ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672

9316 HOUSE LABOR & COMMERCE

in the abstract, but in the light of what we know and intuit about ourselves and our institutions. Can we be sure that freedom rather than coercion, and compassion rather than socioeconomic motives, would drive the writing of legal prescriptions for death?

Is there a right to suicide?

Today's debate over physician-assisted suicide grows out of the right-to-die movement. With the coming of age of intensive-care medicine in the 1960s and 1970s, caregivers and the public became alarmed over the plight of some patients who were being kept alive by the new techniques. Some of these patients had no hope of ever leaving their hospital beds and wished to die. But the moral tenets of medicine, as traditionally understood by many physicians, forbade disconnecting ventilators and feeding tubes.

With a growing number of individuals tethered indefinitely to pumps and monitors in intensive-care netherworlds, patient advocates and ethicists argued that patient autonomy is a primary ethical principle in medical decision making. After intense professional and public debate, a consensus emerged that a patient's normal right of self-determination entails a right to refuse medical treatment or demand that it be stopped—even if death is a sure result.

To proponents of assisted suicide, self-determination logically extends to taking one's life. "We all agree that it's all right to take the patient off the ventilator," says Peter Ubell, MD, an internist and bioethicist at the University of Pennsylvania School of Medicine. "But sometimes it's going to take 48 hours of slow, miserable respiratory failure before the patient dies. How many times have I been asked, 'Is that really humane? If we know the patient is going to die in the next couple of days, why don't we help them?'"

From another perspective, however, suicide and refusal of treatment differ with respect to the issue of patient autonomy. The right to refuse treatment is important in large part because it enables patients to protect themselves from unwanted medicine. The catalyst for establishing this right was the sight of unlucky patients sentenced to semiperpetual dependency on machines. In some of the worst instances, individuals were allegedly preserved so that medical students could practice venipuncture and other techniques upon living human bodies.

While the ability to refuse treatment transfers power to patients, legalizing assisted suicide will give the system more power.

Thus, asserting the ability to refuse treatment transferred power from the medical system to patients. In contrast, legalizing physician-assisted suicide will give the system more power.

In a similar vein, some advocates of assisted suicide point to the use of opiates to abolish pain even when the necessary doses are high enough to hasten the patient's demise. What ethically substantive difference can be drawn between this common practice and that of assisted suicide? they ask.

This argument applies forcefully to cases in which a terminally ill patient wishes to die because of uncontrollable pain. It may not be as relevant when psychic distress is the motivation, since psychotherapeutic drugs reach peak effectiveness in doses that fall far short of lethality.

These two issues—of patient autonomy, and of whether there is a meaningful difference between certain existing end-of-life interventions and helping a patient commit suicide—were the crux of the arguments before the Supreme Court. The Justices and the litigators also explored the ways in which assisted suicide might fit in with our institutions and system of incentives.

The physician's role

"Part of the continuum of care is to relieve suffering, be it by palliative care, helping a patient who refuses treatment or nutrition or hydration, or providing a patient with something to end his or her life," says Faye Girsh, executive director of the Hemlock Society.

"To ask physicians to assist in suicide fundamentally contradicts our role as healers," counters Thomas Reardon, MD, chair of the American Medical Association (AMA) Task Force on Quality of Care at the End of Life: "We have been opposed to this since the time of Hippocrates."

Mainstream caregivers' organizations have nearly all come out against legal physician-assisted suicide. Along with the AMA, the American Neurological, Psychiatric, and Nursing associations, several hospice associations and approximately 45 other groups jointly filed an amicus curiae brief to present to the Supreme Court with their arguments against legalization.

The American College of Physicians pronounced facilitating suicide unethical, then shifted to a neutral position in order to avoid prematurely polarizing or stifling debate. The College is now readying a third edition of its Ethics Manual, in which it will probably renew its opposition.

In contrast to this organizational unanimity, individual caregivers split sharply over helping terminally ill patients take their lives. In a recent nationwide poll of oncologists, 51 percent said they had received requests to make a suicide possible or

easier, and about a quarter of these stated that they had complied at least once. In a sample of Washington State physicians in all specialties, some 15 percent reported being asked to help someone die, and about 20 percent of these had done so. A survey of critical care nurses disclosed a small but significant involvement in euthanasia and assisted suicide.

Given these figures, proponents of legal assisted suicide maintain that caregivers' organizations are out of step with their memberships. That may be true, but there is more to the explanation.

A physician who is willing to facilitate a suicide still may not wish to see the laws changed. As things stand, physicians and patients can discuss values and options within the intimacy and shelter of their unique relationships. Although helping to arrange a suicide is forbidden, and caregivers who defy the law run some real risk of malpractice and wrongful death charges, no physician has ever been strongly sanctioned for doing so.

Legalization would bring with it limitations on which patients can be helped and under what circumstances. Well-meaning statutes designed to protect patients might prohibit action in some cases where compassion and the patient's wishes are compelling. Why risk such complications?

The reason, Girsh responds, is that unenforced laws create an ambiguous zone where communication is inhibited. Nurses have complained that some physicians may give a signal to administer a lethal overdose, but be unwilling to document the order. Clearly, communication that seeks to be undocumentable can be susceptible to tragic misinterpretations.

Further, some patients are afraid to broach the subject of suicide, and some who do may run into barriers of wariness and misunderstanding. Girsh says, "Many patients have told us their doctor said, 'Don't worry, I'll take care of it.' They thought this meant they would have help, but when the time came, the doctor said, 'No, that's against the law.'"

In such cases, the patient can end up dying in precisely the conditions he or she has most desperately feared. Or worse. Alexandra Beckett, MD, a psychiatrist and director of HIV psychiatric services at Boston's Beth Israel Hospital, says, "A number of providers I know have been close to cases where someone tried to commit suicide with the help of a nonphysician, was unsuccessful, and ended up hospitalized or more severely impaired." Although Beckett personally rejects legal assisted suicide and has never knowingly abetted a suicide attempt, she notes, "People ask themselves, 'If someone chooses to take control of their circumstances by dying this way, don't physicians have an obligation to protect them from disaster?'"

The money motive

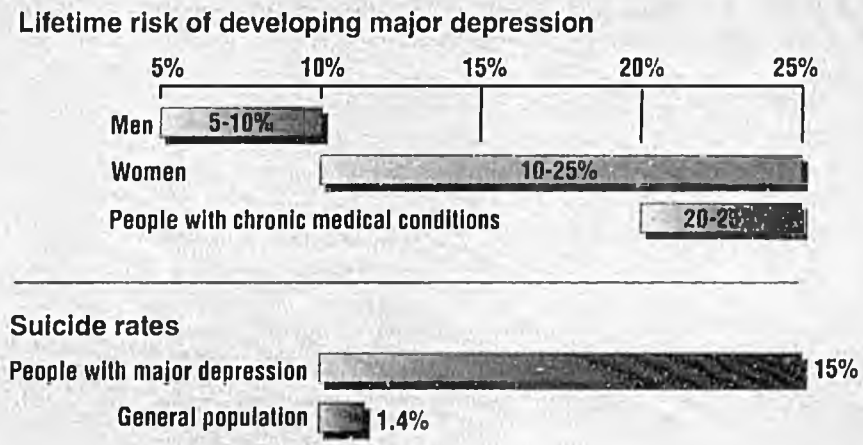
Current laws force physicians and patients who consider collaborating in a suicide to do so privately, even furtively. Negative consequences ensue, but so does a degree of protection. Should legalization occur, many people conjure bleak visions of ways that powerful socioeconomic forces might influence these life-and-death deliberations.

Public and private entities alike are preoccupied with spending less on health care. According to studies, the 5 percent of the population who will die within one year incur some 30 percent of all medical expenses.

Intuitively, if a significant number of these people were to die sooner, perhaps before receiving the most costly end-of-life treatments, the nation's bottom line might improve. Some people ask whether public or

A troubling implication

Not surprisingly, people with chronic medical conditions have a higher risk of developing major depression—an illness with a suicide rate nearly 11 times that of the general population. Such statistics suggest a troubling question about physician-assisted suicide: Is a terminally ill patient with depression in a sufficiently sound state of mind to make such a choice?



Source: *Diagnostic and Statistical Manual—IV* and National Institute of Mental Health.

private policy makers might be tempted to create suicide incentives for caregivers, patients and families.

In fact, intuition is misleading in this case. A careful economic analysis published in *The New England Journal of Medicine* in 1994 indicated that little money would be saved by reducing care at the end of life. Primary author Ezekiel Emanuel, a Boston-based oncologist, explained that this is partly because more than half of such expenditures pay for heroic but futile treatments for young people with traumatic injuries. This population will never include a significant number of candidates for physician-assisted suicide.

Although physician-assisted suicide will not affect overall medical expenditures, individual insurance or provider organizations might conceivably save money if suicide rates were to rise among high-resource-using clientele. Ubell contends that even on the debatable assumption that corporate conscience were swayed by such considerations, "Managed care companies are going to look elsewhere for savings. The end-of-life setting is highly visible and emotional, and companies couldn't get worse publicity than by encouraging physicians to kill off their patients."

Another physician, however, who has extensive experience with managed care, sees a role for creative marketing: "The companies would present the option of assisted suicide as an extra benefit, something good. Rather than overtly pressuring people to choose this service, they might simply narrow the alternatives. Patients would find, for instance, that their contract no longer allowed a third round of chemotherapy."

Fifty or a hundred thousand dollars may make only a moderate difference in a corporation's bottom line, but it is likely to have a momentous effect on a family's resources. Karen Kaplan, Executive Director of Choice in Dying, an educational organization that has filed a neutral amicus curiae brief with the Supreme Court, envisions a troubling scene: A terminally ill patient overhears her children in the corridor saying, "Well, if Mom stays alive much longer, there won't be any money left to send Junior to college." According to Marc Berk, director of the Project Hope Center for Health Affairs, catastrophic health insurance would obviate such pressures, but those proposals lie cradled in the congressional deep with many other aspects of health reform.

