ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 8672

3516 HLAB HB 589 - HB 620

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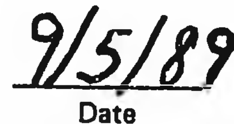

9/5/89

Date

02-519 (REV 8/78)

HB
589

C O R R E C T I O N

Discard HB 589 & Replace with New one

and retain this corrected version.

Introduced: 2/14/86
Referred: Labor & Commerce
Judiciary and Finance

1 IN THE HOUSE BY SUND, M.M.MILLER, HURLEY, DUNCAN, NAVARRE, AND DAVIS

2 HOUSE BILL NO. 589

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FOURTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to participation in the state group
7 life and health insurance policies by residents; and
8 providing for an effective date."

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

10 * Section 1. AS 39.30.090 is amended to read:

11 Sec. 39.30.090. PROCUREMENT OF GROUP INSURANCE. The Department
12 of Administration may obtain a policy or policies of group insurance
13 covering state employees, persons entitled to coverage under AS 14.-
14 25.168, AS 22.25.090, AS 39.35.535 or former AS 39.37.145, [OR] em-
15 ployees of other participating governmental units, or eligible resi-
16 dents, subject to the following conditions:

17 (1) A group insurance policy shall provide one or more of
18 the following benefits: life insurance, accidental death and dismem-
19 berment insurance, weekly indemnity insurance, hospital expense insur-
20 ance, surgical expense insurance, dental expense insurance, audio-
21 visual insurance, or other medical care insurance.

22 (2) Each eligible employee of the state, the spouse and the
23 unmarried children chiefly dependent on the eligible employee for
24 support, and each eligible employee of another participating govern-
25 mental unit shall be covered by the group policy, unless exempt under
26 regulations adopted by the commissioner of administration.

27 (3) A governmental unit may participate under a group
28 policy if

29 (A) its governing body adopts a resolution authorizing

1 participation, and payment of required premiums;

2 (B) a certified copy of the resolution is filed with
3 the Department of Administration; and

4 (C) the commissioner of administration approves the
5 participation in writing.

6 (4) The Department of Administration shall obtain the
7 insurance policy from an [ANY] insurer authorized to transact business
8 in the state under AS 21.09 and AS 21.90.

9 (5) The Department of Administration shall make available
10 bid specifications for desired insurance benefits to all insurance
11 carriers licensed in the state and qualified to provide the desired
12 benefits. The specifications shall be made available on or before
13 July 1, 1965, and at least once every succeeding five years. The
14 lowest responsible bid submitted by an insurance carrier with adequate
15 servicing facilities shall govern selection of a carrier under this
16 section.

17 (6) If the aggregate of dividends payable under the group
18 insurance policy exceeds the governmental unit's share of the premium,
19 the excess shall be applied by the governmental unit for the sole
20 benefit of the employees.

21 (7) A person receiving benefits under AS 14.25.110,
22 AS 22.25, AS 39.35, or former AS 39.37 may continue the life insurance
23 coverage that was in effect under this section at the time of termina-
24 tion of employment with the state or participating governmental unit.

25 (8) A person electing to have insurance under (7) of this
26 section shall pay the cost of this insurance.

27 (9) For each permanent part-time employee electing coverage
28 under this section, the state shall contribute one-half the state
29 contribution rate for permanent full-time state employees, and the

1 permanent part-time employee shall contribute the other one-half.
2 (10) A person receiving benefits under AS 14.25, AS 22.25,
3 AS 39.35, or former AS 39.37 may obtain auditory, visual, and dental
4 insurance for that person and eligible dependents under this section.
5 The level of coverage for persons over 65 shall be the same as that
6 available before reaching age 65 except that the benefits payable
7 shall be supplemental to any benefits provided under the federal old
8 age, survivors, and disability insurance program. A person electing
9 to have insurance under this paragraph shall pay the cost of the
10 insurance. The commissioner of administration shall adopt regulations
11 implementing this paragraph.
12 (11) An eligible resident may participate if the resident
13 applies on forms provided by the department, pays the cost of the
14 insurance and the administrative fee set by the department, and the
15 commissioner of administration approves the application in writing.
16 * Sec. 2. AS 39.30.095(a) is amended to read:
17 (a) The commissioner of administration shall establish the group
18 health and life benefits fund as a special account in the general fund
19 to provide for group life and health insurance under AS 39.30.090 and
20 39.30.160. The commissioner shall maintain accounts and records for
21 the fund. The fund consists of employer contributions, employee
22 contributions, resident contributions, appropriations from the legis-
23 lature, and interest earned on investment of the fund as provided in
24 (d) of this section.
25 * Sec. 3. AS 23.30.095(b) is amended to read:
26 (b) After obtaining the advice of an actuary, the commissioner
27 of administration shall determine the amount necessary to provide
28 benefits under AS 39.30.090 and 39.30.160 and shall set the rate of
29 employer contribution, resident contribution, and employee contri-

1 bution, if any. The commissioner of administration shall pay premiums
2 and claims in accordance with the insurance policies in effect under
3 AS 39.30.090 and 39.30.160 with money in the fund.

4 * Sec. 4. AS 39.30.100 is amended by adding a new paragraph to read:

5 (4) "eligible resident" means a person who is a resident
6 and who has been a resident, except for absences from the state for
7 military service or necessary medical care, for the 12 consecutive
8 months immediately preceding the date of application.

9 * Sec. 5. By January 1, 1987, the commissioner of administration shall
10 secure a group health and life policy or policies to provide coverage for
11 persons who will become eligible for coverage under amendments made by this
12 Act.

13 * Sec. 6. Sections 1 - 4 of this Act take effect on the date that the
14 commissioner of administration has secured coverage under sec. 5 of this
15 Act.

16 * Sec. 7. Section 5 of this Act takes effect immediately in accordance
17 with AS 01.10.070(c).

HB 589

An Act relating to participation in the state group life and health insurance policies by residents; and providing for an effective date.

OVERVIEW

Prepared by Rep. John Sund's office.

HISTORY

Some 13,200 state employees now enjoy one of the best health insurance plans available. But many Alaskans are unable to obtain this optimum health care either because they are seeking coverage as an individual or are part of a group that is not large enough to support maximum coverage.
Insurance companies do not offer their best policies to individuals and, if they did, the policy would most likely be cost prohibitive. Group policies generally offer better coverage, but the benefits normally increase with the size of the group because the insurance company can spread the risk over a large population.
No group in Alaska is as large as the state group. Therefore few group policies are as comprehensive and affordable as the state plan.

WHAT HB 589 DOES

HB 589 would permit residents of at least one year to buy into the state health plan at their own cost. Added to the insurance premium cost would be an administrative fee to offset the cost of processing applicants.

WHY THIS BILL IS NEEDED

Many state residents want and can afford excellent large group health insurance coverage but cannot get it for the reasons outlined above. This bill would permit those residents to enjoy the same health benefits as our state employees at the residents' own cost. These people would not necessarily be high risk individuals. They very likely would be healthy residents who can afford the state plan, estimated at $225 per month, and want to find the best health insurance for themselves and their families. Offering good health coverage can be a preventative measure against long-term costs to the state through lower medicaid costs.

HB 589

An Act relating to participation in the state group life and health insurance policies by residents; and providing for an effective date.

SECTIONAL ANALYSIS

Prepared by Rep. John Sund's office.

Section 1 adds eligible state residents to the list of people who may enroll in the state employee group insurance plan.

Paragraph 11 specifies that the resident must apply to the state for participation in the plan and pay the cost of the insurance and the administrative work to process the plan. The commissioner of the Department of Administration approves the applications.

Section 2 adds resident contributions to the list of sources that support the group health and life benefits fund of the General Fund.

Section 3 adds resident contribution to the list of rates set by the commissioner of the Department of Administration for the insurance plan based on the advice of an actuary.

Section 4 defines an eligible resident as a person who has been a resident of the state for the 12 consecutive months preceding the date of application.

Section 5 states that a group health and life policy for state residents will be secured by January 1, 1987.

Section 6 states that the health insurance plan will be made available to state residents as soon as the plan is secured.

Section 7 states that the department will begin securing the resident plan immediately.

MEMORANDUM

TO: Sid Billingslea

FROM: Shari Kochman

DATE: March 24, 1986

RE: HB 589

Attached is the committee backup for HB 589. Included is:

1. A copy of the bill
2. An overview of the bill
3. A sectional analysis of the bill
4. A position paper from the Division of Retirement and Benefits
5. A fiscal note
6. A memo from the Division explaining the calculations for the fiscal note

CS HB 589

An Act relating to disability insurance.

OVERVIEW

Prepared by Rep. John Sund's office.

The proposed committee substitute for HB 589 combines the concept of that bill, which offered all state residents the opportunity to buy into the state employee health insurance plan, with HB 547, which establishes an assigned risk pool for high-risk health insurance.

The substitute maintains the framework of HB 547 with two major changes: the insurance pool would now offer insurance to all eligible residents, not only those determined to be high-risk, and the plan is to be self-supporting. No cap would be placed on premium rates for the high-risk group.

The proposed substitute also permits groups of [illegible]-25 residents to purchase disability insurance through the pool which would be known as the Comprehensive Disability Insurance Association.

A Medicare supplement plan would also be available for residents age 65 or older.

Rather than leaving the plan benefits up to the discretion of the Division of Insurance, the proposed substitute specifies the coverage which is basically a standard major medical plan.

Premium rates will be scaled to the following variables: individual or group plan; high-risk or standard risk; age group; deductible choice of $200, $500 or $750. The rates would be determined with sound actuarial methods.

As in HB 547, the association would be a nonprofit corporation of all disability insurers and medical service corporations in the state (which would include Blue Cross).

At least 85% of the association's collected premiums must be used to pay claims while a maximum of 15% could be used for administrative costs. The association members would be assessed in amounts based on the amount of business the member writes in the state to cover claim payments that exceed premium receipts.

The intent is that the association and its contracted policy writer be largely responsible for administering the plan. Little cost should be incurred by the state.

POSITION PAPER

House Bill 589

The apparent goal of HB 589, to make available high quality health insurance and basic life insurance coverage at attractive group rates to all Alaskans who are willing to pay for it themselves is hard to argue with. However, there appears to be an underlying misconception that somehow the fact that there are existing policies of group insurance being provided to state employees presents an opportunity for a "free lunch." In fact, when the number of people to be served is large, as it presumably is in this case, there is little if any advantage in combining groups and there are compelling reasons to separate the claims experience of the two groups (state employees and citizens who elect to participate).

Certainly the State of Alaska could make a group health policy available to citizens of the state but it would seem to make more sense to offer a basic, no frills major medical package and price it according to the claims experience of those who choose to enroll in the plan. Bids to provide the coverage could be solicited and a servicing carrier chosen who would collect premiums, pay claims and maintain records. This would provide the maximum advantage to citizens, ensuring a competitive, fair rate without any significant state subsidy and without getting the state

into the insurance business.

Our analysis and position on this bill is based on the assumption that residents would be required to furnish evidence of insurability as a requirement for enrollment in the life insurance coverage or that the bill would be amended to allow for resident participation in the health plan only. Without these requirements, the impact on life insurance premiums would be significant due to the high possibility of adverse selection from the new group.

The question that must be answered is, "What possible advantages does the plan in HB 589 have when compared with the scenario described above?" We think there are no real advantages and several serious disadvantages. One might ask if the rates the state enjoys because of a large group of relatively good risks couldn't be passed on to citizens who enroll. This could only be done at the expense of those rates; in other words, if the experience of those who signed up was worse than the state average (and we are reasonably certain it would be), the rate would be driven up for everyone and the state would be in the position of subsidizing coverage for those individuals. We have tried to show this effect in our Fiscal Note analysis. Also, the coverage provided to state employees, regardless of bargaining unit, is first rate and includes audio, visual and dental coverage; we do not feel it would be appropriate for a general offering in any event.

For these reasons the Department of Administration is opposed to HB 589. If the legislature feels that this issue must be addressed, we feel a

non-subsidized approach such as the one indicated above would be more appropriate.

