 1949)

Cross reference. — For sections dealing with inspection of public records and their use as evidence, see AS 09.25.110 and AS 09.25.120.

Am. Jur. reference. — 1 Am. Jur., Acknowledgments, § 64 et seq.

Sec. 40.10.020. Certificate of acknowledgment. (a) Every certificate of acknowledgment made outside the United States shall contain the name or names of the person or persons making the acknowledgment, the date when and place where made, a statement of the fact that the person or persons making the acknowledgment knew the contents of the instrument and acknowledged the same to be his, her or their act; the certificate shall also contain the name of the person before whom made, his official title, and be sealed with his official seal and may be substantially in the following form:

. . . . (Name of Country)

. . . . (Name of City, Province or other political subdivision)

Before the undersigned . . . . (naming the officer and designating his official title) duly commissioned (or appointed) and qualified, this day personally appeared at the place above named . . . . (naming the person or persons acknowledging) who declared that he (she or they) knew the contents of the foregoing instrument, and acknowledged the same to be his (her or their) act.

Witness my hand and official seal this . . . . . . day of . . . . 19 . . . .

(seal) . . . . (Name of Officer)

. . . . (Official Title)

(b) When the seal affixed contains the name of the official style of the officer, any error in stating or failing to state otherwise the name of the official style of the officer shall not render the certificate defective. (§ 23-2-2 ACLA 1949)

Sec. 40.10.030. Certificate in form required for acknowledgment inside state. A certificate of acknowledgment of a deed or other instrument acknowledged outside the United States before any officer mentioned in § 10 of this chapter shall be valid if in the same form as now is or hereafter may be required by law for an acknowledgment within the state. (§ 23-2-3 ACLA 1949)

Sec. 40.10.040. Construction of chapter. This chapter shall be interpreted and construed as to effect its general purpose to make uniform the laws of those states and territories which enact it. (§ 23-2-4 ACLA 1949)

Sec. 40.10.050. Short title. This chapter may be cited as the Uniform Foreign Acknowledgment Act. (§ 23-2-5 ACLA 1949)

Chapter 15. Subdivisions and Dedications.

Article
1. Recording of Plats (§§ 40.15.010—40.15.060)
2. Control of Plats, Subdivisions and Dedications (§§ 40.15.070—40.15.130)
3. Vacation and Change of Plats and Streets (§§ 40.15.140—40.15.180)
4. General Provisions (§ 40.15.190)

Article 1. Recording of Plats.

Section
10. Approval and recording of subdivisions
20. Plats to be acknowledged and contain certificate that taxes and assessments are paid
30. Dedication of streets, alleys and thoroughfares
40. Certified copy of plat is evidence
50. Recorded plats legalized
60. Missing plats

Sec. 40.15.010. Approval and recording of subdivisions. Before the lots or tracts of any subdivision or dedication may be sold or offered for sale, the subdivision or dedication shall be submitted for approval to the authority having jurisdiction, as prescribed in this chapter. The regular approval of the authority shall be shown on it or attached to it and the subdivision or dedication shall be filed for record in the office of the recorder. The recorder shall not accept a subdivision or dedication for filing unless it shows this approval. If no platting authority exists as provided in §§ 70—130 of this chapter, lands may be sold without approval. (§ 1 (ch I) ch 115 SLA 1953; am § 1 ch 95 SLA 1955; am § 67 ch 69 SLA 1970)

Cross reference. — For sections dealing with inspection of public records and their use as evidence, see AS 09.25.110 and AS 09.25.120.

Effect of amendment. — The 1970 amendment deleted "platting board or" preceding "platting authority" in the last sentence.

Legislative committee report. — For report on ch. 69, SLA 1970 (HB 554), see 1970 House Journal Supplement No. 2, p. 7.

Approved plat must be filed for recording. — This section and AS 40.15.020 are sufficient authority to require the recorder to file for recording a plat when properly approved. Tellinen v.

(c) The postmaster may charge and receive the same fees as a notary for similar services. (§ 13 ch 99 SLA 1961)

Sec. 44.50.190. Savings clause. This chapter shall not be construed as to effect the release or extinguishment of a liability or forfeiture incurred or right accruing under a previous law regulating notaries. All commissions presently in effect continue until they expire or are terminated by death, disqualification, resignation, removal from the state, or until the notary is removed from office by the lieutenant governor under the Administrative Procedure Act (AS 44.62). (§ 14 ch 99 SLA 1961)

Chapter 53. Foreign Commissioners for Acknowledgments.