Whether or not they are concerned with being a financial liability, observes Daniel Callahan, former director of the Hastings Center for Ethics, people with serious illness typically feel that they are a burden. "A worst-case scenario," says Callahan, "is that some people would feel that it was almost their duty to choose suicide to relieve the family."

In fact, surveys have found that more people request a physician's help in dying because of "feeling like a burden" than to escape severe pain. Ironically, Callahan notes, other studies indicate that when patients feel that they are burdens, their families often do not feel burdened at all.

Life's sticks and death's carrots

If suicide becomes a response to economic and social pressures, say opponents of legalization, social stigmatization could amplify the effect in members of devalued subgroups.

A case in point: In the Netherlands, 25 percentage of the people who receive legal euthanasia or assisted suicide have AIDS. This is an outsized portion, considering that people with AIDS account for only a small percentage of total deaths in that country. It suggests that the feelings of shame and rejection associated with this disease may help precipitate many individuals' decisions to preempt natural death.

Even physicians may—unwillingly or unwittingly—reinforce patients' socially instilled feelings of worthlessness. Suppose, for example, that a physician does not understand what enriches life for a person who is poor, elderly or otherwise different. He or she might then introduce the option of suicide sooner or more positively.

Legal assisted suicide would automatically become a medical service that can be sold like any other—hence, an opportunity for entrepreneurship. It requires no special imagination to conjure stacks of brochures on hospital bedside tables, next to Gideon's Bibles, extolling the ease and virtue of a particular way out. One can imagine burgeoning "thanatopic medicine" practices, with specialists offering a spectrum of scientifically tested, foolproof and esthetic self-administered lethal interventions.

Proponents of legal physician-assisted suicide doubt that worries about such eventualities are realistic. There have been few documented complaints, Girsh notes, about ventilator-dependent patients being coerced or inveigled into asking for termination. Should assisted suicide become legal, says Thomas Delbanco, director of general and primary care medicine at Beth Israel Hospital, Boston: "It will be like everything else. Ninety-nine percent of physicians will be conscientious, and a few will abuse it."

Strict libertarians argue that concerns about "undue influences" are not even relevant. They hold that everyone has a perfect right to end his or her life to save money for the next generation, or because they feel ashamed of the way they have behaved, or for any reason whatever. To question anyone's motives is to constrain the very autonomy that is the basis for ethical doctor-patient relationships.

Moreover, to say that terminally ill patients should not take anyone else's interests but their own into account when considering their course of action is to deny them the right to act upon social and altruistic impulses that are vital components of humanity.

What will the court decide?

The Supreme Court is expected to publish its ruling on physician-assisted suicide early this summer. The Court's specific business is to review two lower court decisions that held that individuals have a constitutional right to physician-assisted suicide.

In the case brought by Quill et al., the 9th District Court of Appeals started from the premise that a physician who turns off life support for a terminally ill patient helps that patient die. This being so, the court said that a law denying assistance in dying to terminally ill patients who are not dependent on machines violates the 14th amendment principle of equal rights. In the second case, the 2nd District Court of Appeals held that taking one's own life is an "intimate personal decision," and so immune from governmental interference.

Kathryn Tucker, JD, is one of the team of lawyers who presented arguments in favor of physician-assisted suicide. Interviewed in December, Tucker was optimistic that the Justices would favor her position, saying, "I think this is a Court that will be able to protect an individual choice of this nature."

In support of her optimism, she cited the 1990 case of Cruzan v. Director, Missouri Department of Health. There, the Court ruled that the family of a comatose patient could order her ventilator removed based on their knowledge that she would have preferred dying to living in a vegetative state. Implicitly, Tucker interpreted, "The Court recognized the profoundly personal nature of end-of-life decisions."

Tucker also asserted a second line of precedent: "In its decisions surrounding reproductive freedom, the Court has recognized that personal decisions about your health care, your body and the future course of your life are reserved for the individual."

In the January hearing, however, Justices Antonin Scalia and Ruth Bader Ginsburg differed on the worthiness of the reasoning of the 9th Circuit Appeals Court. Scalia said flatly, "Declining medical treatment is quite different from committing suicide," and noted that the common law tradition has countenanced the second but not the first. Justice Ginsburg asked rhetorically how a physician's withdrawing food and water is "rationally distinguishable" from physician-assisted suicide.

> *"I'm not aware of any doctor being convicted of this . . .and I can't believe it's not happening," said Justice Stevens.*

Opponents' arguments did not pass unchallenged, either. In response to an assertion that physician-assisted suicide would blur the line between physicians as healers and as instruments of death, Justice John Paul Stevens remarked, "Is the real practice as bright a line? I'm not aware of any doctor being convicted of this offense [helping with suicide] . . . and I can't believe it's not happening."

Observers of the issue and the Court generally concur that a ruling in favor of a constitutional right is unlikely. Along with Justice Scalia, Justice Anthony M. Kennedy seemed less than eager to tamper with the traditional legal status of suicide, pointedly noting to proponents, "You're . . . asking us to declare unconstitutional the laws of 50 states." Justice Ginsburg also asked, "Is this ever a proper question for courts, as opposed to legislatures, to decide?" In addition, Justice David Souter expressed misgivings that legal assisted suicide for terminally ill patients might eventually "gravitate down to those who are not terminally ill . . . [and] into euthanasia."

After the ruling

The Supreme Court's decision will not end the debate over assisted suicide. If the Court describes a constitutional right, then every state will need to draft legislation to regulate the circumstances under which people can exercise the right and protocols for helping them die. If the Court rejects a constitutional right to assisted suicide, states would still be allowed to pass laws permitting or forbidding the practice. Currently, lawmakers in Massachusetts, Michigan and New York are considering permissive bills, while the legislatures in Michigan and Rhode Island are deliberating sanctions.

Two years ago, voters in Oregon, a state that has set the pace for the nation on several sweeping issues of medical policy, approved a referendum allowing physician-assisted suicide. As safeguards against precipitate

acts and abuse, the law specifies that a patient must be terminally ill to be eligible for assistance in dying. He or she must request assistance twice, once in writing. In addition to the attending physician, a second doctor must confirm the diagnosis and prognosis and certify that the patient does not seem to be suffering from clinical depression or other psychiatric illness. A 15-day waiting period is required between the second suicide request and the act.

Legal challenges have so far prevented implementation of the Oregon Death With Dignity Act. Critics contend that its supposed safeguards could easily become merely routine protocols for physicians running "suicide mills."

Lois Snyder, JD, a lawyer with the American College of Physicians (ACP), finds fault with the eligibility requirements, too. She points out that one reason why people are interested in suicide is fear of Alzheimer's disease. Yet Alzheimer's abolishes competence long before it becomes terminal (in the accepted sense of leading to death within six months). Therefore, under the Oregon rules, people who develop it would never be eligible for a physician's help in dying. "This raises constitutional issues," Snyder says. "The ACP, like many medical organizations, has argued that patients who become incompetent should retain the right to have a surrogate speak for them in right-to-die situations."

If the Oregon law's requirements are inadequate, can effective safeguards ever be generated for physician-assisted suicide? Callahan thinks not: "The practice is inherently unregulatable because of physician-patient confidentiality. If neither wants to tell, no one will ever know what happens."

Callahan also predicts that physician-assisted suicide, if approved, will not be the end of the line in death-dealing interventions. If logic leads from withdrawal of treatment to putting lethal drugs into a suicidal patient's hand, how can it not continue on to injecting those drugs into terminally ill individuals who ask for them and cannot self-administer them—say, patients with motor disabilities? Then people might ask, if euthanasia is a right, why shouldn't somebody—terminally ill or not—be able to ask for it just because they don't like their life?

Life and death in the balance

The number of people who truly wish to preempt their natural demise is presumably small. Specialists in pain control say that health care workers can reduce this number considerably further by becoming more adept at recognizing and treating pain and depression. Yet most specialists also acknowledge that even the best pain control interventions still cannot extricate certain patients from physical distress so intense and encompassing that they would rather die than bear it any longer.

Similarly, depression is widely considered to be one of the most underdiagnosed of all medical problems as well as a contributor to many suicides. More physician attention to signs of depression, particularly among the terminally ill, can lower this burden and prevent many suicides. But there will remain a small population of individuals who are not depressed and wish to end their lives because illness is preventing them from carrying on with most or all of the activities that have sustained their attachment to life.

Faced with the plight of such patients, advocates of legal physician-assisted suicide invoke principles of compassion and liberty. Opponents fear a sacred breach with the principle of reverence for life and describe forebodings of lethal chaos.

Imagine the two positions placed in a balance scale. The advocates' pan holds the ethical principle of autonomy—our right to do what we wish with our own lives, consistent with our personal values, free of undue restraints. The thesis naturally ensues that if we decide our lives are not worth living, we should be able to end them and have help in doing so.

This pan also contains Quill's example of what might be for advocates an ideal and for opponents a least objectionable instance of assisted suicide. Quill had been Diane's physician for eight years and knew her personality and values well when he helped her die. Moreover, Quill is a general internist with training in psychiatry as well as experience in hospice care. In addition to his compassion and thoughtfulness, he was competent to determine that Diane's illness was terminal, that the possibilities she feared were real and that she was not clinically depressed when she asked to die.

In the pan opposing physician-assisted suicide lies the fear that legalization will pit the patient's will to live against social and economic interests that are indifferent to his or her best interests.

Emanuel notes that today's debate recapitulates one that occurred in the 1890s up to the 1930s. "That was the Gilded Age—Social Darwinism, Standard Oil, railroad trusts, celebrating big business, busting unions, limited government intervention. That is the kind of social milieu in which calls like this can find fertile ground. It is a time that closely parallels ours. The point is that this movement is not born out of the best, the most compassionate aspect, of America."

Finally, the opponent's pan holds the example of Kevorkian, who has helped more than 40 people die since 1988. Kevorkian is a retired pathologist who has little experience treating patients and never met any of the patients he helped die before the consultations that led to their suicides. Some of these patients did not have a terminal diagnosis. One did not have any definite diagnosis.