J. K. Humphreys ______________________ 3/5/86

J.K. Humphreys, Director, Division of Retirement & Benefits   Date

Eleanor Andrews ______________________ 3/5/86

Eleanor Andrews, Commissioner, Department of Administration   Date

REVISIONS TO PROPOSED CS HB 589

(Changes made from CS HB 589 dated 3/28/86 to CS HB 589 dated 4/4/86)

Prepared by Rep. John Sund's office.

Sec. 21.55.010. Page 1, lines 16 and 17:
Association membership would be limited to only those disability insurance writers that have writings for major medical coverage on an expense-incurred basis.

Sec. 21.55.020. Page 1, lines 23 and 24:
The director of the Division of Insurance or the director's designee will be a non-voting, ex officio member of the board of the association.

Page 1, lines 26-29 amended to read:
"The vote shall be a weighted vote based upon the member's premiums or subscriber fees derived from or on behalf of state residents in the previous calendar year, as determined by the director."

Sec. 21.55.040. Page 2, lines 21-29:
The association will have 120 days from the effective date of the bill to establish articles, bylaws and operating rules. After that time the director may adopt the necessary regulations.

Sec. 21.55.100. The reference to AS 21.36.190 (Fictitious Groups) was deleted because it did not apply.

Page 4, lines 10-15:
The medicare supplement plan will include a high-risk and a standard plan with the same criteria as the individual and group plans.

Page 4, lines 20-20 and Page 5, lines 1-8:
Criteria for determining someone to be a high-risk have been added as the following:

1) rejection from an association member for a standard risk plan.
2) rejection from the state standard risk plan.
3) diagnosis within the three years prior to application with one of 22 diseases or illnesses considered presumptive conditions.

Sec. 21.55.110. Page 5, line 13:
Benefit payments will be made for "usual, customary and reasonable or prevailing charges," which will be defined in the last section of the bill.

Page 5, line 20:
Paragraph (2) was rewritten to comply with AS 21.36.090 (d) which states that insurers cannot discriminate by the type of provider. This would not preclude the exclusion of certain services provided. But we cannot flat out exclude certain providers, such as chiropractors and optometrists, from coverage.

Page 7, lines 11-13:
Covered transportation benefits have been reworded to include "transportation by a local state licensed and certified ambulance." Air transport for medical care unavailable locally will also be included for coverage.

Page 7, line 15:
All licensed substance abuse programs will be covered, not just those for alcohol abuse.

Sec. 21.55.120. Page 7, lines 21-29 and Page 8, lines 1-5:
Medicare supplement plan will be offered in two options: a minimum benefits plan or expanded coverage plan. The minimum coverage is in compliance with present regulation. The more comprehensive coverage is as already described in the bill. Medicare supplement plans are regulated by state. These plans are not in violation of any state or federal regulations which was previously indicated to the committee.

Sec. 21.55.130. which limited pregnancy benefits has been deleted. Note that this caused renumbering of the sections.

Sec. 21.55.140. Page 9, line 17:
paragraph (3) which subjected pregnancy to preexisting conditions limitation has been deleted.

Sec. 21.55.160. Page 11, lines 13-15:
was rewritten so that the association would adopt a plan, subject to the director's approval, for coordination of benefits.

Sec. 21.55.170. Page 11, lines 22 and 23:

added a flat rate for coverage of dependents of insureds.

Sec. 21.55.210. Page 13, lines 18 and 19:
The writing carrier is an agent of only the association, not the director as in the original CS.

Sec. 21.55.300 Page 15, line 13:
Reference to AS 21.36.190 did not apply and was removed.

Sec. 21.55.320. Page 16, line 6:
changes payments to quarterly instead of monthly, which will cut down on administrative costs.

Sec. 21.55.340. Page 16, line 12:
limits association publicity responsibilities to the high risk plan only.

Sec. 21.55.410. Page 17, lines 14-17:
is a new section that states the state is not liable for association actions.

Sec. 21.55.500. Pages 17-19:
adds definitions for "copayment," "dependents," "home health agency services," "resident," and "usual, customary, reasonable or prevailing charge."

Section 2. Page 19, lines 18 and 19:
requires that the state plan be available by July 1, 1987.

Section 3. Page 19, line 21:
sets an immediate effective date.

Lauterbach

Original sponsors: Sund, M.M.Miller, Hurley, et al

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 589 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

state in comp. w/ private ind.

For an Act entitled: "An Act relating to disability insurance."

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

* Section 1. AS 21 is amended by adding a new chapter to read:

CHAPTER 55. STATE DISABILITY INSURANCE.

ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit incorporated legal entity to be known as the Comprehensive Disability Insurance Association. Membership consists of all insurers licensed to transact disability insurance in the state and all licensed hospital or medical service corporations in the state. All members shall maintain membership in the association as a condition of doing disability insurance business in the state.

Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the director of the division of insurance. In determining voting rights at members' meetings, a member is entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of disability insurance derived from or on behalf of state residents in the previous calendar year, as determined by the director. In approving members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented. Members of the board may be reimbursed from the association for expenses incurred by them as members, but may not otherwise be compensated

1 by the association for their services. The costs of conducting meet-
2 ings of the association and its board of directors shall be borne by
3 members of the association.
4 Sec. 21.55.030. GENERAL POWERS. The association may
5 (1) exercise the powers granted to insurers under the laws
6 of the state;
7 (2) sue or be sued;
8 (3) enter into contracts with insurers, similar associa-
9 tions in other states, or with other persons for the performance of
10 administrative functions;
11 (4) establish administrative and accounting procedures for
12 the operation of the association.
13 Sec. 21.55.040. OVERSIGHT BY DIRECTOR. The association shall
14 submit its articles, bylaws, and operating rules to the director for
15 approval.
16 Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association
17 is exempt from the Administrative Procedure Act (AS 44.62).
18 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from
19 the payment of fees and taxes levied by the state or any of its polit-
20 ical subdivisions except taxes levied on real or personal property.
21 ARTICLE 2. STATE DISABILITY INSURANCE PLANS.
22 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association
23 shall make available to residents the following types of disability
24 insurance plans:
25 (1) a group state plan for groups of from 3 - 25 residents,
26 subject to the prohibition against fictitious groups in AS 21.36.190;
27 (2) an individual state plan for residents who are standard
28 risks according to criteria established in regulations adopted by the
29 director; and

1 (3) an individual state plan for residents who are high
2 risks according to criteria established in regulations adopted by the
3 director.

4 (b) For each type of plan listed in (a) of this section, the
5 association shall offer three alternatives related to deductibles as
6 described in AS 21.55.120.

7 (c) The association shall make available to residents who are 65
8 years of age and older a medicare supplement plan. The plan shall
9 provide coverage of 50 percent of the deductible and copayment re-
10 quired under medicare and 80 percent of the charges covered in AS 21.-
11 55.110 to the extent that the charges are not paid by medicare. The
12 coverage shall include a limitation of $1,000 per person on total
13 annual out-of-pocket expenses for the covered services. The coverage
14 may be subject to a maximum lifetime benefit of not less than
15 $100,000.

16 (d) The association may not deny coverage under a state plan to
17 a resident who satisfies the requirements of AS 21.55.300 - 21.55.310.
18 The association may determine whether a person is a standard risk or a
19 high risk in accordance with the director's regulations.

20 Sec. 21.55.110. MINIMUM BENEFITS OF STATE DISABILITY INSURANCE
21 PLANS. Except as provided in AS 21.55.120 - 21.55.160, the minimum
22 standard benefits of a disability insurance plan offered under AS 21.-
23 55.100 shall be benefits, including coverage for catastrophic illness,
24 with a lifetime maximum of $1,000,000 per individual, for reasonable
25 charges or, when applicable, the allowance agreed upon between a
26 provider and a carrier for charges actually incurred, for the follow-
27 ing health care services, rendered to an individual covered by the
28 plan for the diagnosis or treatment of nonoccupational disease or
29 injury:

(1) hospital services;

(2) professional services that are rendered by a physician or by a registered nurse at the physician's direction, other than services for mental or dental conditions;

(3) the diagnosis or treatment of mental conditions, as defined in regulations of the director, rendered during the year by one or more physicians on other than an inpatient basis or, at their direction, by their staffs of registered nurses, up to a yearly maximum benefit of $1,000;

(4) legend drugs requiring a physician's prescription;

(5) services of a skilled nursing facility for not more than 120 days in a calendar year if the services commence within 14 days following a confinement of at least three consecutive days in a hospital for the same condition;

(6) home health agency services, as defined in regulations of the director, up to a maximum of 180 visits in a calendar year if the services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, except that in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, the home health agency services may commence irrespective of whether the covered person was previously confined or, if the covered person was confined, irrespective of the seven-day period, and the yearly benefit for medical social services may not exceed $200; in this paragraph, "medical social services" means services rendered under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including assessment of the social, psychological and family problems related to or arising out of the covered person's

illness and treatment, appropriate action and utilization of community resources to assist in resolving the problems, and participation in the development of treatment for the covered person;

(7) use of radium or other radioactive materials;

(8) outpatient chemotherapy for the removal of tumors and treatment of leukemia, including outpatient chemotherapy;

(9) oxygen;

(10) anesthetics;

(11) nondental prosthesis and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of the prosthesis;

(12) rental of durable medical equipment that has no personal use in the absence of the condition for which it was prescribed;

(13) diagnostic x-rays and laboratory tests as defined in regulations of the director;

(14) oral surgery for excision of partially or completely unerupted impacted teeth or excision of a tooth root without the extraction of the entire tooth;

(15) services of a licensed physical therapist rendered under the direction of a physician;

(16) transportation by a local professional ambulance to the nearest health care institution qualified to treat the illness or injury;

(17) confinement in a facility established primarily for the treatment of alcoholism and licensed by the state, or in a part of a hospital used primarily for this treatment, for a period of at least 45 days within any calendar year;

(18) other services that are medically necessary in the

treatment or diagnosis of an illness or injury as may be designated or approved by the director.

Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan may require deductibles of $200 a person, $500 a person, or $750 a person. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall also be applied to that individual's deductible in the following calendar year. The $200 maximum, the $500 maximum and the $750 maximum may be adjusted yearly to correspond with the change in the medical care component of the consumer price index, as adjusted by the director. The base year for the computation shall be the first full calendar year of operation of the association.

(b) A state plan shall require a maximum copayment of 20 percent for charges for all types of health care in excess of the deductible and 50 percent for services described in AS 21.55.110(3) in excess of the deductible.

(c) The sum of the deductible and copayments required in any calendar year under a plan may not exceed a maximum limit of $1,000 per covered individual or $2,000 per covered family. Covered expenses incurred after the applicable maximum limit has been reached shall be paid at the rate of 100 percent, except that expenses incurred for treatment of mental and nervous conditions shall be paid at the rate of 50 percent. The $1,000 and $2,000 maximums shall be adjusted yearly to correspond with the change in the medical care component of the consumer price index as adjusted by the director.