Section
10. Appointment, term of office, and powers
20. Qualifying for office

Sec. 44.53.010. Appointment, term of office, and powers. The governor may appoint as many commissioners in each state, territory, and district of the United States as he considers expedient. Each commissioner holds office for four years. Within the state, territory, or district for which appointed, each commissioner may take and certify

(1) the proof or acknowledgment of a conveyance of real property within the district or of any other written instrument to be used or operated in it;

(2) the acknowledgment of satisfaction of a judgment of a court of this district;

(3) an affidavit or deposition to be used in a court or before a judicial officer of the district. (§ 10-6-1 ACLA 1949)

Am. Jur. 2d reference. — 1 Am. Jur. 2d, Acknowledgments, §§ 13, 26, 58, 78

Sec. 44.53.020. Qualifying for office. Before exercising his powers, a commissioner appointed under AS 44.53.010 shall have a seal of office, and take an oath before a judicial officer in the county, city, or town where he resides, that he will faithfully perform the duties of the office. The commissioner shall file the oath and an impression of the seal in the office of the Department of Administration. The Depart-

ment of Administration shall collect $5 for each certificate of appointment and shall account for and deposit the amounts received in the state treasury. (§ 10-6-2 ACLA 1949)

(Continued in next pamphlet)

S B

83

Original sponsors: Bennett, Parr and Fahrenkamp

Offered: 6/5/81
Referred: Judiciary

1 IN THE SENATE BY THE RESOURCES COMMITTEE

2 HOUSE CS FOR SENATE BILL NO. 83 (Resources)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TWELFTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act restricting the authority of the Department of
7 Natural Resources to regulate certain activities in
8 the Chena River State Recreation Area; and providing
9 for an effective date."

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

11 * Section 1. AS 41.20.020(6) is amended to read:

12 (6) <u>adopt</u> [ESTABLISH], in accordance with <u>this section and</u>
13 the Administrative Procedure Act [,] (AS 44.62)<u>,</u> [RULES AND] regula-
14 tions governing the use and designating incompatible uses within the
15 boundaries of state park and recreational areas to protect the property
16 and to preserve the peace;

17 * Sec. 2. AS 41.20.020 is amended by adding a new paragraph to read:

18 (12) adopt, in accordance with the Administrative Procedure
19 Act (AS 44.62), regulations governing the use of the Chena River State
20 Recreation Area and designating incompatible uses within the boundaries
21 of the Chena River State Recreation Area except that regulations may
22 not be adopted which [prohibit or] unreasonably restrict

23 (A) work on valid mineral leases or mining claims;

24 (B) the legal taking of fur-bearing animals;

25 (C) the traditional use of roads and trails by any
26 means of transportation, including a vehicle propelled by machin-
27 ery, if the use occurred regularly in the area of a state recrea-
28 tion area before the effective date of the Act establishing the
29 state recreation area;

Original sponsors: Bennett, Parr and Fahrenkamp

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27 ery, if the use occurred regularly in the area of a state recrea-
28 tion area before the effective date of the Act establishing the
29 state recreation area;

(D) the cutting of dead and down or burnt timber.

* Sec. 3. AS 41.20.505 is amended to read:

Sec. 41.20.505. INCOMPATIBLE USES PROHIBITED. The commissioner of natural resources shall designate by regulation incompatible uses within the boundaries of the Chena River Recreation Area in accordance with the requirements of AS 41.20.020(12) and 41.20.497, and those incompatible uses designated shall be prohibited or restricted, as provided by regulation.

* Sec. 4. This Act takes effect immediately in accordance with AS 01.10.-070(c).

Regs may not be adopted which Un. Rec. Restrict

A OK

B OK.

C Use of Regular Roads + trails

Regs may separate
+ seasonally restrict

6/2/81
Bradley

Original sponsors: Bennett, Parr
and Fahrenkamp

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3 070(c).