Kevorkian's energy, efficiency and magnetism for publicity exacerbate unease about his motives. To some people, he seems obsessed with death. Soon to undergo a trial in Michigan, he has promised to starve himself to death if imprisoned.

David Anderson is a medical writer and public health consultant residing in Belmont, Mass.

Editor
RICHARD SERVICE

Senior Editor
EMIL VERNAREC

Managing Editor
HELEN LIPPMAN

Associate Editor
JANET GEMIGNANI

Editorial Assistant
LISA SCHIFF

Project Manager
TILGHMAN H. WAESCHE

Art Director
CHRISTIE WILSON

Graphic Associate
DIANE P. SMITH

Illustrator
JAMES ENDICOTT

Manager/Commercial Printing
ANNA MARIA RICCIO

Production Manager
JAMES DUDGEON

Circulation Manager
CHRISTINE SHAPPELL

Senior Research Analyst
STEVEN PFOHL

Senior Vice President & Group Publisher
LEE MANISCALCO

Publisher
JAMES R. PANTALEO

Account Managers
RICHARD DEVANNA
TOM LANGAN
STEVE SVEC

The State of Health Care in America 1997 is published by *Business & Health*, Five Paragon Drive, Montvale, N.J. 07645-1742

For additional copies, write to:
Business & Health
Special Reports,
Five Paragon Drive,
Montvale, N.J. 07645-1742
or call 800-432-4570.

We appreciate your comments.

Business & Health VOL. 15, NO. 5, SUPPLEMENT A.

Brought to you as a professional service by

Hoechst Marion Roussel

Provider of:

allegra™
fexofenadine HCl

Amaryl®
glimepiride TABLETS

CARAFATE®
(sucralfate)
SUSPENSION

CARDIZEM® CD
(diltiazem HCl)

CARDIZEM® Injectable
(diltiazem HCl)

CARDIZEM®
[diltiazem HCl]
Lyo-Ject®

CLAFORAN®
(cefotaxime sodium)*

Nilandron™
(nilutamide)

PENTASA®
(mesalamine)
controlled-release capsules

Trental®
(pentoxifylline)

Hoechst Marion Roussel

Hoechst Marion Roussel, Inc. • Kansas City, MO 64134
A member of the Hoechst Group

Hoechst

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

The State Factor

Volume 23, Number 3 March 1997

COMPLYING WITH KASSEBAUM-KENNEDY

Better Options for the States

By Peter J. Ferrara

Health and Human Services Task Force

910 17th Street N.W. ■ Fifth Floor ■ Washington, D.C. 20006
(202) 466-3800 ■ FAX (202) 466-3801

About the Author

Peter J. Ferrara *is general counsel and chief economist at Americans for Tax Reform. He has also been a senior fellow at the National Center for Policy Analysis, the Heritage Foundation and the Cato Institute. Ferrara served in the Justice Department from 1992-93 as a policy advisor to the attorney general and was counsel at the Washington, D.C., law firm of Shaw, Pittman, Potts & Trowbridge from 1983-1992. He has also taught law, worked in the Reagan White House and in the Department of Housing and Urban Development. Ferrara is a graduate of Harvard College and Harvard Law School.*

American Legislative Exchange Council

Bringing the States and the Nation Together

The American Legislative Exchange Council (ALEC) was founded in 1973 by a small group of Democratic and Republican state legislators who shared a common commitment to the Jeffersonian principles of individual liberty, limited government and free markets.

Today, ALEC has grown to become the nation's largest bipartisan, individual membership organization of state legislators, with nearly 3,000 members throughout the 50 states, Puerto Rico and Guam. Nearly one-third of ALEC's members hold leadership positions in their legislatures.

ALEC brings the states and the nation together through conferences, seminars, publications and its nine National Task Forces. Each provides a unique vehicle for legislators to communicate across state lines, share experiences and ideas, and work in unison with the private sector to create effective public policies.

ALEC's goal is to ensure that our legislative members are fully armed with the information, research and ideas they need to win in the legislative arena. Our publications keep members up to date on emerging trends and provide in-depth analyses of issues at the state level. Our conferences and meetings promote colleague-to-colleague communication by linking like-minded legislators together. Our National Task Forces provide a forum in which legislators and the private sector discuss issues, develop policies and write model legislation.

Unlike other state legislative organizations, ALEC's credo is that business should be an ally, not an adversary, of state legislators. ALEC provides the private sector with an unparalleled opportunity to have their voices heard, their perspectives appreciated, and their interests put before the nearly 3,000 pro-free enterprise state legislators of ALEC. Through ALEC, legislators and the private sector work in a dynamic partnership to develop public policies that harness the immense power of free markets and free enterprise to encourage economic growth, increase the nation's competitiveness, and improve the quality of life for all Americans.

The State Factor: Complying with Kassebaum-Kennedy: Better Options for the States
Volume 23, Number 3

American Legislative Exchange Council
910 17th Street, N.W.
Fifth Floor
Washington, D.C. 20006

(202) 466-3800

Publications Order Code: 9703 Cost to non-members: $10.00 plus $1 per copy shipping and handling

The State Factor: Complying with Kassebaum-Kennedy: Better Options for the States, has been published by the American Legislative Exchange Council (ALEC) Health and Human Services Task Force as part of its mission to discuss, develop and disseminate public policies which expand free markets, promote economic growth, limit government and preserve individual liberty. ALEC is the nation's largest bipartisan, voluntary membership organization of state legislators, with nearly 3,000 members across the nation. ALEC is governed by a 21-member Board of Directors of state legislators, which is advised by a 23-member Private Enterprise Board representing major corporate and foundation sponsors.

ALEC is classified by the Internal Revenue Service as a 501(c)(3) non-profit public policy and educational organization. Individuals, philanthropic foundations, corporations, companies, or associations are eligible to support ALEC's work through tax-deductible gifts. Nothing written herein is to be construed as necessarily reflecting the view of the American Legislative Exchange Council, its Board of Directors, or its membership, or as an attempt to aid or hinder the passage of any bill before the Congress or in state legislatures.

COMPLYING WITH KENNEDY-KASSEBAUM

Better Options for the States

INTRODUCTION

Last year, Congress enacted the *Health Insurance Portability and Accountability Act* of 1996, known as *Kassebaum-Kennedy*, after its two prime Senate sponsors, Senators Edward Kennedy (D-Mass.) and (retired) Nancy Kassebaum (R-Kan.) The bill imposed wide-ranging federal regulatory requirements on health insurance, in large measure displacing the previously predominant role of the states in regulating health insurance. The federal requirements seek to expand the availability and portability of health insurance, and ultimately reduce the number of uninsured. However, some shortsighted provisions of the legislation are likely to prove quite counterproductive in achieving these goals.

In particular, the bill includes "guaranteed issue" provisions that force insurers to accept all applicants in certain circumstances, regardless of health condition. Congress sought to circumscribe the applicability of these guaranteed issue provisions to avoid potential negative effects. Nevertheless, where these provisions apply they are still likely to prove quite destructive, sharply raising costs, reducing access to health coverage as insurers leave the market, and increasing the number of uninsured.

However, in recognition of these potential problems, Congress included a provision that allows states to adopt alternatives to the potentially most damaging guaranteed issue provisions in the bill. If a state adopts one or more of these alternatives, guaranteed issue for the individual insurance market would not apply within that state (though it would continue to apply in the small group market). These alternatives include state risk pools for the uninsurable, the right to convert group coverage into individual coverage, a subsidized insurer of last resort, and others. These alternatives would achieve the goals of the guaranteed issue provisions, but without the destructive and counterproductive effects noted above. Moreover, enacting one of these alternatives would allow the states to retain more of their traditional control over the regulation of health insurance.

The best of these alternative options for states is likely to be risk pools for the uninsurable. These pools are the simplest and most direct way to achieve the goals of the federal legislation, and would probably win the necessary federal approval the most easily.

This report will first describe the enacted *Kassebaum-Kennedy* provisions. It will then discuss the negative effects that are likely to result from the guaranteed issue provisions of the bill. The report will then discuss the better alternatives that states can and should adopt, including, in particular, state risk pools.

THE *KASSEBAUM-KENNEDY* BILL

GROUP MARKET REGULATIONS

The following provisions apply to all insurance sold to employers:

Guaranteed Renewability. The legislation provides for guaranteed renewability of all employer group health insurance. This means that insurers cannot cancel or refuse to renew coverage because one or more of the covered employees or their dependents gets sick. Insurers can only cancel coverage for such events as nonpayment of premiums or fraud in providing insurance information.

Apart from whether this requirement should have been left to the states rather than imposed at the federal level, substantively it is well justified. If insurers can cancel or refuse to renew coverage once the insured gets sick, then they are not providing actual insurance against health risk. The insured would be uncovered for any expensive long-term illness, such as cancer or AIDS. The product insurers are selling would then be of little value. It would be like fire insurance that could be canceled once the house caught fire.

While it is true that insurance with guaranteed renewability costs more than insurance without guaranteed renewability, it is also true that cars with engines in them cost more than cars without engines. But just as consumers buy cars to drive

them, not to build their own engines, they buy health insurance for protection against high health costs due to serious illness, which they wouldn't have without guaranteed renewability. There is no sense in insisting that consumers be free to buy dysfunctional insurance, which almost surely is not what they thought they were buying, especially when this will only undermine consumer confidence in the workability of the private market and increase support for ultimately disastrous total government control.

Group-to Group Portability and Non-Discrimination. The legislation provides as well for group-to-group portability. That means that when a worker leaves a job with health coverage and goes to another, the health plan of the new employer must accept the worker as well.

Indeed, the legislation goes beyond that and provides for nondiscrimination in group health plans. That means an employer's health plan cannot exclude any employee due to health status or medical condition. As a result, even new employees that did not have prior health coverage at their old job must be covered by the new employer's health plan, if the employer has a health plan. Moreover, the new employee cannot be charged any higher premiums or provided any less in benefits than other employees.