(d) In this section, "consumer price index" means the consumer

1 price index for all urban consumers for the Anchorage Metropolitan
2 Area compiled by the Bureau of Labor Statistics, United States
3 Department of Labor.
4 Sec. 21.55.130. BENEFIT LIMITATIONS. (a) A state plan shall
5 limit benefits with respect to each pregnancy, other than a pregnancy
6 involving complications of pregnancy, to a maximum of $250. In this
7 subsection, "complications of pregnancy" means
8 (1) conditions requiring hospital stays, when the pregnancy
9 is not terminated, whose diagnoses are distinct from pregnancy but are
10 adversely affected by pregnancy or are caused by pregnancy, such as
11 acute nephritis, nephrosis, cardiac decompensation, missed abortion
12 and similar medical and surgical conditions of comparable severity,
13 but does not include false labor, occasional spotting, physician-
14 prescribed rest during the period of pregnancy, morning sickness,
15 hyperemesis gravidarum, pre-eclampsia and similar conditions associ-
16 ated with management of a difficult pregnancy not constituting a noso-
17 logically distinct complication of pregnancy; and
18 (2) nonelective caesarean section, ectopic pregnancy that
19 is terminated, and spontaneous termination of pregnancy, that occurs
20 during a period of gestation in which a viable birth is not possible.
21 (b) A state plan may limit lifetime benefits to a maximum of not
22 less than $1,000,000 per covered individual.
23 Sec. 21.55.140. PREEXISTING CONDITIONS. (a) A preexisting
24 condition exclusion in a state plan may not exclude coverage of a
25 pr[illegible]xisting condition unless
26 (1) the condition first manifested itself within the period
27 of six months immediately before the effective date of coverage in a
28 manner that would cause a reasonably prudent person to seek diagnosis,
29 care, or treatment;

1 (2) medical advice or treatment was recommended or received
2 within the period of six months immediately before the effective date
3 of coverage; or
4 (3) the condition is pregnancy existing on the effective
5 date of coverage.
6 (b) A policy may not exclude coverage for a loss due to pre-
7 existing conditions for a period greater than 12 months following the
8 effective date of coverage. An individual state plan issued as a
9 result of conversion from a group state plan shall credit the time
10 covered under the group state plan toward the exclusion for preexist-
11 ing conditions. An individual high risk plan issued as a result of
12 conversion from an individual standard risk plan shall credit the time
13 covered under the standard risk plan toward the exclusion for preex-
14 isting conditions.
15 Sec. 21.55.150. CARE AND SERVICES NOT COVERED. A state plan may
16 not provide benefits for charges for the following:
17 (1) care for an injury or disease either
18 (A) arising out of and in the course of an employment
19 subject to a workers' compensation or similar law or where the
20 benefit is required to be provided under a workers' compensation
21 policy to a sole proprietor, business partner, or corporation
22 officer; or
23 (B) to the extent benefits are payable without regard
24 to fault under a coverage statutorily required to be contained in
25 a motor vehicle or other liability insurance policy or equivalent
26 self-insurance;
27 (2) treatment for cosmetic purposes other than surgery for
28 the prompt repair of an accidental injury sustained while covered or
29 for replacement of an anatomic structure removed during treatment of

1 tumors;

2 (3) travel, other than transportation by local professional
3 ambulance to the nearest health care institution qualified to treat
4 the illness or injury;

5 (4) private room accommodations to the extent it is in
6 excess of the institution's most common charge for a semiprivate room;

7 (5) services or articles to the extent that the charge
8 exceeds the reasonable charge in the locality for the service;

9 (6) services or articles that are determined not to be
10 medically necessary, except for the fabrication or placement of the
11 prosthesis as specified in AS 21.55.110(11) and (2) of this section;

12 (7) services or articles the provision of which is not
13 within the scope of the license or certificate of the institution or
14 individual rendering the services or articles;

15 (8) services or articles furnished, paid for or reimbursed
16 directly by or under any law of a government, except as otherwise
17 provided in this chapter;

18 (9) services or articles for custodial care or designed
19 primarily to assist an individual in the activities of daily living;

20 (10) service charges that would not have been made if no
21 insurance existed or for which the covered individual is not legally
22 obligated to pay;

23 (11) eyeglasses, contact lenses, or hearing aids or the
24 fitting of them;

25 (12) dental care not specifically covered by this chapter;
26 and

27 (13) services of a registered nurse who ordinarily resides
28 in the covered individual's home, or who is a member of the covered
29 individual's family or the family of the covered individual's spouse.

Sec. 21.55.160. COORDINATED COVERAGE. The minimum standard benefits of a state plan may be satisfied by catastrophic coverage offered in conjunction with basic hospital or medical-surgical plans on an expense incurred or service basis as approved by the director as providing at least equivalent benefits.

Sec. 21.55.170. STATE PLAN PREMIUMS. (a) The association may not charge a rate for coverage issued by or through the association that is excessive, inadequate, or unfairly discriminatory.

(b) The association shall use separate scales of premium rates based on age for individual risks and group risks. The association may charge a higher premium for a high risk plan than for a standard risk plan.

(c) Notwithstanding (a) of this section, the schedule of premiums for coverage under each type of state plan listed in AS 21.55.100 shall be designed so that each type of plan is self-supporting. The premiums shall be based on generally accepted actuarial principles.

ARTICLE 3. ADMINISTRATION OF PLANS.

Sec. 21.55.200. SUBMISSION OF PLANS. A member of the association may submit to the director for approval a policy of disability insurance or medicare supplement that is being proposed to serve as a state plan. The time and manner of the submission and approval shall be prescribed by regulations of the director.

Sec. 21.55.210. SELECTION OF WRITING CARRIERS. The association may select policies and contracts, or parts of them, submitted by a member of the association, or by the association or others, to develop specifications for bids from a member that wishes to be selected as a writing carrier to administer a state plan. The selection of the writing carrier shall be based upon criteria including the member's proven ability to handle large group disability insurance cases,

efficient claim paying capacity, and the estimate of total charges for administering the plan.

Sec. 21.55.220. DUTIES OF WRITING CARRIERS. (a) The writing carrier shall perform the administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the director. The director shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be considered an approval. Six months before the expiration of each three-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of AS 21.55.210 in selecting a writing carrier for the subsequent three-year period.

(b) The writing carrier shall provide to all eligible persons enrolled in a state plan an individual policy or certificate, setting out a statement of the insurance protection to which the person is entitled, with whom claims are to be filed, and to whom benefits are payable. The policy or certificate must indicate that coverage was obtained through the association.

(c) The writing carrier shall submit to the association and the director on a monthly basis a report on the operation of the state plans. Specific information to be contained in the report shall be determined by the association.

(d) Claims shall be paid by the writing carrier and shall indicate that the claim was paid under a state plan. A claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

(e) The writing carrier shall be reimbursed from the state plan

premiums received for its direct and indirect expenses. Direct and indirect expenses shall include a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses that are assignable to the maintenance and administration of the state plans. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms before selection as the writing carrier.

(f) The writing carrier shall at all times when carrying out its duties under this chapter be considered an agent of the association and the director.

Sec. 21.55.230. OPERATION OF THE PLAN. (a) Upon notification as an eligible person or group under AS 21.55.320, a person or group may enroll in a state plan by payment of the appropriate state plan premium to the writing carrier.

(b) An employer that has in its employ one or more eligible persons enrolled in a state plan may make all or a portion of a state plan premium payment directly to the writing carrier.

(c) At least 85 percent of the state plan premiums paid to the writing carrier shall be used to pay claims; not more than 15 percent may be used for the payment of agent referral fees under this chapter and for payment of the writing carrier's direct and indirect expenses under this chapter.

(d) Each contributing member of the association shall share the losses due to claims expenses of the state plans for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be

1 incurred by the association incident to the conduct of its affairs.
2 Claims expenses of the state plan that exceed the premium payments
3 allocated to the payment of benefits shall be the liability of the
4 contributing members. Contributing members shall share in the claims
5 expense of the state plans and operating and administrative expenses
6 of the association in an amount equal to the ratio of the contributing
7 member's total disability insurance premium, received from or on
8 behalf of state residents, as divided by the total disability insur-
9 ance premium received by all contributing members from or on behalf of
10 state residents, as determined by the director.

11 (e) The association shall make an annual determination of each
12 contributing member's liability, if any, and may make an annual fiscal
13 year end assessment if necessary. The association may also, subject
14 to the approval of the director, provide for interim assessments
15 against the contributing members as may be necessary to assure the
16 financial capability of the association in meeting the incurred or
17 estimated claims expenses of the state plans and operating and admin-
18 istrative expenses of the association until the association's next
19 annual fiscal year end assessment. Payment of an assessment is due
20 within 30 days of receipt by a contributing member of a written notice
21 of a fiscal year end or interim assessment. Failure by a contributing
22 member to tender to the association the assessment within 30 days
23 shall be grounds for termination of the contributing member's member-
24 ship. A contributing member that ceases to do disability insurance
25 business in the state remains liable for assessments through the
26 calendar year during which the disability insurance business ceased.
27 The association may decline to levy an assessment against a contribut-
28 ing member if the assessment would not exceed $10.

29 (f) Net gains, if any, from the operation of the state plans

1 shall be held at interest and used by the association to offset future
2 losses due to claims expenses of a state plan or allocated to reduce
3 state plan premiums.
4 ARTICLE 4. ENROLLMENT IN THE STATE DISABILITY INSURANCE PLAN.
5 Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a)
6 Subject to AS 21.36.190, a state resident or a group of from 3 to 25
7 state residents is eligible to enroll in a state plan described in
8 AS 21.55.100.
9 (b) Additional eligibility requirements may not be imposed by
10 the director, the association, or a writing carrier.
11 Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON OR GROUP. (a)
12 A person or group may enroll in a state plan by submission of a cer-
13 tificate of eligibility to the writing carrier. The certificate must
14 include the following:
15 (1) name, address, age, and length of time at residence of
16 the applicant;
17 (2) name, address, and age of spouse and children if any,
18 if they are to be insured; and
19 (3) a designation of the plan desired, including deductible
20 option chosen.
21 (b) A person may not be covered by more than one policy under
22 this chapter at any one time. Upon ceasing to be a resident of the
23 state a person is not eligible to purchase or renew coverage under a
24 state plan.
25 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days of
26 receiving the certificate described in AS 21.55.310, the writing
27 carrier shall either reject the application for failing to comply with
28 the requirements of AS 21.55.300 and 21.55.310 or forward the eligible
29 person a notice of acceptance and billing information. Insurance is

1 effective immediately upon receipt of the first month's premium, and
2 is retroactive to the date of the application, if the applicant other-
3 wise complies with the requirements of this chapter.
4 Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The
5 association, under a plan approved by the director, shall disseminate
6 appropriate information to the residents of the state regarding the
7 existence of the state plans and the means of enrollment. Means of
8 communication may include use of the press, radio, and television, as
9 well as publication in appropriate state offices and publications.
10 (b) The association shall devise and implement means of main-
11 taining public awareness of the provisions of this chapter and shall
12 administer this chapter in a manner that facilitates public participa-
13 tion in the state plans.
14 (c) The writing carrier shall pay an agent's referral fee of $50
15 to each insurance agent who refers an applicant to a state plan, if
16 the application is accepted. Selling or marketing of qualified state
17 plans is not limited to the writing carrier or its agents. The refer-
18 ral fees shall be paid by the writing carrier from money received as
19 premiums for a state plan.
20 (d) An insurer that rejects or applies underwriting restrictions
21 to an applicant for disability insurance in the state shall notify the
22 applicant of the existence of the state plans, the requirements for
23 being accepted, and the procedure for applying.
24 ARTICLE 5. GENERAL PROVISIONS.
25 Sec. 21.55.400. DUTIES OF DIRECTOR. The director may
26 (1) formulate general policies to advance the purposes of
27 this chapter;
28 (2) supervise the creation of the State Comprehensive
29 Disability Insurance Association;

1 (3) approve the selection of the writing carrier by the
2 association and approve the association's contract with the writing
3 carrier including the coverages and premiums to be charged;
4 (4) appoint advisory committees;
5 (5) conduct periodic audits to assure the general accuracy
6 of the financial data submitted by the writing carrier and the asso-
7 ciation;
8 (6) contract with the federal government or another unit of
9 government to assure coordination of the state plans with other gov-
10 ernmental assistance programs;
11 (7) undertake directly or through contracts with other
12 persons studies or demonstration programs to develop awareness of the
13 benefits of this chapter;
14 (8) contract with insurers and others for administrative
15 services; and
16 (9) adopt regulations necessary to administer this chapter.
17 Sec. 21.55.500. DEFINITIONS. In this chapter
18 (1) "association" means the Comprehensive Disability Insur-
19 ance Association created in AS 21.55.010;
20 (2) "state plan" means a policy of insurance offered by the
21 association through a writing carrier;
22 (3) "writing carrier" means the insurer or insurers select-
23 ed by the association and approved by the director to administer a
24 state plan.
25
26
27
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29

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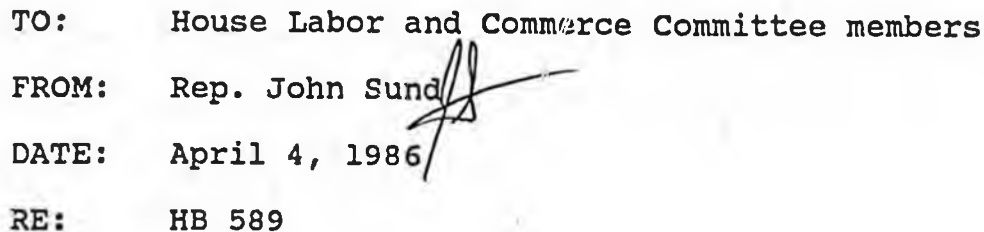
MEMORANDUM



TO: House Labor and Commerce Committee members

FROM: Rep. John Sund

DATE: April 4, 1986

RE: HB 589

I have attached a new CS for HB 589 along with a sectional analysis that explains the changes made from the CS dated 3/28/86.