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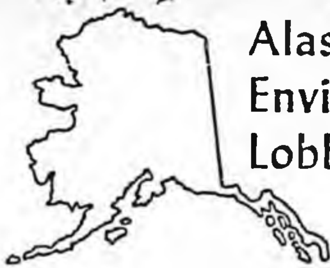

Alaska
Environmental
Lobby

419 6th St., Suite 321
Juneau, Alaska 99801

586-2345

Testimont before the House
Resources Committee on SB 83
by
Roland Shanks

Thank You Mr. Chairman,

As a reident of Fairbanks and a frequent user of the Chena Recreation Area, I'm very concerned about this Legislation. The Chena Rec. Area was established about 10 years ago, and at that time there was not alot of use in the area and it seemed like a long ways from town. But, in the intervining years the residential area of Chena Hot Springs Road has expanded right to the boundry of the Rec. area. Also, the use in the area has increased. I've camped on the banks of the Chena Riverand counted more than a hundered boats in one day during the summer. With the reopening of Chena Hot Springs resort the winter use has increased dramatically too. The area recieves heavy use by skiers, snowshoers, and mushers.

This legislation would make it impossible for the Div. of Parks to manage the area. By taking away their ability to manage mining, trapping, ORV use and wood cutting.

I think we should take a good look at these activities.

Last winter the Div. of Parks issued a permit for 62 pieces of heavy equipment to cross the Rec. area. We protested the permit, but it was finally issued. During the discussions we had an attorney look at the situation, and he informed us that there was no legal recourse. To my knowledge there are no mining claims within the Rec. area, and we can see from last years activities, that not only can Div. of Parks issue a crossing permit but that they will.

Another provision of the legislation prohibits the Div. of Parks from prohibiting or unreasonably restricting the taking of fur-bearing animals. Since state law allows the taking of some fur-bearing animals by firearm does that mean they cannot control firearm use. The Board of Game is primarily responsible for manageing trapping not the Div. of Parks. Does this also mean that they can't do anything to control snow-goes if it is being used for trapping. That distorys one of the basic management tools a recreation manager has the ability to designate seperate areas for incompatible uses.

The next provision requires that roads and trails traditionally used before the Rec. area was established must be left open to uncontroled use. Again this will take away a very important management tool. If you can't close a traditional road or trail, we need to define road and trail. Is anyplace a vehicle has passed a road. Under this provision even if a road becomes unsafe because of it's physical condition or traffic it could no be closed, not even to insure public safety.

The last provision makes it illegal to control the cutting of dead and down or brunt timber. These types of uses may be compatible in some areas of the Rec. area, but they must be controled. They must be done in a way that protects the recreationist and the Rec. area. Does this provision mean that they can't control ORV use if they are cutting fire wood. The Div. of Parks wouldn't be able to stop someone from driving a 4X4 across the marshy parts of the Chena Rec. area in the summer. Indiscriminate use of that type could distroy the Recreational Values of the area.

Because of the problems I've cited above I hope you defeat this bill. There have been management problems in the Rec. area before, but those are not solved by taking away the Div. of Parks ability to manage. This area has become a very important area to the people of Fairbanks.

And I believe that it should be managed in the most profes-
sional manner possible and to do that they can't have their
hands tied.

This piece of legislation also has some language pro-
blems. What does "unreasonably restrict" mean. I can see
nothing but problems using a phase like that. The only way
we'll ever know what that means is after a court defines it.
I feel that this legislation could be improved by deleting
on page one line 21 all language starting with expect and
continuing thru line 28. This would allow the Div. of Parks
to designate and manage incompatible uses.

I hope that you will take action today that protects the
Chena Recreation Area instead of distroying it.

MEMORANDUM

State of Alaska

DIVISION OF PARKS

TO: Legislative Staff

DATE: 5/28/80

FILE NO:

TELEPHONE NO:

FROM: Chip Dennerlein
Director

SUBJECT: SB 83

I have received several requests to comment on SB 83, "An Act restricting the authority of the Department of Natural Resources to regulate certain activities within state recreation areas, and providing for an effective date". I offer the following as the Department's position of the legislation.