Apart again from whether such regulation should be adopted at the federal or state level, substantively no one thinks these provisions will cause any serious harm. People would be receiving the new coverage under these provisions only as a result of employment changes, not as a matter of choice due to health condition. So the opportunity for any gaming or adverse selection is minimal. Moreover, those receiving the new coverage must by healthy enough to be employable, so the danger of imposing catastrophic health costs on the new health plan is not great.

Limitation on Exclusion of Preexisting Conditions. Under *Kassebaum-Kennedy*, new employees covered under an employer's plan can be subject to exclusion of coverage for a preexisting condition if they did not have health coverage before taking the new job. A preexisting condition is a health problem for which medical advice, diagnosis, care or treatment was received within the prior six months. For those without prior insurance, coverage for that condition can be excluded under the new employer's plan for up to 12 months (18 months if the new employee enrolled late after an initial sign up period).

However, the maximum exclusion period for the condition is reduced by the time period the worker did have prior health coverage. So, if a worker was covered by health insurance over the prior 12 months (with no break in coverage of more than 63 days,), then no exclusion of coverage for a preexisting condition can be imposed.

The maximum preexisting exclusion period of 12 months has long been standard in health insurance, so that is not a problem. Reducing or eliminating this period altogether within the context of employer-provided insurance would have some impact in increasing costs. But this would be limited because, again, the health coverage changes would be due to job changes, not health factors, and those covered must in any event be healthy enough to be employed.

SMALL GROUP MARKET REGULATIONS

The following regulatory provision applies only to insurance sold in the small employer group market. Small employer is defined as an employer of more than one but less than 51 employees.

Guaranteed Issue For Employer Group Coverage. *Kassebaum-Kennedy* provides that health insurers that sell coverage to small employers in a state must provide coverage to all small employers that apply within the insurer's geographic service area, regardless of the health condition of the employer's workers or their dependents. The bill consequently provides for guaranteed issue of health coverage for all such small employers. The problems caused by this provision are discussed later in this study.

INDIVIDUAL MARKET REGULATIONS

The following regulatory provisions apply to insurance sold directly to individuals outside the employer group context.

Guaranteed Renewability. Insurance sold in the individual market is subject to the same guar-

anteed renewability provisions described above for the employer group market. Such guaranteed renewability has long been standard in the individual market, whether due to state regulation or market competition.

Group-to-Individual Portability. The most controversial component of *Kassebaum-Kennedy* provides for guaranteed issue of individual insurance to workers who previously had employer group coverage. To qualify for this provision, a worker must meet the following requirements:

- The worker must have been insured over the previous 18 months with no gap in coverage of more than 62 days;
- The worker's most recent coverage must have been under a group employer plan, a governmental plan, or a church plan;
- The worker must not be eligible for coverage under another employer group health plan, Medicare, or Medicaid, and must not have other health insurance coverage;
- The worker must not have been terminated under his last insurance plan for nonpayment of premiums or fraud;
- The worker must have fully exercised any rights to continue former employer coverage under COBRA.[1]

Individuals who meet these qualifications have the right to buy health coverage from any insurer in the state who sells individual insurance policies in a geographic service area covering the individual. These insurers, however, can designate two policies out of the range of policies they sell that may be subject to this mandate. The legislation specifies requirements that these policies must meet to ensure that they are similar to the other policies the insurer sells to the public.

The problems caused by these provisions are discussed later in this study.

Preexisting Condition Limitations. For policies sold to individuals who qualify for the group-to-individual portability as described above, preexisting condition exclusions are limited in the same way as for group employer insurance.

Alternative Options for States. States have an option under the legislation to choose alternative policies only for the last two requirements described above — group-to-individual portability and the limitations on exclusions for preexisting conditions for individual policies. They can not opt out of the guaranteed renewability (for individual or group policies), the group-to-group portability provisions, the nondiscrimination group provisions, the preexisting condition exclusions for group policies, and the guaranteed issue for employer group coverage.

To replace the two legislated provisions for which alternatives are allowed, the state must enact an alternative that meets the following requirements:

- The alternative must provide a choice of health insurance coverage to all the individuals who would have been eligible for the replaced provisions in the federal legislation;
- The alternative must include no preexisting condition exclusion for the eligible individuals;
- The alternative must include at least one insurance coverage option comparable to comprehensive health insurance coverage offered in the individual market in the state or to a standard option of coverage specified under the state's law;
- The alternative involves either:

(1) the *Small Employer and Individual Health Insurance Availability Model Act* or the *Individual Health Insurance Portability Model Act* adopted by the National Association of Insurance Commissioners (NAIC); or

(2) a high-risk pool that provides for premium rates and covered benefits consistent with the standards included in the NAIC model *Health Plan for Uninsurable Individuals*; or

(3) any other mechanism that provides for risk adjustment, risk spreading, or some financial subsidization of the individuals eligible for the standard provisions of the federal legislation, or that provides such individuals with a choice of all individual health insurance coverage otherwise available.

The legislation in addition specifies that state uninsurable risk pools, mandatory conversion of group to individual policies, and open enrollment by one or more last resort insurers are among the alternative state policies that would be acceptable if properly implemented. These alternatives are discussed in more detail later in this study.

To opt for one of the alternative plans, the state's Governor should notify the Secretary of Health and Human Services (HHS) by April 1, 1997, that the state has adopted or intends to adopt one of the acceptable alternatives. The state must then enact the alternative by April 1, 1998, to be effective by July 1, 1998. The notice should be accompanied by thorough information regarding the proposed state alternative, sufficient to enable HHS to determine if it meets the above described requirements. HHS may disapprove the state's alternative within 90 days of receiving the notice if it determines that the alternative does not meet the federal requirements. In that case, the federal provisions would go into effect in the state.

States may choose to opt for alternative policies in place of the federally required policies at any later time if they do not meet these initial deadlines, or if their initial submission is disapproved.

Other Provisions. The *Kassebaum-Kennedy* bill includes other provisions relating to medical savings accounts, health care fraud and abuse, administrative simplification, medical liability reform and others. While often problematic, these provisions are beyond the scope of this study.

KASSEBAUM-KENNEDY'S REGULATORY DISASTER

The classic problem with guaranteed issue is that the healthy don't need to buy health insurance until they get sick, as they can always get health insurance at that time. As a result, with guaranteed issue in force, the low-cost healthy beneficiaries start to drop their coverage. Premiums then have to be raised for the relatively sicker, higher-cost pool that remains. This causes more healthy people to drop out, raising premiums still more. As a result, premiums eventually soar for the sick and others who remain covered, and insurance coverage may even become prohibitively expensive and unavailable.

The authors of *Kassebaum-Kennedy* sought to avoid this problem by circumscribing when the guaranteed issue would apply. Under the bill, the healthy cannot forgo health insurance until they get sick. To be eligible for individual guaranteed issue, they must have prior coverage for at least 18 months. To get group coverage, they must at least be healthy enough to hold a job that has employer-provided coverage.

Unfortunately, these limitations will not be sufficient to avoid the problems of guaranteed issue.

Destroying the Individual Market. The most compelling problems arise from the group-to-individual portability provisions. The employer group market is the big market, with about 150 million covered workers. The individual market is relatively small, with about 10.4 million insured beneficiaries. Yet, the portability provisions of *Kassebaum-Kennedy* allow the larger group market to dump its sickest and highest-cost beneficiaries on the much smaller individual market.

Take a young and healthy employee who starts working for his employer at age 25. Suppose he continues to work for that or other employers for the next 25 years and remains healthy. Some big group insurer received premiums for him each of those years when he was healthy and low cost.

Now suppose at age 50 the worker discovers that he has cancer or heart disease or AIDS, and can no longer work. The worker leaves the group employer market and under *Kassebaum-Kennedy* he can now force an insurer in the individual insurance market to cover him. That insurer received no premiums for all the years the worker was healthy and low cost. But the insurer must cover the worker now that he is sick and high cost.

As more and more of the sickest individuals from the big group employer market are similarly dumped on the smaller individual market, the insurers in that market must raise their premiums to

cover the new costs imposed by these new beneficiaries. In response to these premium increases, many low-cost healthy individuals with individual insurance will now find it too costly and will drop their coverage. This will force the insurers to raise premiums again, which will cause more healthy workers to leave the individual market, leading to still higher premiums.

The Health Insurers Association of America estimates that this process will cause the cost of individual insurance to increase by 30 percent. The American Academy of Actuaries produced a much smaller estimate of around 5 percent. But the Academy assumed that most of the new costs imposed by the new sick individuals dumped on the individual market from the big group market would be charged to the sick individuals themselves through higher-than-average premiums. But in fact state regulation of premiums is likely to prevent that, forcing the insurers to charge the new sick individuals no more than others. After all, what good would the right to buy individual insurance under *Kassebaum-Kennedy* be if the insurers could charge prohibitively expensive rates for it?

These higher premiums would effectively be an unfair tax on everyone currently covered in the individual insurance market. The cost of all of the sickest individuals in the big group employer market would be dumped on them. These costs should be spread across the 150 million workers in the group market where the sick individuals were formerly covered, not the 10 million in the individual market. To the extent that the sickest individuals need a subsidy to meet their costs, that subsidy cost should be borne by the general public, not the relatively small number of workers currently in the individual market.

Moreover, this effective tax on these workers would be highly regressive. If the reform causes premiums in the individual market to rise by $1,000 per year, it would take 10 percent of the income of a family earning $10,000 per year but only 1 percent of a family earning $100,000.

Naturally, many covered in the individual market will drop their coverage to avoid this effective tax. In fact, studies show that the uninsured are very responsive to the cost of health insurance.[2] Sixty percent of them are below 30, the healthiest population age group.[3] They also have below-average incomes and few assets, with over half earning less than $20,000 per year. As a result, when insurance prices rise, many choose to drop or forgo coverage. Since they are young and healthy, insurance coverage is not a top concern for them. With their modest resources, they are more concerned about avoiding high and unnecessary insurance costs.