The bill is expected to be taken up again Monday or Tuesday at which time I hope it can move out of committee. Otherwise, the chances of getting it through both bodies is slim.

I will be in Washington, D.C. early next week and unavailable to address the committee. My staff will be on hand to answer any questions.

We have been cleaning up the bill technically. But the big question here is one of policy: Should this state plan be available for only high-risk individuals or should all state residents, even standard risks, be permitted into the plan.

Testimony has shown that there is a need for high-risk health insurance in the state and that concept is unopposed -- even by the insurance industry. But the industry does oppose the inclusion of standard risk in the belief that it would be a duplication of services already provided in the state and, therefore, competition with private enterprise.

I believe that ethically the health insurance made available through this association should be offered to all residents. Standard risk individuals and small groups should not be excluded. But that is the major decision we face with HB 589.

I do hope that this decision will not hold the bill in your committee. Any delay could prevent the bill from passage and then everbody would lose -- including the high-risk individuals who need insurance protection.

Thank you for your consideration.

REVISIONS TO PROPOSED CS HB 589

(Changes made from CS HB 589 dated 3/28/86 to CS HB 589 dated 4/4/86)

Prepared by Rep. John Sund's office.

Sec. 21.55.010. Association membership would be limited to only those disability insurance writers that have writings for major medical coverage on an expense-incurred basis.

Sec. 21.55.020. Line 23 amended to read: "The vote shall be a weighted vote based upon the member's premiums or subscriber fees derived from or on behalf of state residents in the previous calendar year, as determined by the director."

The director of the Division of Insurance or the director's designee will be a non-voting, ex officio member of the board of the association.

Sec. 21.55.040. The association will have 120 days from the effective date of the bill to establish articles, bylaws and operating rules. After that time the director may adopt the necessary regulations.

Sec. 21.55.100. The reference to AS 21.36.190 was deleted because it did not apply.

Criteria for determining someone to be a high-risk have been added as the following:
1) rejection from an association member for a standard risk plan.
2) rejection from the state standard risk plan.
3) diagnosis within the three years prior to application with one of 22 diseases or illnesses considered presumptive

conditions.

The medicare supplement plan will include a high-risk and a standard plan with the same criteria as the individual and group plans.

Sec. 21.55.110. Benefit payments will be made

for "usual,

customary and reasonable or prevailing

charges," which will be defined in the last section of the bill.

Paragraph (2) was rewritten to comply with AS 21.36.090 (d) which states that insurers cannot discriminate by the type of provider. This would not preclude the exclusion of certain services provided. But we cannot flat out exclude certain providers, such as chiropractors and optometrists, from coverage.

Covered transportation benefits have been reworded to include "transportation by a local state licensed and certified ambulance." Air transport for medical care unavailable locally will also be included for coverage.

All licensed substance abuse programs will be covered, not just those for alcohol abuse.

Sec. 21.55.120. Medicare supplement plan will be offered in two options: a minimum benefits plan or expanded coverage plan. The minimum coverage is in compliance with present regulation. The more comprehensive coverage is as already described in the bill. Medicare supplement plans are regulated by state. These plans are not in violation of any state or federal regulations which was previously indicated to the committee.

Sec. 21.55.130. which limited pregnancy benefits has been deleted. Note that this caused renumbering of the sections.

Sec. 21.55.140. paragraph (3) which subjected pregnancy to preexisting conditions limitation has been deleted.

Sec. 21.55.160. was rewritten so that the association would adopt a plan, subject to the director's approval, for coordination of benefits.

Sec. 21.55.170. added a flat rate for coverage of dependents of insureds.

Sec. 21.55.210. (new draft). The writing carrier is an agent of only the association, not the director as in the original CS.

Sec. 21.55.300 Reference to AS 21.36.190 did not apply and was removed.

Sec. 21.55.320. changes payments to quarterly instead of

monthly, which will cut down on administrative costs.

Sec. 21.55.340. limits association publicity responsibilities to the high risk plan only.

Sec. 21.55.410. is a new section that states the state is not liable for association actions.

Sec. 21.55.500. adds definitions for "copayment," "dependents," "home health agency services," "resident," and "usual, customary, reasonable or prevailing charge."

Section 2 requires that the state plan be available by July 1, 1987.

Section 3 sets an immediate effective date.

WORK DRAFT WORK DRAFT WORK DRAFT

Lauterbach
4/4/86

Original sponsors: Sund, M.M.Miller, Hurley, et al

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 589 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to disability insurance; and providing for an effective date."

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

* Section 1. AS 21 is amended by adding a new chapter to read:

CHAPTER 55. STATE DISABILITY INSURANCE.

ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

Sec. 21.55.[illegible]. CREATION; MEMBERSHIP. There is established a nonprofit incorporated legal entity to be known as the Comprehensive Disability Insurance Association. Membership consists of all licensed hospital or medical service corporations in the state and all insurers licensed to transact disability insurance in the state who offer policies for major medical coverage on an expense incurred basis. All members shall maintain membership in the association as a condition of doing disability insurance business in the state.

Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the director of the division of insurance. The director or the director's designee shall serve as a nonvoting ex officio member of the board. In determining voting rights at members' meetings, a member is entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's premiums or subscriber fees derived from or on behalf of state residents in the previous calendar year, as determined by the director. In approving members of the board, the director shall

1 consider, among other things, whether all types of participating
2 members are fairly represented. Members of the board other than the
3 director or the director's designee may be reimbursed from the asso-
4 ciation for expenses incurred by them as members, but may not other-
5 wise be compensated by the association for their services. The costs
6 of conducting meetings of the association and its board of directors
7 shall be borne by members of the association.
8 Sec. 21.55.030. GENERAL POWERS. The association may
9 (1) exercise the powers granted to insurers under the laws
10 of the state;
11 (2) sue or be sued;
12 (3) enter into contracts with insurers, similar associa-
13 tions in other states, or with other persons for the performance of
14 administrative functions;
15 (4) establish administrative and accounting procedures for
16 the operation of the association.
17 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall
18 submit to the director a plan of operation and any amendments neces-
19 sary or suitable to assure the fair, reasonable, and equitable admin-
20 istration of the association. The plan of operation and amendments
21 become effective upon approval in writing by the director. If the
22 association fails to submit a suitable plan of operation by a date
23 that is 120 days after the effective date of this Act, or if at any
24 subsequent time the association fails to submit suitable amendments to
25 the plan, the director shall, after notice and hearing, adopt reason-
26 able regulations necessary or advisable to effectuate the provisions
27 of this chapter. These regulations shall continue in force until
28 modified by the director or superseded by a plan submitted by the
29 association and approved by the director.

1 (b) All members of the association shall comply with the plan of
2 operation.
3 (c) The plan of operation shall
4 (1) establish the procedures whereby all the powers and
5 duties of the association under this chapter will be performed;
6 (2) establish procedures for handling assets of the asso-
7 ciation;
8 (3) establish the amount and method of reimbursing members
9 of the board of directors under AS 21.55.020;
10 (4) establish regular places and times for meetings of the
11 board of directors;
12 (5) establish procedures for records to be kept of all
13 financial transactions of the association, its agents, and the board
14 of directors;
15 (6) provide that any member insurer aggrieved by a final
16 action or decision of the association may appeal to the director
17 within 30 days after the action or decision;
18 (7) establish the procedures whereby selections for the
19 board of directors will be submitted to the director;
20 (8) contain additional provisions necessary or proper for
21 the execution of the powers and duties of the association.
22 Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association
23 is exempt from the Administrative Procedure Act (AS 44.62).
24 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from
25 the payment of fees and taxes levied by the state or any of its polit-
26 ical subdivisions except taxes levied on real or personal property.
27 ARTICLE 2. STATE DISABILITY INSURANCE PLANS.
28 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association
29 shall make available to residents the following types of disability

1 insurance plans:
2 (1) a group state plan for groups of from 3 - 25 residents;
3 (2) an individual state plan for residents who are not high
4 risks; and
5 (3) an individual state plan for residents who are high
6 risks.
7 (b) For each type of plan listed in (a) of this section, the
8 association shall offer three alternatives related to deductibles as
9 described in AS 21.55.130.
10 (c) The association shall make available to residents who are 65
11 years of age and older a minimum coverage medicare supplement plan and
12 an expanded coverage medicare supplement plan as these plans are
13 described in AS 21.55.120. Each type of medicare supplement plan
14 shall be made available to residents who are high risks and residents
15 who are not high risks.
16 (d) The association may not deny coverage under a state plan to
17 a resident who satisfies the requirements of AS 21.55.300 - 21.55.310.
18 The association shall determine whether a person is a high risk in
19 accordance with (e) of this section and the director's regulations.
20 (e) In this section, "residents who are high risks" means resi-
21 dents who
22 (1) have been rejected after applying for a policy of
23 disability insurance or a medicare supplement policy by at least one
24 association member within the six months immediately preceding the
25 date of application for a state plan;
26 (2) are rejected because of risk factors after applying for
27 a state plan offered to persons who are not high risks;
28 (3) have been treated for any of the following conditions
29 within the three years immediately preceding application for a state

1 plan: angina pectoris, ascites, chemical dependency, cirrhosis of the
2 liver, coronary insufficiency, coronary occlusion, cystic fibrosis,
3 Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's
4 chorea, juvenile diabetes, leukemia, metastatic cancer, motor or
5 sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia
6 gravis, myotonia, open heart surgery, Parkinson's disease, polycystic
7 kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, or
8 Wilson's disease.

9 Sec. 21.55.110. MINIMUM BENEFITS OF STATE DISABILITY INSURANCE
10 PLANS. Except as provided in AS 21.55.120 - 21.55.160, the minimum
11 standard benefits of a disability insurance plan offered under AS 21.-
12 55.100 shall be benefits with a lifetime maximum of $1,000,000 per
13 individual, for usual, customary, reasonable, or prevailing charges
14 or, when applicable, the allowance agreed upon between a provider and
15 the writing carrier for charges actually incurred, for the following
16 medical services performed for an individual covered by the plan for
17 the diagnosis or treatment of nonoccupational disease or nonoccupa-
18 tional injury:

19 (1) hospital services;

20 (2) Subject to the limitations of AS 21.36.090(d), profes-
21 sional services that are rendered by a physician or by a registered
22 nurse at the physician's direction, other than services for mental or
23 dental conditions;

24 (3) the diagnosis or treatment of mental conditions, as
25 defined in regulations of the director, rendered during the year on
26 other than an inpatient basis, up to a yearly maximum benefit of
27 $1,000;

28 (4) legend drugs requiring a physician's prescription;