1. The bill, as presently amended, would preclude the department from promulgating regulations which "prohibit or unreasonalby restrict" certain activities (emphasis added). The origninal version of the bill included the word "restrict". This word was deleted by the Senate Resources Committee for several reasons. For example, one of the uses mentioned in the bill is "the legal taking of fur bearing animals". While this is regulated by the Boards of Game, the department of natural resources does have authority over firearm discharge. It is legal to trap or take furbearing animals in Alaska through the use of firearms. In legal terms, a restriction on the use of firearms in certain areas would represent a "restriction" on the legal taking of fur bearing animals. Similarly, a traditional trail which might have very adequately accomedated a handful of motorized vehicle users might not have the physical ability to accommedate a great amount of such use without serious permanent damage to the terrain. Or - five horses over a wet spring trail is a lot different than fifty or one hundred horses. Restrictions may be necessary simply to ensure continued use and enjoyment in the future. Seeing these problems the Senate Resources committee struck the word "restrict", thus ensuring the continuance of certain uses without opening a Pandora's box of questionable authority and legal uncertainties. Unfortunately, the Senate Judiciary committee inserted the phrase "unreasonably restrict" into the bill. This phrase causes even more ambiguous legal problems and is not acceptable.

2. The bill would mandate that the cutting of dead and down or burnt timber be allowed in recreation areas. This is genrally acceptable and the Senate Resources Committee changed the origninal phrase "dead timber" to "dead and down or burnt". The resoning behind this change was that many trees which may appear dead during the winter are very much alive. Moreover, a number of bird species rely on standing dead timber for feeding, nesting and perching. To more clearly illustrate that only trees which are both dead and down should be cut, parenthesis should encircle dead and down to show that the phrase as used is a "term of art" in forestry.

3. The bill, as written and sponsored, stems from a few past problems in the Chena Recreation Area near Fairbanks which predate my tenure as director. I have researched these problems and while I am convinced that they can (and for the most part have) been

solved by evolving and better management for the area, I can respect the desire of those who wish to see certain guarnatees for use of the area. However, no problems of the nature of which the bill seeks to address have ever occured in any other state recreation areas. Since these other areas, such as Captian Cook in the Kenai District and Nancy Lake in the Mat-Su District have been established for more than ten years, it is reasonalbe to assume that any problems involving "traditional" uses would have cropped up by now. In accordance with the time tested principle "if it ain't broke, don't fix it" the act should not apply to any other areas besides Chena River Recreation Area. Several trails within the Nancy Lake Recreation Area were used by motorized vehicles prior to the establishment of the area in the late 1960's. One other trail was closed to snowmachine use about five years ago in a plan to separate and accomedate both snowmachiners and cross country skiers. There has never been a problem. Management is more effective and the public is happy. The"traditional users" have all been provided for. Posit for a moment, however, a new arrival to the state who has moved to Alaska because its the last frontier and he doesn't want any #$*! !#$#&*! regulations telling him what to do. Unfortunately this individual decides to seek his "last frontier" just outside the limits of Anchorage, Palmer and Wasilla in a heavily used state recreation area known as Nancy Lake. Because motorized use once occured on a certain trail within the recreation area, the department does not have the authority to prevent this individual from destroying the experience of many citizens along a family canoe trail system or in a quiet cross country ski area. This story may be a bit dramtic, but it is not far fetched. In fact, it happens every day in park and recreation system units where legal authorities are ambiguous.

SB 83 was introduced by Senators Bennet, Parr and Fahrenkamp. Senator Bennet testified on the bill before Chairman Fahrenkamps committee. Representative Bettisworth testified before Senate Judiciary where Senator Parr made the amendment to include "unreasonably restrict" in the legislation. The department respects the concerns of those legislators who wish to amend AS 41.20.497 to ensure certain uses in the Chena Recreation Area near Fairbanks. However, the department respectfully requests that SB 83 be amended along the lines of my comments here and be limited to incorporation into the statute affecting Chena Recreation Area.

ALASKA

STATE LEGISLATURE

MEMORANDUM

TO: Representative Fred Brown
House Judiciary Committee

FROM: Representative Fred Zharoff
House Resources Committee

RE: CS SB 83 (Resources) DATE: June 9, 1981

During the Resources Committee review of this bill several work drafts were prepared for the Committee's review, consideration, and passage. However, when the finalized draft was returned to Legal Services for a final bill there was a miscommunication on which version was passed by the Committee. Therefore a version not approved by the Committee was returned from Legal Services and sent on to your Committee.

Attached is a copy of the correct work draft version of SB 83 as passed out of the Resources Committee.