A model of the health economy constructed by the National Center for Policy Analysis and Fiscal Associates estimates that a 10 percent increase in premiums will produce a 6 percent reduction in the number of people who are insured.[4] A 30 percent increase could lead to 2 million people leaving the individual insurance market and becoming uninsured. Such a sharp reduction would lead to ultimate premium increases greater than 30 percent.

At a minimum, therefore, the group-to-individual portability provisions of *Kassebaum-Kennedy* are likely to produce:

- a sharp increase in premiums in the individual insurance market, perhaps 30 percent or more; and

- a substantial increase in the number of uninsured, perhaps 2 million individuals.

But the end result could be even worse. Insurers may find their premiums are increasing so much and so many of the healthy are dropping coverage that their insurance is no longer viable and they must withdraw from the market. Others may decide not to take the risk or just refuse to participate under these oppressive rules and withdraw as well. Those without employer coverage would then have fewer choices and less access to health coverage. Indeed, in some states at least the market for individual health insurance could collapse completely, with all or almost all of the individual insurers withdrawing. Those who do not have employer-provided coverage might then be left without any viable option for health coverage. This would provide a powerful basis for the return of efforts to have the government take over health insurance coverage.

Destroying the Small Employer Group Market. The guaranteed issue provisions in the small employer group market will have analogous effects. Insurers would be forced to cover the sickest and costliest workers in this market who were formerly not covered. This will cause premiums for small employers to rise. Many of these employers, often surviving on small margins, will then drop their coverage altogether. This would be especially true for small firms with healthier workers who will often conclude that they would rather be paid higher wages and forgo the overly costly insurance which they do not expect to use much anyway. This loss of relatively healthier workers will raise premiums further again, which will result in the loss of more lower cost healthy workers in a continuing downward spiral.

Moreover, this guaranteed issue provision can be easily gamed. An uninsured individual who is sick himself or has a sick family member can sign on with a small firm and receive coverage, even if the worker or his family had never been covered before. Such individuals may be able to convince friends or relatives who run small businesses to hire them as a favor to obtain health coverage in a crisis, particularly if the individual can pay any added cost to the employer. Indeed, friends or family who are moved to help can open a putative two-person firm that hires the uninsured individual, again especially if the individual can pay for the coverage. After all, there is no requirement as to how profitable or successful the firm must be. Through such devices, the cost of insurance in the small group employer market will be raised even higher, causing even more small firms to drop coverage altogether.

Just as for the individual market, these higher premiums in the small group market will effectively be an unfair regressive tax on those covered in this market to pay for the costs of the sick that should be spread over the broader market or society as a whole. The end result of this tax will be higher costs for those already in the market and an increase in the number of uninsured as many drop out of the market. Moreover, faced with these requirements, insurers may well withdraw from the small group employer market, leaving employers and workers in this market with less choice and access to health coverage, or ultimately even no access at all. Then, once again, there will be no choice but to turn to the government to cover this market as well.

A DISASTROUS HISTORY

Different forms of guaranteed issue have had disastrous results wherever they have been tried. New York adopted guaranteed issue for health insurance sold there in 1993. Over the next three years, insurance premiums in the state soared by 132 percent, compared to 9 percent nationally. Moreover, about 500,000 individuals in the state dropped coverage. In addition, several insurers left the state altogether. Even Empire Blue Cross Blue Shield, the largest carrier in the state, had to withdraw from the individual market because of mounting losses. Mutual of Omaha withdrew after its New York claim costs rose by 130 percent in 1994, compared to 9 percent nationally. The company laid off 12 percent of its work force as a result.

New Jersey adopted guaranteed issue in 1993 for insurance sold in the individual market. By the third year, insurance rates there had doubled. New Jersey rates were more than twice as high as in nearby Connecticut, and two to three times higher than in neighboring Pennsylvania. Moreover, only two major sellers of individual insurance remained in the state, and despite the higher rates, they were both suffering large losses. Close to 200,000 individuals in that state had also dropped their insurance coverage, indicating a substantial increase in the number of uninsured.

Vermont adopted guaranteed issue in 1992. Since then, rates have soared about 400 percent, or about five times as high as before. A typical individual policy there now costs almost one-fourth of average annual after-tax income. Moreover, the number of insurers in the state has decreased dramatically.

Kentucky just adopted guaranteed issue in July 1995. In the first year alone, individual insurance premiums rose by 80 percent, and almost two-thirds of individual insurers left the state. Premiums for small group insurance rose by more than 20 percent.

Finally, after Florida adopted guaranteed issue for its small group market, premiums there have grown by almost 10 percent per year faster than in other nearby states. As a result, small employers in the state now pay $600 to $700 more for each employee each year for their health insurance.

THE FALLACY OF GUARANTEED ISSUE

Guaranteed issue is so ineffective and even counterproductive because it fundamentally misconceives the problem of the uninsured. Overwhelmingly, the uninsured are not people who are sick and turned down for insurance coverage. According to the U.S. Department of Health and Human Services, only 2.5 percent of the uninsured can't get coverage because of their health.[5] The U.S. Public Health Service estimates that nationally about 2 million Americans are uninsurable, compared to 35 to 40 million who are uninsured.[6]

Rather than sick, the uninsured are in fact young and healthy, as indicated above. Again, 60 percent are below age 30. Moreover, as also noted above, their finances are tight, with below-average income and assets. Again, over half earn less than $20,000 per year.

Consequently, the problem of the uninsured cannot be addressed by forcing the relatively small number of sick and uninsurable on insurers, as guaranteed issue does. Quite to the contrary, the resulting rise in premiums will just cause more cash-strapped young and healthy families to drop their coverage and join the uninsured. That is why guaranteed issue tends to increase rather than reduce the number of uninsured.

The same problem can be found in the small group employer market. A National Federation of Independent Business survey of small employers without insurance found that 65 percent said they didn't have coverage because they couldn't afford the premiums, while only 2 percent said they were denied coverage. Another survey for the Robert Woods Johnson Foundation found 85 percent of small employers without insurance citing the high cost of premiums as the reason, with only 3 percent reporting that they had been turned down for coverage. A survey of Connecticut small employers without insurance again found 65 percent citing cost as the reason, with only 5 percent reporting they had been turned down.[7]

So again, the problem is cost, not denial of coverage. Since 85 percent of the uninsured are in families headed by a worker, the number of uninsured could be sharply reduced if more employers provided coverage. Yet, by adding to costs, guaranteed issue only causes more of them to drop coverage, increasing the problem.

ALTERNATIVE REFORM OPTIONS FOR STATES

Clearly, states should try to avoid the *Kassebaum-Kennedy* regulatory disaster by adopting the alternatives the bill will allow. Following is a discussion of the best alternative policies states should adopt. Again, these policies can only be adopted as an alternative to the guaranteed issue and limitation on preexisting condition exclusions for the individual insurance market. States cannot choose to opt out of the guaranteed issue for the small employer group market.

STATE UNINSURABLE RISK POOLS

How Risk Pools Work. As described above, *Kassebaum-Kennedy* specifically names risk pools as an alternative states can choose in place of guaranteed issue for individual insurance. Ideally, the risk pool would be set up by an association of private health insurers in the state, in accordance with state enabling legislation. That legislation would establish general guidelines for the coverage the risk pool would provide. But the insurers in the association would determine exactly what the package of coverage provided by the risk pool would be. The package would provide benefits similar to those in typical comprehensive insurance policies in the state. The association would then conduct a competitive bidding process to select one private insurer to administer the pool, collect the funds and pay out the benefits.

The risk pool would then offer its coverage to anyone in the state who is uninsured and has been refused coverage by at least one private insurer due to medical condition. Those who accept this

coverage would pay a premium to the risk pool at some level above standard insurance rates, perhaps 50 percent more. These higher premiums would help to recover some of the higher costs of the otherwise uninsurable individuals covered by the pool. The higher rates would also ensure that only those who could not get other, standard, private coverage would apply to the pool. The state could offer subsidies to the poor to help pay the risk pool premiums.

Even with rates 50 percent above market standards, the premiums paid by those insured by the pool would not be nearly enough to cover the costs of these otherwise uninsurable beneficiaries. So the state would have to subsidize the pool to cover all its costs. Sources of financing to pay for these subsidies are discussed later in this report.

The number of people who are truly uninsurable and, therefore, eligible to be covered by the risk pool is tiny. The Agency for Health Care Policy and Research of the Public Health Service estimates that less than 1 percent (0.7 percent) of the U.S. population has been denied health insurance due to a medical condition.[8] Providing necessary risk pool subsidies for this small group would consequently amount to a small cost for each state. One study estimated that in 1989 extending risk pools nationwide would have required only about $300 million for the year in state subsidies for the pools, out of total health costs for the year of about $600 billion. Today, such costs would amount to around $500 million nationwide, or about one-tenth of 1 percent of the nation's total health costs.

Some 29 states have already enacted legislation to create such high risk pools, which already cover more than 100,000 individuals. The pools generally charge 25 to 50 percent more than for comparable policies. They are usually managed by a major insurer, such as Blue Cross.

Nebraska offers an example of a well-run risk pool. Coverage from the pool is available to any state resident who has been denied health insurance within the last six months. The pool charges 35 percent more than standard rates. The pool covers close to 3,500 state residents, or about 0.2 percent of the state's population.

Another good example is Illinois. Blue Cross Blue Shield administers the plan there. It covers hospital, physician, and surgeon services; x-ray and diagnostic services; prescription drugs; skilled nursing, hospice and home health care; durable medical equipment; medically necessary physical, speech or occupational therapy; and mental or nervous disorders. The beneficiary can choose front-end deductibles of either $500, $1,000 or $2,500, with lower premiums for higher deductibles. Benefits are subject to a maximum lifetime limit of $500,000.

Premiums are set 35 percent above standard rates. The state covers remaining pool costs out of general revenues.

Such risk pools assure that everyone in the state will be able to get essential health coverage. But they do so without disrupting the insurance market for the 99 percent who can obtain standard insurance of their choice. Instead, the less than 1 percent who cannot obtain market coverage are provided with an alternative system that focuses needed subsidies only on them. Moreover, these subsidies can be funded more broadly by the general public, as discussed below, rather than by a narrow segment of the market.