29 (5) services of a skilled nursing facility for not more

1 than 120 days in a calendar year if the services commence within 14
2 days following a confinement of at least three consecutive days in a
3 hospital for the same condition;
4 (6) home health agency services up to a maximum of 180
5 visits in a calendar year if the services commence within seven days
6 following confinement in a hospital or skilled nursing facility of at
7 least three consecutive days for the same condition, except that in
8 the case of an individual diagnosed by a physician as terminally ill
9 with a prognosis of six months or less to live, the home health agency
10 services may commence irrespective of whether the covered person was
11 previously confined or, if the covered person was confined, irrespec-
12 tive of the seven-day period, and the yearly benefit for medical
13 social services may not exceed $200; in this paragraph, "medical
14 social services" means services rendered under the direction of a
15 physician by a qualified social worker holding a master's degree from
16 an accredited school of social work, including assessment of the
17 social, psychological and family problems related to or arising out of
18 the covered person's illness and treatment, appropriate action and
19 utilization of community resources to assist in resolving the prob-
20 lems, and participation in the development of treatment for the cover-
21 ed person;
22 (7) use of radium or other radioactive materials;
23 (8) outpatient chemotherapy for the removal of tumors and
24 treatment of leukemia, including outpatient chemotherapy;
25 (9) oxygen;
26 (10) anesthetics;
27 (11) nondental prosthesis and maxillo-facial prosthesis used
28 to replace any anatomic structure lost during treatment for head and
29 neck tumors or additional appliances essential for the support of the

1 prosthesis;
2 (12) rental, or purchase if purchase is more cost effective
3 than rental, of durable medical equipment that has no personal use in
4 the absence of the condition for which it was prescribed;
5 (13) diagnostic x-rays and laboratory tests;
6 (14) oral surgery for excision of partially or completely
7 unerupted impacted teeth or excision of a tooth root without the
8 extraction of the entire tooth;
9 (15) services of a licensed physical therapist rendered
10 under the direction of a physician;
11 (16) transportation by air or by a local licensed or certif-
12 ied ambulance to and from the nearest health care institution qualif-
13 ied to treat the illness or injury;
14 (17) confinement in a facility established primarily for the
15 treatment of alcohol or drug abuse and licensed by the state, or in a
16 part of a hospital used primarily for this treatment, for a period of
17 at least 45 days within any calendar year;
18 (18) other services that are medically necessary in the
19 treatment or diagnosis of an illness or injury as may be designated or
20 approved by the director.
21 Sec. 21.55.120. MEDICARE SUPPLEMENT PLANS. (a) The minimum
22 coverage medicare supplement plan must meet the minimum policy stan-
23 dards and the minimum benefit standards established by regulations
24 adopted by the director under AS 21.89.060.
25 (b) The expanded coverage medicare supplement plan must include
26 the coverage required under (a) of this section and, in addition,
27 (1) must provide coverage of 50 percent of the deductible
28 and copayment required under medicare and 80 percent of the charges
29 covered in AS 21.55.110 to the extent that the charges are not paid by

1 medicare;

2 (2) coverage shall be based on usual, customary, reason-
3 able, or prevailing charges for services specified in AS 21.55.110 and
4 may not be limited to medicare eligible expenses or medicare schedules
5 of coverage.

6 Sec. 21.55.130. DEDUCTIBLES AND COPAYMENTS. (a) A state plan
7 other than a medicare supplement plan may require deductibles of $200
8 a person, $500 a person, or $750 a person. The amount of the deduct-
9 ible may not be greater when a service is rendered on an outpatient
10 basis than when that service is offered on an inpatient basis. Ex-
11 penses incurred during the last three months of a calendar year and
12 actually applied to an individual's deductible for that year shall
13 also be applied to that individual's deductible in the following
14 calendar year. The $200 maximum, the $500 maximum, and the $750
15 maximum may be adjusted yearly to correspond with the change in the
16 medical care component of the consumer price index, as adjusted by the
17 director. The base year for the computation shall be the first full
18 calendar year of operation of the association.

19 (b) A state plan other than a medicare supplement plan shall
20 require a maximum copayment of 20 percent for charges for all types of
21 health care in excess of the deductible and 50 percent for services
22 described in AS 21.55.110(3) in excess of the deductible.

23 (c) The sum of the deductible and copayments required in any
24 calendar year under a plan may not exceed a maximum limit of $2,000
25 per covered individual or $4,000 per covered family. Covered expenses
26 incurred after the applicable maximum limit has been reached shall be
27 paid at the rate of 100 percent, except that expenses incurred for
28 treatment of mental and nervous conditions shall be paid at the rate
29 of 50 percent. The $2,000 and $4,000 maximums shall be adjusted

1 yearly to correspond with the change in the medical care component of
2 the consumer price index as adjusted by the director.
3 (d) In this section, "consumer price index" means the consumer
4 price index for all urban consumers for the Anchorage Metropolitan
5 Area compiled by the Bureau of Labor Statistics, United States Depart-
6 ment of Labor.
7 Sec. 21.55.140. PREEXISTING CONDITIONS. (a) A preexisting
8 condition exclusion in a state plan may not exclude coverage of a
9 preexisting condition unless
10 (1) the condition first manifested itself within the period
11 of six months immediately before the effective date of coverage in a
12 manner that would cause a reasonably prudent person to seek diagnosis,
13 care, or treatment; or
14 (2) medical advice or treatment was recommended or received
15 within the period of six months immediately before the effective date
16 of coverage.
17 (b) A policy may not exclude coverage for a loss due to pre-
18 existing conditions for a period greater than 12 months following the
19 effective date of coverage. An individual state plan issued as a
20 result of conversion from a group state plan shall credit the time
21 covered under the group state plan toward the exclusion for preexist-
22 ing conditions. An individual high risk plan issued as a result of
23 conversion from an individual standard risk plan shall credit the time
24 covered under the standard risk plan toward the exclusion for preex-
25 isting conditions.
26 Sec. 21.55.150. CARE AND SERVICES NOT COVERED. A state plan may
27 not provide benefits for charges for the following:
28 (1) care for an injury or disease either
29 (A) arising out of and in the course of an employment

1 subject to a workers' compensation or similar law or where the
2 benefit is required to be provided under a workers' compensation
3 policy to a sole proprietor, business partner, or corporation
4 officer; or
5 (B) to the extent benefits are payable without regard
6 to fault under a coverage statutorily required to be contained in
7 a motor vehicle or other liability insurance policy or equivalent
8 self-insurance;
9 (2) treatment for cosmetic purposes other than surgery for
10 the prompt repair of an accidental injury sustained while covered or
11 for replacement of an anatomic structure removed during treatment of
12 tumors;
13 (3) travel, other than transportation by air or by a local
14 licensed or certified ambulance to and from the nearest health care
15 institution qualified to treat the illness or injury;
16 (4) private room accommodations to the extent it is in
17 excess of the institution's most common charge for a semiprivate room;
18 (5) services or articles to the extent that the charge
19 exceeds the reasonable charge in the locality for the service;
20 (6) services or articles that are determined not to be
21 medically necessary, except for the fabrication or placement of the
22 prosthesis as specified in AS 21.55.110(11) and (2) of this section;
23 (7) services or articles the provision of which is not
24 within the scope of the license or certificate of the institution or
25 individual rendering the services or articles;
26 (8) services or articles furnished, paid for or reimbursed
27 directly by or under any law of a government, except as otherwise
28 provided in this chapter;
29 (9) services or articles for custodial care or designed

1 primarily to assist an individual in the activities of daily living;
2 (10) service charges that would not have been made if no
3 insurance existed or for which the covered individual is not legally
4 obligated to pay;
5 (11) eyeglasses, contact lenses, or hearing aids or the
6 fitting of them;
7 (12) dental care not specifically covered by this chapter;
8 (13) services of a registered nurse who ordinarily resides
9 in the covered individual's home, or who is a member of the
10 covered individual's family or the family of the covered indi-
11 vidual's spouse; and
12 (14) experimental procedures.
13 Sec. 21.55.160. COORDINATED COVERAGE. The association shall
14 adopt a procedure for coordination of benefits with other insurance
15 coverage, subject to the approval of the director.
16 Sec. 21.55.170. STATE PLAN PREMIUMS. (a) The association may
17 not charge a rate for coverage issued by or through the association
18 that is excessive, inadequate, or unfairly discriminatory.
19 (b) The association shall use separate scales of premium rates
20 based on age of the insured for individual risks and group risks. The
21 association may charge a higher premium for a high risk plan than for
22 a standard risk plan. The association shall charge a flat rate for
23 coverage of dependents of an insured.
24 (c) Notwithstanding (a) of this section, the schedule of premi-
25 ums for coverage under each type of state plan described in AS 21.55.-
26 100 shall be designed so that each type of plan is self-supporting.
27 The premiums shall be based on generally accepted actuarial princi-
28 ples.
29 ARTICLE 3. ADMINISTRATION OF PLANS.

1 Sec. 21.55.200. SELECTION OF WRITING CARRIERS. The association
2 shall develop bid specifications for members that wish to be selected
3 as a writing carrier to administer a state plan. The selection of the
4 writing carrier shall be based upon criteria including the member's
5 proven ability to handle large group disability insurance cases,
6 efficient claim paying capacity, and the estimate of total charges for
7 administering the plan.
8 Sec. 21.55.210. DUTIES OF WRITING CARRIERS. (a) The writing
9 carrier shall perform the administrative and claims payment functions
10 required by this section. The writing carrier shall provide these
11 services for a period of three years, unless a request to terminate is
12 approved by the director. The director shall approve or deny a re-
13 quest to terminate within 90 days of its receipt. A failure to make a
14 final decision on a request to terminate within the specified period
15 shall be considered an approval. Six months before the expiration of
16 each three-year period, the association shall invite submissions of
17 policy forms from members of the association, including the writing
18 carrier. The association shall follow the provisions of AS 21.55.210
19 in selecting a writing carrier for the subsequent three-year period.
20 (b) The writing carrier shall provide to all eligible persons
21 enrolled in a state plan an individual policy or certificate, setting
22 out a statement of the insurance protection to which the person is
23 entitled, with whom claims are to be filed, and to whom benefits are
24 payable. The policy or certificate must indicate that coverage was
25 obtained through the association.
26 (c) The writing carrier shall submit to the association and the
27 director on a monthly basis a report on the operation of the state
28 plans. Specific information to be contained in the report shall be
29 determined by the association.

1 (d) Claims shall be paid by the writing carrier and shall indi-
2 cate that the claim was paid under a state plan. A claim payment
3 shall include information specifying the procedure to be followed in
4 the event of a dispute over the amount of payment and a contact per-
5 son's name and telephone number that can be used for inquiries regard-
6 ing the claim.
7 (e) The writing carrier shall be reimbursed from the state plan
8 premiums received for its direct and indirect expenses for administer-
9 ing the plan. Direct and indirect expenses shall include a pro rata
10 reimbursement for that portion of the writing carrier's administra-
11 tive, printing, claims administration, management and building over-
12 head expenses that are assignable to the maintenance and administra-
13 tion of the state plans. The association shall approve cost account-
14 ing methods to substantiate the writing carrier's cost reports consis-
15 tent with generally accepted accounting principles. Direct and in-
16 direct expenses may not include costs directly related to the original
17 submission of policy forms before selection as the writing carrier.
18 (f) The writing carrier shall at all times when carrying out its
19 duties under this chapter be considered an agent of the association.
20 Sec. 21.55.220. OPERATION OF THE PLAN. (a) Upon notification
21 as an eligible person or group under AS 21.55.320, a person or group
22 may enroll in a state plan by payment of the appropriate state plan
23 premium to the writing carrier.
24 (b) An employer that has in its employ one or more eligible
25 persons enrolled in a state plan may make all or a portion of a state
26 plan premium payment directly to the writing carrier.
27 (c) At least 85 percent of the state plan premiums paid to the
28 writing carrier shall be used to pay claims; not more than 15 percent
29 may be used for the payment of agent referral fees under this chapter

1 and for payment of the writing carrier's direct and indirect expenses
2 under this chapter.
3 (d) Each contributing member of the association shall share the
4 losses due to claims expenses of the state plans for plans issued or
5 approved for issuance by the association, and shall share in the
6 operating and administrative expenses incurred or estimated to be
7 incurred by the association incident to the conduct of its affairs.
8 Claims expenses of the state plan that exceed the premium payments
9 allocated to the payment of benefits shall be the liability of the
10 contributing members. Contributing members shall share in the claims
11 expense of the state plans and operating and administrative expenses
12 of the association in an amount equal to the ratio of the contributing
13 member's total disability insurance premium, received from or on
14 behalf of state residents, as divided by the total disability insur-
15 ance premium received by all contributing members from or on behalf of
16 state residents, as determined by the director.
17 (e) The association shall make an annual determination of each
18 contributing member's liability, if any, and may make an annual fiscal
19 year end assessment if necessary. The association may also, subject
20 to the approval of the director, provide for interim assessments
21 against the contributing members as may be necessary to assure the
22 financial capability of the association in meeting the incurred or
23 estimated claims expenses of the state plans and operating and admin-
24 istrative expenses of the association until the association's next
25 annual fiscal year end assessment. Payment of an assessment is due
26 within 30 days of receipt by a contributing member of a written notice
27 of a fiscal year end or interim assessment. Failure by a contributing
28 member to tender to the association the assessment within 30 days
29 shall be grounds for termination of the contributing member's