6/2/81

Bradley

Original sponsors: Bennett, Parr
and Fahrenkamp

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(D) the cutting of "dead and down" or burnt timber.

* Sec. 3. This Act takes effect immediately in accordance with AS 01.10.-070(c).

SB
84

Sunrise, Mt. McKinley Ansel Adams

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TESTIMONY BEFORE HOUSE JUDICIARY ON SB84

My name is Mollie Dent. I am an attorney with the Sierra Club Legal Defense Fund. Thank you for the opportunity to testify on SB 84.

We have followed the Governor's Permit Reform Project very closely for the past 6 months, at the request of nearly 20 public interest groups around the State. We reviewed several drafts of the Governor's proposal, and submitted several sets of detailed comments. We attended many, many meetings, with the Governor's staff, with State agencies, with local governments, and with public interest groups. We did legal research on many of the proposals; we analyzed permit reform efforts in other states, and we submitted several of our own proposals for consideration.

After all this effort, we still believe that the Governor's reform measures give too much advantage to vested private interests.

We still believe that the "coastal consistency" determination should not be made by DNR and that a procedure for reviewing these determinations is necessary.

However, on the whole, we believe that the Governor's process has been fair and that a sincere effort has been made to balance the many important interests affected by permits.

We cannot say the same for SB 84. This bill threatens to replace the Governor's workable permit reform measures with a scheme that is not only unworkable, but also illegal.

This is more than ironic. It is unnecessary and very ill-advised. We have worked closely with the Governor's staff for 6 months in order to avoid litigation. We have resolved many of differences.

But with SB 84, I am sure that at least one of the many public interest groups or local governments we have worked with will bring an immediate legal challenge.

The most obvious ground for such a legal challenge is the denial of "equal protection" to the public and to local governments. SB 84 denies "equal protection" by giving an unfair advantage to permit applicants. The bill does this by shifting the burden of proof from the applicant to the agency, whenever a permit is denied. This means

that an applicant can challenge an agency for denying a permit, and force the agency to defend its position in court.

However, if the public or a local government challenges a permit, the burden remains on them to show that the agency was wrong.

Even the Department of Law believes this is unconstitutional.

SB 84 also does not address the additional expenses that will be imposed by this scheme. The agencies will need more staff to process permits within the 30-day limit; the Attorney General's office will need more lawyers to defend the challenges; and the courts will need more judges and clerks to hear the de novo trials.

I was informed by the Committee staff that the testimony should be brief, so I will conclude. There is a mood throughout the country that developers are overregulated and that the country suffers because of it. This may be true in many instances.

The solution, however, is a reform measure like the Governor's -- a measure that cuts out the excess "fat" in government permits, but leaves the "muscle" intact. Under this kind of reasoned approach to permit reform, everyone is better off, including industry. Even an industrial giant like Dow Chemical Company has

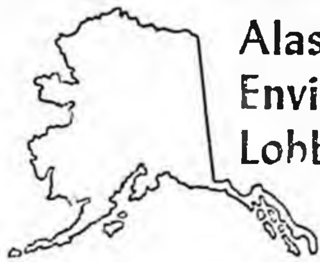
stated that compliance with sound environmental permits can eventually make money for the company.*/

And that's all we're asking -- sound, reasonable permit procedures.

Thank you.

---

*/ Statement by Chester E. Otis, Manager, Environmental Affairs, Dow Chemical Company, reported in Rodgers, Environmental Law (West, 1977)



Alaska
Environmental
Lobby

419 6th St., Suite 321
Juneau, Alaska 99801

586-2345

TESTIMONY BEFORE HOUSE JUDICIARY
COMMITTEE ON CSSB 84

My name is Roland Shanks. Thank you for the opportunity to testify on SB 84.

Unfortunately this bill does not solve the problems of permit delay. Nor does SB 84 balance the diverse interests affected by State environmental permits. Rather, the bill's inflexible permit deadlines are designed to eliminate local government and public involvement in the decision-making process.

On the other hand, the Governor's permit reform proposals also establish permit deadlines, but in a manner that attempts to consider the rights of all Alaskans and their local governments. After 6 months of cooperation with the Governor's office on Permit Reform in order to avoid litigation, I must stress the fact that environmental groups are certain to challenge the AOGA bill in court. It's either that or roll over and play dead.