Risk Pool Premiums. To qualify as an acceptable alternative under *Kassebaum-Kennedy*, the state risk pool must charge premium rates consistent with standards included in the NAIC model *Health Plan for Uninsurable Individuals Act*.[9] The NAIC model provides that the risk pool premiums should start at 125 to 150 percent of standard rates and then be adjusted upward to cover costs to a maximum of 200 percent of standard rates. Given the high costs of the uninsurables covered by the pool, this would result in stabilized premiums for the pool of twice the standard rates.

As noted above, most state risk pools today charge 25 to 50 percent more than standard rates. The Secretary of HHS would probably approve a state plan that included these lower rates. But the higher rates in the NAIC model may be desirable. They would recoup even more of the costs of the pool, reducing the state subsidy. Moreover, the higher rates would further ensure that the pool would be restricted only to those who were truly uninsurable, as those who could get insurance elsewhere at lower cost would do so. This would keep

as many people in the regular private market as possible. A state program to help the poor pay risk-pool premiums would avoid any hardship to the poor from these higher premium rates.

Risk Pool Benefits. *Kassebaum-Kennedy* specifies as well that the risk pool must provide benefit coverage consistent with the NAIC risk-pool model. That model actually provides for two alternative approaches to specifying the benefits to be provided by the plan. One is for the risk pool's governing board to determine the exact coverage package to be offered by the pool, subject to the approval of the state insurance commissioner. The other is for the state to specify in legislation the exact benefits to be provided by the pool.

The first alternative is far more desirable. If the state legislature tries to specify the benefits, it will be subject to unyielding pressure from every health related special interest to be included, ultimately resulting in a more costly and less workable risk pool plan. The package would also be rigid and ineffective, requiring an act of the legislature every time a change must be made.

Better to have the benefits determined by the private insurers running the pool, who would be insulated from special interest pressure groups. The package could then also be changed promptly as needed. The legislature should simply adopt a general guideline requiring the pool to provide coverage equivalent to standard comprehensive coverage sold in the state. This could then be enforced by requiring final approval by the state insurance commissioner of the coverage package.

It would be best for the risk pool to offer a choice of higher deductibles for the risk pool coverage in return for lower premiums, as in Illinois and some other states. Higher deductibles are an ideal way of controlling costs for more routine expenses, as patients would be more careful with their own out-of-pocket funds than with insurance pool funds. A range of low and high deductibles with actuarially fair premiums should be acceptable to HHS, since that would provide a choice of coverage as specified in *Kassebaum-Kennedy*.

The risk pool could offer other cost-saving options, as well. It could allow beneficiaries to take their coverage through a medical savings account, or any of a full range of managed care plans, as well as a traditional fee-for-service plan. The beneficiaries could be allowed lower premiums or other financial benefits for the lower-cost plans.

Preexisting Conditions. *Kassebaum-Kennedy* specifies as well that the state risk pool cannot impose any preexisting condition exclusion on those who would have been eligible for group-to-individual portability without such exclusion under the standard *Kassebaum-Kennedy* provisions. The NAIC risk pool model actually includes a preexisting condition exclusion of six months for any condition treated or examined during the six months before coverage. To be acceptable under *Kassebaum-Kennedy*, the risk pool cannot apply such an exclusion to the individuals covered under the standard *Kassebaum-Kennedy* provisions. The pool can apply such an exclusion period to others, however.

Lifetime Caps. The NAIC model provides as well for the state to impose a lifetime cap on benefits the risk pool would provide. If the cap is the same as any lifetime cap allowed on the insurance individuals would be able to buy under *Kassebaum-Kennedy*, then it should be permissible for the risk pool. However, such caps are contrary to the idea of risk pools serving as a health insurance safety net of last resort, ensuring that those in need would always have somewhere to turn to get coverage. Such a true safety net would better enable the state to resist bad reforms imposed on the rest of the private insurance market, such as guaranteed issue.

Waiting Lists. Some states limit the number of people to be covered by the risk pools to the amount of funding available each year. This results in a waiting list including people who apply after the limit has been reached. To be acceptable under *Kassebaum-Kennedy*, a state risk pool cannot apply such a waiting list to individuals eligible for the standard *Kassebaum-Kennedy* individual market provisions. These eligible individuals must be able to receive risk-pool coverage as soon as their eligibility is established.

The risk pool can apply such a waiting list to others. But, again, such a waiting list undermines the risk pool's role as a health insurance safety net of last resort, which again is valuable in trying to avoid bad reforms for the rest of the market.

Funding Sources. The NAIC risk-pool model offers a number of alternative funding sources for the state risk-pool subsidies. One alternative is to impose assessments on insurance policies sold throughout the state, which is the most common revenue source in current state risk pools. But such an assessment raises the cost of insurance and increases the number of uninsured. Another alternative is to tax hospitals and doctors directly. But this would focus the risk-pool costs only on those in need of medical care. The best option is simply to use the state's general revenues. Then the cost would be covered by the public as a whole in each state. Since the subsidy is based on a social decision to help those in need of health care, it should be broadly funded by the public as a whole, rather than any narrower group.

Risk Pool Eligibility. State risk pools generally provide that individuals must be turned down by one or more private insurers before they can receive risk-pool coverage. Whether a risk pool serving as a state alternative under *Kassebaum-Kennedy* can impose this requirement on those who are eligible for the standard individual market provisions of *Kassebaum-Kennedy* is uncertain. This should be allowed, because those who can get other private market coverage would have a choice of coverage available to them, which is the goal of *Kassebaum-Kennedy*.

The NAIC risk-pool model and some states allow risk-pool coverage to anyone who would be charged a higher rate by private insurers than the risk-pool premium. If the risk pool is 200 percent of standard rates, then this may be workable. But at lower pool rates, this provision may draw more people than necessary into the risk pools and out of the private market. On the other hand, it seems unfair to reject individuals because their insurance accepted them at higher rates than the pool, while allowing others to enjoy the pool's subsidies and lower rates because they were turned down altogether. The best solution may be to adopt the higher NAIC model premiums and then allow in the pool those who would be charged higher private rates.

The NAIC model provides that resident dependents of a person accepted for risk-pool coverage would be eligible for the risk pool as well. But that would unnecessarily draw people into the pool and out of the standard private market where they should be covered if at all possible. The state-supported pools would then be unnecessarily displacing the private market, where the public would be best served. For the same reason, states should not adopt an NAIC model provision providing for risk-pool coverage for those who have incurred certain specified illnesses, regardless of whether they have been turned down for private coverage. Everyone should have to apply for such coverage first, to ensure that all who can be accepted by the standard private market are accepted.

Risk Pool Administration. The NAIC risk-pool model seems to call for the state to set up and run the pool, with administration contracted out to a private insurer. But a better alternative would be to have an association of private insurers set up and run the pool, with administration contracted out to one insurer. Then the government would only regulate the pool. This would keep the pool in the private sector as much as possible and help to insulate the pool from political pressure.

Risk Pools — the Best Option. The many states that already have risk pools should be able to qualify them as an acceptable alternative under *Kassebaum-Kennedy* with only minor changes. These risk pools are the best option for states not only because they would probably be the easiest alternative to win federal approval. They would also assure the public of essential health coverage when needed, without burdening everyone else in the standard market, as guaranteed issue or other bad reforms would do.

Other NAIC Models. *Kassebaum-Kennedy* also specifically names two NAIC models as acceptable alternatives. One is the *Individual Health Insurance Portability Act*. This alternative, however, is worse than the standard provisions of *Kassebaum-Kennedy*. It has even broader guaranteed issue requirements, mandating that insurers provide insurance to anyone who has had qualifying coverage within the previous 31 days. *Kassebaum-Kennedy* requires qualifying coverage for 18 months prior to eligibility for a guaranteed issue policy. Moreover, under the NAIC model, the state specifies benefits in the two policies in-

surers must offer subject to guaranteed issue requirements. Under *Kassebaum-Kennedy*, the insurers determine what is in their plans, subject to broad regulatory requirements.

The NAIC model also contains numerous restrictions on premiums not included in *Kassebaum-Kennedy*. The government would restrict the differences in premiums between different policies, and differences in premium increases over time. Rates charged for the two policies that must be available for guaranteed issue would be determined by an average of the rates for the insurer's other policies.

Moreover, insurers would be subject to a so-called risk-adjustment arrangement. Under this option, bureaucrats would take funds from insurers that earned more on the policies subject to guaranteed issue and give them to insurers that earned less on such policies, until all had the same net profit.

This NAIC model would do nothing to relieve the problems created by standard *Kassebaum-Kennedy* regulation, as previously discussed. Rather, it would make these problems worse by mandating broader guaranteed issue to more people. The model would allow healthy individuals to drop their coverage and not pay any premiums for years and years, and then become eligible for guaranteed issue after purchasing coverage for just a few weeks.

Moreover, the government specifying policy coverage and benefits reduces freedom of choice in the open market and will probably result in higher costs, as political pressures cause the bureaucrats to add more and more unnecessary benefits and coverage. The premium restrictions would add to costs for most people as well, as what could be charged to sicker individuals would be reduced and their costs would then have to be paid for by others through higher premiums.

Even the risk-adjustment mechanism would add to costs, as insurers would lose incentives to control costs for their own plans since they would not be able to keep any net profits from their efforts. Moreover, this risk adjustment would force insurers to cede control over their finances and funds to the risk redistributing adjustment bureaucrats. This and the other factors mentioned above would likely cause most or all insurers to leave the state, reducing access to coverage. In addition, the higher costs described above would again lead to more uninsured, as more of the young and healthy dropped coverage to save money in their tight budgets.