1 membership. A contributing member that ceases to do disability insur-
2 ance business in the state remains liable for assessments through the
3 calendar year during which the disability insurance business ceased.
4 The association may decline to levy an assessment against a contribut-
5 ing member if the assessment would not exceed $10.
6 (f) Net gains, if any, from the operation of the state plans
7 shall be held at interest and used by the association to offset future
8 losses due to claims expenses of a state plan or allocated to reduce
9 state plan premiums.
10 ARTICLE 4. ENROLLMENT IN THE STATE DISABILITY INSURANCE PLAN.
11 Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a)
12 A state resident or a group of from 3 to 25 state residents is eligi-
13 ble to enroll in a state plan described in AS 21.55.100.
14 (b) Additional eligibility requirements may not be imposed by
15 the director, the association, or a writing carrier.
16 Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON OR GROUP. (a)
17 A person or group may enroll in a state plan by applying to the writ-
18 ing carrier. The application must include the following:
19 (1) name, address, age, and length of time at residence of
20 the applicant;
21 (2) name, address, and age of spouse and children if any,
22 if they are to be insured; and
23 (3) a designation of the plan desired, including deductible
24 option chosen.
25 (b) A person may not be covered by more than one policy under
26 this chapter at any one time. Upon ceasing to be a resident of the
27 state a person is not eligible to purchase or renew coverage under a
28 state plan, but previously purchased coverage remains in effect for
29 the period covered by payments made while a resident.

1 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days
2 after receiving the certificate described in AS 21.55.310, the writing
3 carrier shall either reject the application for failing to comply with
4 the requirements of AS 21.55.300 and 21.55.310 or forward the eligible
5 person a notice of acceptance and billing information. Insurance is
6 effective immediately upon receipt of the first quarterly premium, and
7 is retroactive to the date of the application, if the applicant other-
8 wise complies with the requirements of this chapter.
9 Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The
10 association, under a plan approved by the director, shall disseminate
11 appropriate information to the residents of the state regarding the
12 existence of the state plans for persons who are high risks and the
13 means of enrollment. Means of communication may include use of the
14 press, radio, and television, as well as publication in appropriate
15 state offices and publications.
16 (b) The association shall devise and implement means of main-
17 taining public awareness of the provisions of this chapter and shall
18 administer this chapter in a manner that facilitates public participa-
19 tion in the state plans.
20 (c) The writing carrier shall pay an agent's referral fee of $50
21 to each insurance agent who refers an applicant to a state plan, if
22 the application is accepted. Selling or marketing of qualified state
23 plans is limited to licensed disability insurance agents. The refer-
24 ral fees shall be paid by the writing carrier from money received as
25 premiums for a state plan.
26 (d) An insurer that rejects or applies underwriting restrictions
27 to an applicant for disability insurance or a medicare supplement plan
28 in the state shall notify the applicant of the existence of the state
29 plans, the requirements for being accepted, and the procedure for

1 applying.

2 ARTICLE 5. GENERAL PROVISIONS.

3 Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

4 (1) approve the selection of the writing carrier by the
5 association and approve the association's contract with the writing
6 carrier including the coverages and premiums to be charged;

7 (2) contract with the federal government or another unit of
8 government to ensure coordination of the state plans with other gov-
9 ernmental assistance programs;

10 (3) undertake directly or through contracts with other
11 persons studies or demonstration programs to develop awareness of the
12 benefits of this chapter; and

13 (4) adopt regulations necessary to administer this chapter.

14 Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for
15 acts or omissions of the association or a writing carrier under this
16 chapter, nor is the state liable for payment of a claim under a state
17 plan issued by a writing carrier.

18 Sec. 21.55.500. DEFINITIONS. In this chapter

19 (1) "association" means the Comprehensive Disability Insur-
20 ance Association created in AS 21.55.010;

21 (2) "child" includes a biological child, an adopted child,
22 and a stepchild;

23 (3) "copayment" means out-of-pocket costs for which the
24 insured is responsible;

25 (4) "dependent" means a spouse, an unmarried child younger
26 than 19 years of age if not a full-time student and younger than 23
27 years of age if a full-time student, and an unmarried child of any age
28 who is dependent upon the child's parents due to a physical or mental
29 disability of the child;

1 (5) "home health agency services" means any of the follow-
2 ing services provided upon recommendation of a licensed physician as
3 part of a treatment plan:
4 (A) intermittent or part-time nursing services of a
5 registered professional nurse or a licensed practical nurse, that
6 are provided to a person under the continued direction of the
7 person's physician and within the limitation of the nurse's
8 license;
9 (B) nursing services that are provided to a person at
10 the person's residence, including a residential care facility or
11 adult boarding home; a hospital, skilled nursing facility or
12 intermediate care facility is not considered a residence;
13 (C) home health aide services that are prescribed by
14 and under the continued direction of a physician and supervised
15 by a professional nurse;
16 (D) home health aide services that are provided to a
17 person at the person's residence, as described in (B) of this
18 paragraph;
19 (E) physical and occupational therapy services, speech
20 pathology, and audiology services that are prescribed by a physician
21 and provided to a person by or under the supervision of a qualified
22 practitioner; these services may be provided to a person who is a
23 patient in an intermediate care facility or skilled nursing facility;
24 (6) "resident" means a person who has lived in the state
25 for at least the 12 consecutive months immediately preceding applying
26 for a state plan; a person ceases to be a resident if the person is
27 absent from the state for more than 90 consecutive days for reasons
28 other than verifiable medical reasons.
29 (7) "state plan" means a policy of insurance offered by the

1 association through a writing carrier;

2 (8) "usual, customary, reasonable, or prevailing charge"
3 means the charge for a medical care procedure, service, or supply item
4 that is the lowest of the following amounts:

5 (A) the billed amount for the medical service pro-
6 vider's actual charge;

7 (B) the charge usually made by that provider for
8 performing that procedure or service or for providing the supply
9 item; or

10 (C) the customary charge, based on a profile of
11 charges made for the same medical procedure, service, or supply
12 item in the same geographical area by other providers that have
13 performed the same procedure or service or can provide the same
14 supply item;

15 (9) "writing carrier" means the insurer or insurers select-
16 ed by the association and approved by the director to administer a
17 state plan.

18 * Sec. 2. The association established by sec. 1 of this Act shall make
19 available to residents the plans required by AS 21.55.100, enacted in
20 sec. 1 of this Act, by July 1, 1987.

21 * Sec. 3. This Act takes effect immediately in accordance with AS 01.-
22 10.070(c).

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RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James O. Smith
Signature of Camera Operator

9/5/89
Date

02-519 (REV 8/78)

HB

603

BILL SHEFFIELD
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

February 14, 1986

The Honorable Ben Grussendorf
Speaker of the House
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Representative Grussendorf:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill to extend the Board of Dispensing Opticians until June 30, 1988 and to make minor changes in two sections of AS 08.71, concerning opticians' eligibility for examination for licensure and renewal of licensure.

Although the June 30, 1985 termination date for the Board of Dispensing Opticians has passed, the board continues in existence until June 30, 1986 under the wind-down provisions of AS 08.03.020.

Last spring, I vetoed CSSB 167(L&C) which would have continued the board until 1989 and made the same change as does sec. 3 of this bill regarding optician license renewal, along with several other changes to AS 08.71, concerning licensing of opticians. After that veto, I appointed a working group identical to that which would have been required by the vetoed bill. That working group recommended, by unanimous vote, all of the provisions of the attached bill.

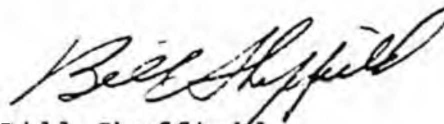
I believe that the best way to solve the inefficiencies, controversies, and sometimes bitter contention, that pervades the sometimes overlapping and deeply interrelated professions of optometry and opticianry is to pursue combining the two separate boards and statutes now regulating each. I agree with the working group that this somewhat radical change from the status quo can be most productively pursued as part of simultaneous sunset review of both

boards. That is why this bill extends the Board of Dispensing Opticians until the June 30, 1988 sunset date for the Board of Examiners in Optometry.

Meanwhile, the working group, also by unanimous vote, recommended other changes to AS 08.71, the dispensing optician statutes, which are also part of the bill. I agree with these changes, including the doubling of the number of continuing education hours in sec. 3 of the bill. In 1980 the license renewal date was changed from every two years to every four years, but a corresponding doubling of the continuing education hour requirement was overlooked. Now that all the 66 dispensing optician licenses were renewed last summer, for four years, the licensees will have ample notice and time to comply with the doubled requirement. The changes made by sec. 2 of the bill affect the qualifications that must be met by an applicant for examination.

I urge your prompt action to pass this bill so that we can continue to work with the opticians and the optometrists to pursue a better, more efficient way to regulate these two interrelated professions in truly the best interests of the consuming public.

Sincerely,



Bill Sheffield
Governor

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date : ______

REQUEST

Bill/Resolution No. : HB (DRAFT)
Title : An Act relating to dispensing opticians; and providing for an effective date.
Sponsor : By request of the Governor
Requestor :
Date of Request :

FISCAL DETAIL

Agency Affected : Commerce & Econ. Dev.
BRU : Occupational Licensing
Components :

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE		0	0	0	0	0

FUNDING : (Thousands of Dollars)

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
GENERAL FUND		-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL		-0-	-0-	-0-	-0-	-0-

POSITIONS :

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
FULL-TIME		0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

This legislation is not expected to incur new costs since operating expenses are already built into the division's operating budget for FY 87. Although the board is in its final year of sunset, continuation of the board remains a possibility. New revenues are not expected to be generated by the bill.
(see attached)

Prepared by : Jennifer Strickler, Management Analyst — Phone : 465-2144
Division : Occupational Licensing — Date : 2/11/86

Approved by Commissioner : [signature] — Date : 2/11/86
Agency : Commerce and Economic Development

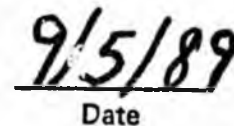
Distribution (by Agency preparing fiscal note) :
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

10/25/85

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

Signature of Camera Operator



Date

02-519 (REV 8/78)

HB

620

DIRECT SELLING ASSOCIATION
1776 K Street, N.W., Suite 600, Washington, D.C. 20006
202/293-5760

April 11, 1986

The Honorable Mike Navarre
State Capitol
P.O. Box V
Juneau, Alaska 99811

Dear Chairman Navarre:

I write on behalf of the Direct Selling Association (DSA) with regard to H.B. 620, a bill relating to dealership practices in the State of Alaska. The bill is scheduled for hearing before your committee on Wednesday, April 16. DSA has very serious concerns with the bill which I would like to relate.

Please bear with me while I give you some brief information about our organization. DSA is a national trade association representing some 145 member companies who market their products primarily through personal demonstration and explanation in the home. (A membership roster is enclosed). I'm sure you are familiar with the person-to-person sales and home party-plan marketing methods of our companies. As the industry representative, DSA has worked hand-in-hand with the National Association of Attorneys General, the Federal Trade Commission and other state and local authorities in formulating effective consumer protection policy which serves both the interest of the buying public and the legitimate and reliable businesses which serve them. DSA administers perhaps the nation's strongest consumer code of ethics, a self-regulation program which the White House has lauded as an exemplary example of private sector initiatives. DSA and its member companies are justifiably proud of the leadership position which they have taken in the consumer protection area.