The 30-day deadline imposed by the bill on state agencies for most permits make it impossible for local governments or the public to review the permits.

The Governor's proposal also establishes a 30-day deadline for many permits, but at least it allows an extension when the project is too complex for quick review. Also the Governor's proposal provides a 20-day extension if a public hearing is necessary. The AOGA bill allows no extensions, regardless of how complex or controversial a project is.

Confronted with an inflexible and unrealistic deadline and a complex or controversial permit, conscientious state agencies will be forced to deny a permit rather than let it be issued automatically because the deadline for reviewing the application has run. This dilemma, created by the AOGA bill, will prevent state agencies from reaching legally defensible decisions on those permit applications that are most likely to generate litigation.

SB 81 also abandons the requirement that parties "exhaust their administrative remedies" before going to court. The requirement to exhaust remedies serves important purposes. It avoids unnecessary litigation; it shortens court proceedings by giving the court a complete record to review; and it keeps everyone's costs down -- the court's, the agencies, the applicant's, and the public's.

Errors that might have been corrected by an

agency without litigation, must be reviewed directly by the courts under SB 84. Because public hearings and local government review of permits are not permitted by the AOGA bill, no record will be available for the courts to review. Cases must be decided de novo (from scratch) in a court trial. This hurts everybody.

Not only does SB 84 send everyone immediately to court, it also changes the rules once they get there. And it is easy to guess who benefits from the change, and who is left out in the cold.

The oil and gas companies benefit. The rules are changed so that when a company does not get its permit, the burden is on the agency to prove it was justified in denying the permit. This is a reversal of the usual rule, which puts the burden on the party challenging the agency.

The burden, however, is shifted only for those who apply for permits. The citizens and the cities who challenge a permit have the usual burden of showing that the agency was wrong.

This rule change means that permits will be granted that should not be, and that citizens and the cities will rarely never win a challenge.

This rule change is grossly unfair to citi-

zens and cities. It is also illegal. The State Constitution gives every Alaskan "equal protection" under the laws. I stress equal. There are many things you could say about SB 84, but you could never say it provided "equal protection". It benefits only the oil and gas companies, at the expense of all other Alaskans.

To conclude, the proposed "reforms" in SB 84 will increase litigation and increase the delay and expense of obtaining permits. The public interest is not served by advancing the interests of a few private companies above all other Alaskans. The AOGA bill will shut off the public's voice and shut out local governments in matters of great importance to their futures.

State agencies will be prevented from adequately reviewing permit applications. Many may deny permits rather than have them automatically issued because a deadline has run. A few may exploit the scheme and issue all permits, no matter how destructive. As the Department of Law analysis concluded, "the potential for collusion and abuse in this regard is monstrous."

I urge you to reject this extremely biased bill. The damage to state and local government, and to the entire democratic process in Alaska, is too great to risk.

Thank you.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

POUCH K–STATE CAPITOL
JUNEAU, ALASKA 99811

465-3603

June 1, 1981

The Honorable Fred E. Brown
Chairman
House Judiciary Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: Department of Law Analysis of CSSB 84

Dear Representative Brown:

Enclosed is the Department of Law's analysis of CSSB 84 (Resources). I have also enclosed a copy of the administration's Uniform Procedural Regulations.

As the analysis indicates, the Department of Law has severe problems with the legislation in its current form. We are also deeply concerned over the absence of a fiscal note accompanying this legislation. The possible fiscal impact of this legislation is three-fold:

1. By establishing a 30-day deadline for most state permits, even in complex cases, the bill exceeds the capabilities of the administrative agencies affected. The administration's Uniform Procedural Regulations also establish permit deadlines, but allow for extensions in complex and controversial cases. Even so, the notice of proposed rule-making projected a fiscal impact for these regulations of $302,000 for fiscal year 1982. Because of the nature of the deadlines imposed in the bill, the fiscal impact of CSSB 84 will in all likelihood be significantly higher. In addition, the bill imposes additional procedural obligations on the administrative agency even for permits which the Uniform Procedural Regulations envision will be issued "over the counter;"

2. As the attached analysis indicates, the Department of Law is concerned that this legislation will result in additional litigation, because administrative agencies will no longer have the opportunity to correct staff errors through an appeal to the commissioner's office. Additionally,