The second NAIC model referred to in the legislation is the individual health insurance provisions of the *Small Employer and Individual Health Insurance Availability Model Act*. This model, however, is even worse than the first one. The model provides for full-scale guaranteed issue without even the protections offered by *Kassebaum-Kennedy*. Individual insurers would have to sell their policies to anyone without other coverage, regardless of their health condition or whether they were previously insured. Healthy people would then have no reason to pay for health coverage, knowing that they could "buy" it when they got sick. As the sick signing up for the coverage caused premiums to soar, even more of the healthy would drop out faster. As a result, premiums would soar even more, the uninsured would increase even faster, and insurers would flee, leaving little or no access to individual insurance in the state.

To make it even worse, the model provides for modified community rating as well. This means that premiums for the guaranteed issue insurance plans could vary only due to differences in costs among geographic areas, number of people insured in a family policy, and the age of those covered. There could be no difference in premiums due to health risks. A person with AIDS or cancer who showed up for a guaranteed-issue policy could be charged no more for the coverage than a healthy person of the same age in the same geographic area. Moreover, even the differences that could be charged for different ages would not nearly reflect actual differences in health costs due to age.

This would cause premiums to soar even more for the young and healthy, as they would be forced to bear even more of the costs of the sick who couldn't nearly be charged the costs of their care. This in turn would only further exacerbate the increase in the uninsured, the flight of insurers from the state, and the collapse in available health coverage.

States should adopt this NAIC model only if they actually want to destroy their private insurance markets so they can adopt outright state-run socialized medicine instead.

OTHER ALTERNATIVES

Mandatory Right of Conversion. *Kassebaum-Kennedy* also explicitly mentions mandatory group conversion as one of the alternatives states could adopt. Under this approach, workers covered by group employer insurance would have an automatic right to convert that coverage into an individual policy they could take with them if they left their job. They would then pay the premiums for such coverage themselves, rather than their employers. This would provide automatic full portability for employer group coverage.

Moreover, under this approach the large group employer market would not be able to dump its sickest workers on the individual insurance market, as under *Kassebaum-Kennedy*. Instead, workers who had been covered by the large group employer market while they were healthy and low cost would continue to be covered by that market when they became sick, with the same insurers bearing their costs who had received their premiums all of the years when they were healthy.

To make this workable, those who convert their group coverage to individual policies should not be priced as though they were a separate pool. This would make their premiums quite expensive, as sicker individuals who could no longer work or who could not obtain coverage elsewhere would tend to predominate in this pool. Rather, these workers should continue in the same employer group pool as before and be charged the standard rates in that pool. State premium regulation could provide for this.[10]

Such a policy would simply extend the principal of guaranteed renewability, discussed earlier. In the individual market where guaranteed renewability applies, an individual who becomes sick must continue to be covered at the same standard rates. Similarly, under the option proposed here, a worker covered by employer group insurance who became sick would be able to continue coverage at the same standard rates as before.

Just as guaranteed renewability makes insurance somewhat more expensive, so would a right of conversion for group employer insurance make that insurance somewhat more expensive. But just as for individual guaranteed renewability, this is the price of real insurance coverage that provides actual protection to the worker against the cost of sickness, rather than ineffective insurance that can leave the covered beneficiary in the lurch when a serious illness develops. The added cost here is not the redistributed costs of others imposed on a segment of the market, as under the group-to-individual portability provisions of *Kassebaum-Kennedy*. Rather, it is the cost of providing real insurance protection to the workers themselves.

Under this reform, the insurance sold to the employer would include a provision granting workers the right to convert to an individual policy. If desired, the group insurer could contract with an individual insurer to administer such policies, but under the terms and the rates set by the original group insurance policy.

However, states could not impose this requirement on employers who self-insure, as those employers are exempt from state regulation under ERISA. The federal government would have to adopt legislation providing for such a requirement for these employers. Until then, a state could only adopt this requirement for employers who purchased group coverage from an insurer. To have an acceptable alternative under *Kassebaum-Kennedy*, the state would then have to also adopt a risk pool or some other policy alternative for those who worked for self-insured employers.

Open Enrollment. *Kassebaum-Kennedy* again explicitly mentions open enrollment as one of the other possible alternatives. Eleven states have in fact arranged for their state Blue Cross Blue Shield plan to maintain such open enrollment, accepting everyone who applies, regardless of health condition.

In return, the states grant the Blue Cross Blue Shield plans special subsidies and advantages, such as exemptions from premium taxes or contributions to state guarantee funds, or hospital discounts

States that wish to adopt this alternative can simply contract with one or more insurance firms

to accept this role, and pay the firm an annual subsidy to offset losses. This would then effectively be the same policy as an uninsurable risk pool, with all the same advantages previously described. The arrangement should involve many of the same features discussed above for risk pools, such as required premiums at some level above standard rates for those who would otherwise be uninsurable.

To be acceptable under *Kassebaum-Kennedy*, this open-enrollment insurance must again be offered without a preexisting condition exclusion for those who would have been eligible for group-to-individual portability under the standard *Kassebaum-Kennedy* provisions. Moreover, the benefits provided by the open-enrollment insurance policy must be similar to the benefits provided by standard comprehensive insurance coverage offered in the state.

Guaranteed Issue. Finally, *Kassebaum-Kennedy* explicitly mentions as an alternative for states "a mechanism under which each eligible individual is provided a choice of all individual health insurance coverage otherwise available."[11] This seems to be another option for states to offer guaranteed issue of individual insurance plans. This would be counterproductive for all of the reasons mentioned earlier, and consequently, states should avoid it.

CONCLUSION

Kassebaum-Kennedy threatens a regulatory disaster for states, with rapidly rising insurance premiums, sharp increases in the number of uninsured, and withdrawal of private health insurers from the state, reducing choice and access to health coverage. These provisions in fact may ultimately destroy the market for individual health insurance in each state, leaving those without employer-provided insurance nowhere to go except the government. The same may ultimately be true of the small employer group market.

To avoid these problems, states should adopt the alternatives *Kassebaum-Kennedy* allows to its individual insurance market regulations. The best of these is state insurable risk pools, which would achieve the goals of *Kassebaum-Kennedy* without its destructive effects. Such risk pools would assure the public of essential health coverage when needed, without hurting the 99 percent who are best served by coverage in the standard market. These risk pools would also probably be the easiest alternative to win *federal* approval. With such an approved alternative, states can then retain their traditional control over the regulation of health insurance.

ENDNOTES

[1] Under COBRA, any worker employed by a firm of 20 or more workers has the right to continue the firm's coverage for 18 months after leaving the firm, as long as the worker continues to pay the premiums during that time. Workers employed by firms with less than 20 workers do not have such rights and could go directly to individual insurance under *Kassebaum-Kennedy*.

[2] Peter J. Ferrara, The Health Policy Debate: Options for Return, NCPA Policy Backgrounder No. 13, National Center for Policy Analysis, Dallas, Texas, July 7, 1994; Jill D. Foley, Uninsured in the United States: The Nonelderly Population Without Health Insurance, (Washington, DC: Employee Benefits Research Institute, April, 1991)

[3] Foley, *supra*, p. 16.

[4] *See* Ferrara, *supra*, p. 15.

[5] See Council For Affordable Health insurance, Guaranteed Issue: Guaranteed to Make the Problem in the Small Group Market Worse, Nov. 1992, p. 8.

[6] *See* National Center for Policy Analysis.

[7] These surveys are reported in Council For Affordable Health insurance, supra, p. 9

[8] Risk Pools: A Better Solution for Preexisting Conditions, Brief Analysis No. 112, National Center for Policy Analysis, June 30, 1994.

[9] Sect. 2744(c)(2)(B) as codified in Sect. 102(a) of Title XXVII of the Public Health Services Act, as amended.

[10] Such a premium arrangement would constitute a risk-spreading mechanism as mentioned in *Kassebaum-Kennedy*, since the costs of those who became sick after coverage would be shared with those who remain healthy, as in true insurance. This is just the principal of guaranteed renewability applied the same as in the individual market as discussed below.

[11] Sect. 2744(C)(3)(B), in Sect. 102(9) of Title XXVII of the Public Health Insurance Act, as amended.

AMERICAN LEGISLATIVE EXCHANGE COUNCIL
910 17th Street N.W.
Fifth Floor
Washington, D.C. 20006

(202) 466-3800
FAX (202) 466-3801

HB
218
File 3

0-LS0850\E
Ford
4/3/97

CS FOR HOUSE BILL NO. 218(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

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

A BILL

FOR AN ACT ENTITLED

"An Act to regulation and examination of insurers and insurance agents; relating to kinds of insurance; relating to payment of insurance taxes and to required insurance reserves; relating to insurance policies; relating to regulation of capital, surplus, and investments by insurers; relating to hospital and medical service corporations; and providing for an effective date."

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

* Section 1. AS 21.06.030 is amended by adding a new subsection to read:

(h) A volunteer member of an advisory committee who has been appointed by the director under a provision of this title to assist and advise the director on issues or matters concerning a specific area of insurance is not entitled to payment of per diem or travel expenses authorized under AS 39.20.180.

* Sec. 2. AS 21.06.110 is amended to read:

Sec. 21.06.110. Director's annual report. As early in each calendar year as

is reasonably possible, the director shall prepare and deliver an annual report to the commissioner, who shall notify the legislature that the report is available, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in this state, with a summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose **certificate of authority was surrendered, suspended, or revoked** [BUSINESS WAS CLOSED] during the year **and** [,] the cause of **surrender, suspension, or revocation** [THE CLOSING, AND THE AMOUNT OF ASCERTAINABLE ASSETS AND LIABILITIES OF EACH CLOSED BUSINESS];

(3) the name of each insurer **authorized to do business in this state** against which delinquency or similar proceedings were instituted [,] and**, if against an insurer domiciled in this state,** a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipt and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance [,] or the office of director;

(7) other pertinent information and matters the director considers proper.