The focus of direct selling's relationship with the consumer is the direct salesperson. These independent contractor salespeople work an average of only a few hours a week making under $30. A typical direct salesperson is a woman who uses her earnings to supplement the family's regular income. Entry costs into the business are negligible and purchases of mass amounts of inventory are neither required nor encouraged.

H.B. 620 seeks to promote fair business relations between dealers and manufacturers, a laudable goal when applied to situations involving sizeable investments and parties with wildly disproportionate bargaining powers. However, the protections envisioned by H.B. 620 are not necessary or appropriate when applied to direct selling businesses.

Direct salespeople normally leave the industry when they decide to stop selling. It is vital to the industry that as many people as possible remain as vendors in the marketplace. Thus, manufacturers rarely terminate their sellers, but rather encourage a widespread participation in their marketing plans through no or minimal investments and ease of entry into the business.

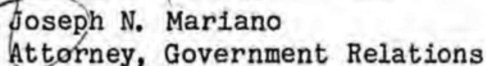
In order to limit the coverage of the bill without gutting its regulations of dealership agreements where appropriate, DSA would suggest that the definition of "dealership" in Section 45.50.750(2) of dealership be amended so as not to include the typical direct selling relationship. Specifically, we would suggest that you consider the following language:

> Sec. 45.50.750. DEFINITIONS. In as 45.50.650-45.50.760
> (2) "Dealership" means a business arrangement based on an oral or written agreement, expressed or implied under which the total investment of a person during the first six months of operation of his or her business is $500 or greater excluding inventory, sales demonstration equipment or materials and operating expenses and under which a person receives from the other party to the agreement the right to . . . (suggested language underlined).

This amendment would be consistent with the Federal Trade Commission Regulations which exempt the type of commercial relationship typified by direct selling and with the language utilized by other states to remove direct sellers from similar legislation. The typical direct selling relationship is not one which should be included within the ambit of H.B. 620, and on behalf of the tens of thousands of direct sellers in Alaska, I urge you to amend the legislation as suggested.

Thank you for your time and consideration in this matter. If you or your colleagues have any questions, I will be happy to discuss the matter in greater detail with you.

Sincerely,



Joseph N. Mariano
Attorney, Government Relations

kak

cc - The Honorable Mike Davis
The Honorable Red Boucher
The Honorable Niilo Koponen
The Honorable Virginia Collins
The Honorable Alyce Hanley
The Honorable Drew Pearce

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PEORIA, ILLINOIS 61602-8806
(309) 673-1681

OAK BROOK OFFICE:
OAK BROOK REGENCY TOWERS
SUITE 850
1415 WEST 22ND STREET
OAK BROOK, ILLINOIS 60521-2008
(312) 954-2100

FILE NUMBER 627/012/080
DIRECT DIAL 876-3446

March 21, 1986

By Federal Express

The Honorable Marco A. Pignalberi
House of Representatives
State of Alaska
Pouch V
Juneau, Alaska 99811

Re: House Bill No. 620

Dear Representative Pignalberi:

As general counsel for Schwinn Bicycle Company, we are writing to express Schwinn's strong opposition to House Bill 620, "An Act regulating certain dealerships." Schwinn is opposed because the terms "dealer", "dealership", "distributor" and "franchisor" are so broadly defined that virtually every selective distribution or authorized dealer relationship in Alaska would be unnecessarily regulated.

Schwinn does not believe that there is any need or justification for this type of broadly inclusive dealership legislation. If legislation is necessary because of some perceived specific problem, the Bill should be limited to covering the affected relationships.

Your office advised us recently that the proponents of the Bill are a group of "franchise owners". As will be discussed below, franchises are different than selective distribution arrangements and should not be regulated together.

Schwinn urges you to withdraw this bill. Alternatively, Schwinn strongly urges you to amend the "Definitions" section of the Bill to limit its applicability to the true or uniform business format franchise relationship. Some suggested definitional language changes are enclosed for your review.

Background on Schwinn

As your office advised, concerns apparently have been raised by franchisees located in Alaska. It might be helpful for you to understand how Schwinn operates so that you will be able to better understand how its type of distribution operation differs from that of a franchise (e.g., fast food restaurant).

Like hundreds of other manufacturers of quality products, Schwinn sells its brand name and trademarked products only through about 1800 independently-owned authorized sales and service dealers, seven of which are located in Alaska. All of Schwinn's dealers are free to sell other brands of bicycles and non-bicycle items. The dealers do not pay any fee or royalty to Schwinn and are not required to deal exclusively with Schwinn in return for the right to buy bicycles from Schwinn. The Authorized Dealer Agreement is personal and not assignable or transferable by the dealer.

Schwinn's selective distribution program is a simple buy/sell arrangement and has never been considered to be franchising because: the dealer pays no fee to Schwinn; there is no marketing plan; there is no uniform business format; there is no centralized management by Schwinn; Schwinn neither exerts significant control over, nor provides significant assistance in, its dealer's method of operation; and Schwinn dealers are free to sell competing products. As a result, the Federal Trade Commission, the California Department of Corporations, and the Virginia State Corporation Commission have each issued advisory opinions that Schwinn's selective distribution program is not a franchise.

Schwinn's selective distribution program is typical of hundreds of similar buy/sell arrangements in a variety of industries (e.g., refrigerators, stereos, farm equipment, sewing machines, pianos, lawn mowers, computer equipment, etc.). In those arrangements, the dealer only purchases goods at a bona fide wholesale price for his inventory. For examples of the hundreds of types of authorized dealer programs which are similar to Schwinn's, consult any Yellow Pages directory.

Manufacturers who sell through selective distribution typically represent highly regarded manufacturers in particular industries who desire to sell their quality products to reputable dealers who are willing to provide service to the consumer. Granting the use of a trademark in such a manner for merchandising purposes without charging a fee or royalty has never been found to pose an inherent risk of injury or loss to the investing public. The independent businessman who is the dealer in such a

relationship bears the burden of the business risk in operating his own store.

In contrast, franchising is characterized by the payment of an initial franchisee fee and/or continuing royalty, and the franchisor's substantial involvement in the franchisee's method of operation whereby the franchisor provides the franchisee with a marketin plan or system on how to sell the franchisor's products or service to the public. The Federal Trade Commission, when it promulgated its Trade Regulation Rule on Franchising and Business Opportunities Ventures (16 C.F.R. Part 436), concluded that the three distinct conceptual characteristics of franchising, "increased potential for success, loss of independence, and a payment of capital to the franchisor by the franchisee," make entering into a franchise "strikingly similar to the purchase of a security." 43 Fed. Reg. at p. 59699 (Dec. 21, 1978). In making this conclusion, the FTC aptly observed:

> "Perhaps the most important characteristic that distinguishes franchising from conventional producer-dealer/distributor relationships is the premise that the franchisee's association with the franchisor significantly increases his potential for success and reduces the risk of doing business which attends the independent businessman".

Id. at p. 59698

It is because of these significant differences that all disclosure and almost all relationship laws cover only franchise operations.

Coverage and Scope of House Bill 620

The "Definitions" section of House Bill 620 broadly covers all types of distribution relationships, including franchises. Section 45.50.750 defines "dealership" as a business arrangement under which a person receives from the other party the right to (1) purchase and resell a product that is manufactured, distributed or imported by the other party, (2) use the trademark, trade name or commercial symbol of the other party in the sale and resale of the products of the other party, and (3) rely on the other party for continued supply of the products of the other party. A "distributor" is defined as a person, other than the manufacturer, who sells, leases or distributes a product to a dealer. A "franchisor" is defined as a person who grants the rights listed in the "dealership" definition. A "dealer" is

defined as the person who receives the rights listed in the "dealership" definition.

Unlike the franchise laws adopted by other states, House Bill 620 does not include a requirement that the franchisor prescribe a marketing plan or system or that the franchisee pay a franchise fee. As a result of these omissions, this unprecedented definition is so broad that it will regulate not only franchises, but also the myriad of relationships which exist between the hundreds of manufacturers of brand name products and the many more thousands of retailers who are authorized dealers for those products.

In addition, the scope of House Bill 620 is so broad that it would regulate a variety of activities which the courts historically have permitted in distribution relationships where no consideration was paid by a dealer for the right to sell a product line. Courts throughout the country accept the principle that the parties to a distribution relationship can enter into any contractual relationship they wish. House Bill 620 would change existing law as it relates to distribution relationships.

Even worse from a distributer's standpoint, House Bill 620 adopts a statutory approach which has been used by many other states to regulate the dealings between a franchisor and franchisee, where a fee or royalty has been paid. Without justifiable reason, this franchise relationship concept would be applied to selective distribution or authorized dealer programs, where no fee or royalty is involved. As explained above, the situations are not parallel and the reasons, if any, which may exist to justify such restrictions in franchise relationships do not apply to other types of distribution relationships.

<u>There Is No Need to Regulate Selective Distribution</u>

There is no need to regulate simple buy/sell relationships, such as Schwinn's, where the authorized dealer or distributor does not pay any fee or royalty and is free to sell any kind of competitive products and where the seller does not control how the dealer sells the product to the public. Moreover, none of the proposed restrictions in House Bill 620 make sense in a selective distribution context.

For example, Section 45.50.675 would permit succession to dealership by a designated family member. Because the dealer under a selective distribution program does not pay a fee or any other consideration for the grant of his dealership, there is no

justifiable reason to require the company granting the dealership to allow that dealer to transfer it to someone else. In Schwinn's situation, if a Schwinn dealer's relationship with Schwinn ended, the dealer could easily continue in business selling bicycles or any other type of product suitable for that location. There are literally hundreds of other brands of bicycles which could take the place of the Schwinn line. The same kind of deficiencies exist with respect to each of the other restrictions imposed by House Bill 620.

Significantly, the absence of any substantial body of law in other states dealing with such relationships confirms the absence of problems in relationships where no investment is involved. Every state legislature which has considered such broad sweeping distribution relationship legislation since 1974 has rejected the need for such laws. Schwinn is not aware of any special circumstances in Alaska that there have been any abuses by manufacturers who sell through selective distribution type of arrangements which would justify this type of legislation.

If adopted, the House Bill 620 will operate to perpetuate existing dealerships without justifiable cause, thereby insulating ineffective business persons from the usual risks associated with the operation of a business which those business persons should rightfully bear. Restricting the ability of a company to select the dealers to whom it wishes to sell is likely to affect adversely the integrity of that company's selective distribution system. It will also likely have a detrimental effect on the other dealers in the system, thereby adversely affecting the reputation of the company. Because there is a limit to the number of authorized dealerships a company can grant, the proposed act would also restrict the opportunities available for the creation of a wholly new dealership for persons who may be better qualified to operate one. Ultimately, the real losers will be the consuming public who may have to deal with ineffective dealers and probably end up having to pay higher prices for the goods sold by that company.

House Bill 620 is also likely to clog the Alaska courts with litigation. It is also anti-competitive because manufacturers who sell their products through selective distribution systems will find themselves at a competitive disadvantage with those manufacturers who have chosen instead to sell to wholesalers who can then indiscriminately resell those products to any retailer they want.

Schwinn Urges That The Bill Be Withdrawn Or Amended

Schwinn strongly believes that this bill is unnecessary because there have been no demonstrated abuses in the relationships between the hundreds of companies who sell a variety of products through selective distribution and their respective authorized dealers. Schwinn urges you to withdraw House Bill 620.

If you have evidence that there are problems in a particular industry or with a particular type of relationship, Schwinn urges you to amend the Bill to address only that specific problem. If the proponents of this legislation, who we understand are a group of businessmen who are "franchise owners," can prove that there are problems with franchising relationships in Alaska, House Bill 620 should be amended to regulate only those relationships. The fact that the Bill, starting with section 45.50.655 and thereafter, throughout confusingly uses the terms "franchisor" for the seller and "dealership" for the buyer leads us to believe that the bill was not only patterned after a franchise relationship law from some other state but also was intended to regulate only franchise relationships.

If you are going to amend the Bill to limit its coverage to the true or uniform business format franchising area, you would need to delete your definitions of dealership, dealer, distributor and franchisor, and substitute a "franchise" definition containing three elements: trademark identification, a marketing plan or system prescribed by the franchisor, and the payment of a franchise fee.

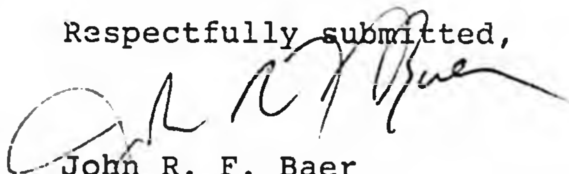
To assist you in making such an amendment, we are enclosing for your use copies of the California Franchise Relations Act. This Act uses the commonly accepted state definition of "franchise" which would regulate only those personsinvolved in a true or uniform business format franchise. You should also include the definition of "franchise fee", which clarifies that the purchase of goods of a bona fide wholesale price is not the payment of a franchise fee. The California Franchise Relations Act definition of "franchise" is used by a large number of other states throughout the country.

* * * * *

KECK, MAHIN & CATE

If you have any questions or if we can be of any further assistance, please feel free to call me.

Respectfully submitted,



John R. F. Baer

cc: House Labor and Commerce Committee
Schwinn Bicycle Company

(689/X)

INTERNATIONAL FRANCHISE ASSOCIATION
STATEMENT IN OPPOSITION TO H.B. 620
APRIL 16, 1986

The International Franchise Association

The International Franchise Association (IFA), a trade association representing more than 600 companies which use franchising as a method of conducting their business, has served as the voice of the franchising community since 1960. We take a special interest in laws and regulations governing business format franchising. IFA and its members strongly oppose H.B. 620.

Franchising's Balance of Interest

Distribution of goods and services through franchising represents a vital segment of Alaska's economy. The most recent figures available from the U.S. Department of Commerce indicate that in 1983 there were over 550 franchised businesses in Alaska. Fully one-third of all retail sales nationwide are made by franchised businesses. Inasmuch as franchising by its nature promotes the establishment of new small businesses and jobs, its health should be of vital concern to members of the Alaska legislature.

The genius of franchising lies in its careful balance of business interests; franchisees remain independent businessmen afforded an opportunity to enter a proven business and enjoy the advantages of being part of a larger system; franchisors build the strength of their trademark and image through growth unavailable by conventional means of expansion and receive royalty income from their franchisees as the system grows.

This balance is struck in the contract signed by both the franchisor and franchisee which sets forth their respective rights and obligations. The terms of these contracts vary from one franchisor to the next according to the design of their franchise systems. Members of the International Franchise Association

range from Hilton Hotels, to Century 21 Real Estate, to McDonald's, to H & R Block, to Western Auto Supply, to Holiday Inns. Each system is unique.

H.B. 620

H.B. 620 would provide for a pervasive and intrusive form of substantive regulation of franchising without regard for the variation among franchisors. The bill would undermine franchisors' ability to tailor franchise agreements according to the needs of their systems.

The bill seriously impairs the ability of ALL franchisors to enforce uniform standards of products and services -- the very essence of franchising.

The bill forbids franchisors from terminating or failing to renew a franchise agreement except for "good cause."

The sweeping definition of "good cause" in the bill injects a complex and unpredictable legal component into those business judgements critical to the vitality of a franchisee system. Decisions regarding termination and non-renewal would trigger a legal minefield.

The Burden on the Courts

Because key provisions of this bill are at once novel, broad, and vague, it will have many unforeseen effects. But the very indefiniteness of its terms makes one impact crystal-clear: Enactment of the bill will spawn a significant new legal speciality, lucrative no doubt to lawyers, but a severe burden on already burdened state courts. Reviewing the bill, one can readily note the question that will bedevil the courts for years; to what extent and under what circumstances is "good cause" for termination or non-renewal the same as or consistent with the breach of substantive contract provision? When and to what extent is it different?

One can be confident that this question, and myriad variations of it, will be litigated over and over. Franchisees would be granted substantial incentives to litigate every termination or non-renewal -- they can obtain damages and injunctive relief. The vaguaries of the bill may well mean that lawyers would be the primary beneficiaries of its implementation.

H.B. 620 is Unnecessary

To justify radical legislative action like this proposal, a showing must be made that there is systematic problem. What public policy need justifies H.B. 620 and the burdens it imposes on franchisors, the courts, and the freedom of contract? The answer is clear -- there is no need, the bill is quite unnecessary.

According to the U.S. Department of Commerce information about termination, non-renewal, and transfer activity in franchising for the year 1984:

- Of the 15,354 franchise agreements up for renewal, 90 percent were renewed; of those not renewed, 63 percent were at the initiative of the franchisee or by mutual consent.
- Of the 357,335 franchisee-owned outlets, only 6,615 -- or 1.8 percent -- were terminated. A clear majority of those contracts terminated -- 60 percent -- were at the initiative of the franchisee or by mutual consent.

H.B. 620 is Anti-Consumer

The cornerstone of franchising's success is the maintenance of a specified consistent level of quality in the delivery of the franchised product or service by all franchisees. The reputation of each franchisee with the consuming public is directly affected by the perceived level of quality of operations of each and every other franchisee. A consistent level of quality is clearly in the consumer's interest.

The franchisor must have the authority to demand and maintain this consistent level of quality throughout its franchised system and in each and every franchised outlet, as well as the authority to remove in a timely manner from its franchised system any franchisee that does not maintain minimum quality standards as called for and agreed to in the franchise contract. H.B. 620 would prohibit franchisors from terminating substandard franchises without a three-month notice period exposing the public to substandard conditions and service in the interim.

Franchisees are Protected by Existing Law

Franchisees are already afforded protection through extensive pre-sale disclosure requirements. Under the Federal Trade Commission Trade Regulation Rule on Franchising, franchisors must deliver a disclosure document at least 10 days prior to the execution of the contract. The disclosure document must include, among other things, information relating to the obligation of the parties upon termination or non-renewal of the franchise and the numbers of any terminations and non-renewals which have occurred in the system.

Business Format Franchises v. Dealerships

It is important to note the distinct differences between business format franchisors, such as the companies represented by IFA, and dealership product distribution arrangements. One key difference is that the typical franchise agreement has a duration of 15-20 years while most dealerships are fairly short term arrangements. Attached is a chart which compares and contrasts the two distinctly different arrangements, both of which are covered by H.B. 620.

Conclusion

Passage of H.B. 620 would interfere with franchisors' ability to enforce their agreement and be destructive to all franchise systems now operating in Alaska. Franchisors able to expand by establishing vertical integrated, company-owned stores would be likely to do so in order to avoid the interference and inflexibility of H.B. 620. Other franchisors deterred from franchising would choose not to offer new franchise opportunities to Alaska citizens. For these reasons, the International Franchise Association urges members of the Labor and Commerce Committee to reject H.B. 620.

COMPARISON OF BUSINESS FORMAT FRANCHISES AND DEALERSHIPS

Business Format Franchises	Dealerships
* Payment of fee for right to use franchisor's trade and service marks.	* Pays for products at wholesale and resells at retail.
* Franchisor provides comprehensive, on-going marketing and operational assistance.	* Marketing assistance limited to basic information regarding product, warranty procedures and advertising materials.
* Franchisee contracts with single franchisor.	* Product may be one of many sold by dealer.
* Franchisor creates format for the franchisee's sale of products and/or services. Franchisor generally not the manufacturer of products.	* Dealership is designed primarily or exclusively to sell products made by manufacturer; substitute products may not be marketed under manufacturer's name.
* Franchisor's profit derived primarily from royalties based upon gross sales of franchisee.	* Manufacturer's profit derived exclusively from products it sells to dealer. No royalty involved.
* Requires some form of franchise fee, other than from sales of products at a bona fide wholesale price within six months of commencing operation.	* Only payments made to manufacturer or its affiliates within first six months of establishment of business are for inventory purchased at a bona fide wholesale price.
* Disclosures and written contracts identify all material aspects of arrangement, including termination, nonrenewal, transfer, purchase of obligations, litigation history - before relationship commences.	* May not have written contract. No obligation to explain terms, conditions and company history.

Herb Heller

SUGGESTED AMENDMENT TO H.B. 620

Sec. 45.50.740 EXEMPTION. AS 45.50.650 - 45.50 760 do not apply to a lease covered by AS 45.50.800 - 45.50 850. or to franchises covered by the Federal Trade Commission Trade Regulation Rule entitled Disclosure Requirements and Prohibitions Concerning Franchising and Business Opportunity Ventures, 16 C.F.R. 436.1 et. seq.

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(g) To sell or offer to sell any new motor vehicle to any franchised motor vehicle dealer at a lower actual price therefor than the actual price offered to any other franchised motor vehicle dealer for the same model vehicle similarly equipped or to utilize any device including, but not limited to, sales promotion plans or programs which result in such lesser actual price. Provided, however, the provisions of this paragraph shall not apply to sales to a franchised motor vehicle dealer for: (i) resale to any unit of government; or (ii) donation or use by said dealer in a driver education program. This paragraph shall not be construed to prevent the offering of incentive programs or other discounts if such discounts are available to all franchised motor vehicle dealers in this state on a proportionately equal basis.

(h) To sell or offer to sell any new motor vehicle to any person, except a distributor, at a lower actual price therefor than the actual price offered and charged to a franchised motor vehicle dealer for the same model vehicle similarly equipped or to utilize any device which results in such lesser actual price.

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM February 19, 1986

SUBJECT: Sectional analysis of HB 620

TO: Representative Marco Pignalberi

FROM: Theresa L. Bannister
Legislative Counsel

This memo contains the sectional analysis that you requested for HB 620.

Section 1 presents the findings and purpose of the bill.

Section 2 contains the main provisions of the bill.

Sec. 45.50.650 establishes the criteria and procedures for the establishment or relocation of a dealership.

Sec. 45.50.655 allows a franchisor under certain conditions to condition the renewal or extension of a dealership on the dealer substantially renovating the place of business of the dealership or constructing, purchasing, acquiring or leasing a new place of business for the dealership.

Sec. 45.50.660 allows a franchisor to terminate, refuse to renew or fail to renew a dealership for good cause if the franchisor satisfies certain notification requirements.

Sec. 45.50.665 provides for the continuation of the operation of existing dealerships under a newly appointed distributor if the existing distributor is terminated, unless the new distributor and a dealer agree otherwise.

Sec. 45.50.670 establishes the compensation to be paid by the franchisor to a terminated or nonrenewed dealer, whether the termination or nonrenewal is for good cause or without good cause. Requires a dealer to take reasonable steps to mitigate the damages arising from termination or nonrenewal without good cause. Provides that franchisor does not have

to provide the required compensation if the dealer acted illegally or fraudulently in the procurement or operation of the dealership.

Sec. 45.50.675 establishes the procedures and rights involved for a dealer to designate a family member to take over the dealership at the death or incapacity of the dealer.

Sec. 45.50.680 prohibits the franchisor, or the manufacturer, distributor, subsidiary or agent of the franchisor, from engaging in the listed trade practices.

Sec. 45.50.685 prohibits a franchisor, or the manufacturer or distributor of the franchisor, from requiring a dealer to act as its agent in certain situations.

Sec. 45.50.690 prohibits the franchisor, or the manufacturer or distributor of the franchisor, from requiring a dealer to sell, assign, or transfer sales installment contracts to finance companies specified by the franchisor.

Sec. 45.50.695 establishes the procedures and rights of a franchisor, or the manufacturer or distributor of the franchisor, and a dealer for compensating the dealer for labor, parts, and other expenses incurred by the dealer to comply with the warranty agreements of the franchisor, manufacturer, or distributor.

Sec. 45.50.700 establishes the remedy for a person who is injured by a violation of the provisions of section 2 of the bill.

Sec. 45.50.705 a civil action allowed under Sec. 45.50.700 must be brought by the injured party within four years after discovering the violation.

Sec. 45.50.730 prohibits a person from waiving the provisions of section 2 of the bill.

Sec. 45.50.740 exempts a lease under the Alaska Gasoline Products Leasing Act from the coverage of section 2 of the bill.

Sec. 45.50.750 defines the terms used in section 2 of the bill.