* Sec. 3. AS 21.06.160(a) is amended to read:

(a) Each person examined, other than [AS TO] examinations under AS 21.06.130, shall pay **a reasonable rate calculated on** [ALL THE COSTS OF, AND EXPENSES INCURRED BY DIVISION STAFF EXAMINERS, INCLUDING] salary, [AND] benefit costs, **and estimated division overhead** for time spent directly or indirectly related to the examination**. Each person examined, other than examinations under AS 21.06.130, shall pay actual out-of-pocket business expenses, including travel expenses, incurred by division staff examiners** [,] and shall pay the compensation of a contract examiner, to be set at a reasonable customary

rate, for conducting the examination [,] upon presentation of a detailed account of the charges and expenses by the director or under an order of the director. The accounting may either be presented periodically during the course of the examination or at the termination of the examination. A person may not pay and an examiner may not accept additional compensation for an examination.

* **Sec. 4.** AS 21.09.210(b) is amended to read:

(b) Each insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall pay a tax on the total direct premium income received during the year ending on the preceding December 31 and paid for the insurance of property or risks resident or located in the state, other than wet marine and transportation insurance, after deducting from the total direct premium income the applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to their policies. No deductions may be made of cash surrender value of policies. Considerations received on annuity contracts are not included in the direct premium income and are not subject to tax. The tax shall be paid to the director **at least** annually **but not more often than once each quarter** on **the dates specified by the director. The method of payment must be by the electronic or other payment method specified by the director. The tax** [OR BEFORE MARCH 1, AND] is computed at the rate of

(1) for domestic and foreign insurers, except hospital and medical service corporations, 2.7 percent;

(2) for hospital and medical service corporations, six percent of their gross premiums less claims paid.

* **Sec. 5.** AS 21.09.210(d) is amended to read:

(d) An authorized insurer shall, with respect to all wet marine and transportation contracts written in this state during the preceding calendar year, [ON OR BEFORE MARCH 1 OF EACH YEAR,] pay to the director a tax of three-quarters of one percent on its gross underwriting profit. **The director shall specify the dates that payment is due and the electronic or other method by which payment is to**

be made. The gross underwriting profit is computed by deducting, from the net premiums on wet marine and transportation insurance contracts, the net losses paid during the calendar year under the contracts. In the case of an insurer issuing participating contracts, the gross underwriting profit may not include, for computation of the tax prescribed by this section, the amounts refunded or paid as participation dividends by the insurers to the holders of the contracts. In this subsection,

(1) "net losses" means gross losses less salvage and recoveries on reinsurance ceded;

(2) "net premiums" means gross premiums less all return premiums and premiums for reinsurance.

* Sec. 6. AS 21.09 is amended by adding a new section to read:

Sec. 21.09.245. Required notice. (a) If an insurer intends to change the insurer's name, domicile, or other information provided on the certificate of authority, the insurer shall file a notice of the change with the director within 30 days before or after the intended change takes effect.

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

(c) Failure by an insurer to provide notification required by this section may result in a civil penalty of up to $1,000 and, additionally, a civil penalty of up to $50 for each day that the information is withheld from the director.

* Sec. 7. AS 21.09 is amended by adding a new section to read:

Sec. 21.09.320. Maintenance of records. (a) An insurer domiciled in a jurisdiction other than this state shall keep at its principal place of business a complete record of its assets, transactions, and affairs in accordance with the methods and systems that are customary or suitable to the kind of insurance transacted.

(b) To meet the requirements of (a) of this section, the insurer shall keep the records specified in AS 21.69.390(d) for 10 years from the date the record was created or as required by the record maintenance requirements of the insurer's domicile jurisdiction, whichever is longer.

* Sec. 8. AS 21.12.020(a)(4)(A)(iii) is amended to read:

(iii) in the case of a single assuming insurer, the trust shall consist of trust money representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, include a trust surplus of not less than $20,000,000; the single assuming insurer shall make available to the director an annual certification of the insurer's solvency [BY THE INSURER'S DOMICILIARY REGULATOR AND] by an independent certified public accountant or an accountant holding a substantially equivalent designation as determined by the director;

* Sec. 9. AS 21.12.050 is amended to read:

Sec. 21.12.050. Health insurance defined. Health insurance is insurance of human beings (1) against bodily injury, disablement, or death by accident or accidental means; (2) against the resulting expenses of the injury, disablement, or death; (3) against disablement or expense resulting from sickness or childbirth; (4) against expense incurred in prevention of sickness; (5) for dental care; and (6) **including every insurance** that applies to injury, disablement, or death. Transaction of health insurance includes disability insurance **and stop-loss insurance** but does not include workers' compensation insurance.

* Sec. 10. AS 21.12.050 is amended by adding a new subsection to read:

(b) In this section, "stop-loss insurance" means insurance purchased by a self-insured employer to cover benefits the employer incurs in excess of a preset limit.

* Sec. 11. AS 21.14.010(a) is amended to read:

(a) A life and health domestic insurer, property and casualty domestic insurer, or other insurer required by the director shall, on or before March 1, submit to the director a report of its risk based capital covering the previous calendar year [, IF REQUIRED BY THE DIRECTOR]. The report must be in a form and contain the information required by risk based capital instructions. A domestic insurer required to submit a report under this subsection shall file the report with

(1) the National Association of Insurance Commissioners; and

(2) the insurance regulatory agency in each state in which the insurer

is authorized to transact business [,] if the insurance regulatory agency has requested the report in writing from the insurer; a report requested under this paragraph shall be delivered

(A) not later than 15 days from the receipt of a request if the report has already been filed with the director; or

(B) at the time the report is filed with the director, if the report has not yet been filed with the director.

* **Sec. 12.** AS 21.14.200(18) is amended to read:

(18) "risk based capital instructions" means risk based capital instructions for a life and health insurer or for a property and casualty insurer adopted by order of [REGULATION BY] the director **after an open meeting as provided** under AS 44.62.310 [AS 21.14.010];

* **Sec. 13.** AS 21.18.050 is amended to read:

Sec. 21.18.050. Reserves and liabilities, in general. In a determination of the financial condition of an insurer, capital stock and liabilities to be charged against its assets shall include

(1) the amount of its capital stock outstanding, if any;

(2) the amount, estimated consistent with the provisions of this title, necessary to pay all of its unpaid losses and claims incurred on or before the date of statement, whether reported or unreported, together with the expenses of adjustment or settlement;

(3) with reference to life and health insurance and annuity contracts,

(A) the amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and methods adopted under this title that are applicable;

(B) reserves for disability benefits, for both active and disabled lives;

(C) reserves for accidental death benefits;

(D) additional reserves that may be required by the director, consistent with practice formulated or approved by the National Association of Insurance Commissioners, on account of the insurance;

(4) with reference to health insurance, the amount of reserves required under AS 21.18.080 - 21.18.086 [AS 21.18.080];

(5) with reference to insurance other than specified in (3) and (4) of this section, and other than title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with this chapter;

(6) taxes, expenses, and other obligations due or accrued at the date of the statement.

* **Sec. 14.** AS 21.18.080 is repealed and reenacted to read:

Sec. 21.18.080. Reserve standards for health insurance. (a) The adequacy of health insurance reserves must be determined based on the sum of policy reserves determined under AS 21.18.082, claim reserves determined under AS 21.18.084, and premium reserves determined under AS 21.18.086.

(b) Reserve adequacy must be determined by a prospective gross premium valuation. For policies in force, in a claims status, or in a continuation of benefits status on the valuation date, the gross premium valuation must take into account the present value of all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, including expected future premium increases.

(c) A gross premium valuation must be performed whenever there is an indication that reserves and future premiums may be insufficient to cover future claims for a particular block of policies or for the entire health insurance block. If a reserve inadequacy is determined to exist, the loss must be immediately recognized and reserves increased to account for the inadequacy. The increased reserves will be considered minimum reserves.

* **Sec. 15.** AS 21.18 is amended by adding new sections to read:

Sec. 21.18.082. Policy reserves for health insurance. (a) Except as provided in (b) of this section, policy reserves are required for all individual and group health insurance policies or groups of policies

(1) with level premiums or with a gross premium pricing structure at time of issue that results in future benefits exceeding the corresponding future valuation net premiums at any time; or

(2) for which gross premiums are restricted by contract, regulation, or another reason that results in future gross premiums, reduced by expenses for administration, commissions, and taxes, being insufficient to cover future claims.

(b) Policy reserves are not required for health insurance policies that cannot be continued after one year from the date of issue.

(c) The structure of valuation net premiums used under a health insurance policy must be consistent with the structure of gross premiums on the date the policy is issued.

(d) For return of premium benefits, deferred cash benefits, policies with premium rates that are not guaranteed, and where the effects of insurer underwriting by policy duration are specifically used in the valuation morbidity standard, termination rates that exceed the mortality rates in the tables required in (g)(2) of this section may be used but may not exceed the lesser of

(1) 80 percent of the total termination rate used in the calculation of gross premiums; or

(2) eight percent.

(e) The methods and procedures used to determine health insurance policy reserves must be consistent with the methods and procedures used to determine claim reserves for a health insurance policy.

(f) Negative reserves on a benefit may be offset against positive reserves for other benefits in the same policy, but the total policy reserve with respect to all benefits combined may not be less than zero.

(g) Except as provided in (d) and (h) - (k) of this section, policy reserves for policies issued after July 1, 1997, must be determined based on

(1) a maximum interest rate equal to the maximum interest rate allowed under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the health insurance policy;

(2) a termination assumption equal to the mortality table allowed under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the health insurance policy or equal to a mortality table approved by the director for use in determining the policy reserves;

(3) for long-term care policies issued after July 1, 1997,

(A) a mortality assumption equal to the 1983 Group Annuity Mortality Table without projection;

(B) a lapse assumption for policy durations one through four equal to the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums or eight percent; and

(C) a lapse assumption for policy durations five and later of 100 percent of the voluntary lapse rate used in the calculation of the gross premiums or four percent;

(4) a two-year full preliminary term method under which the terminal reserve is zero on the first and second policy anniversary dates;

(5) a morbidity assumption for

(A) individual disability income insurance issued (i) after December 31, 1997, equal to Tables A or B of the 1985 Commissioners' Individual Disability Tables for policies; and (ii) before January 1, 1998, equal to the 1964 or 1985 Commissioners' Individual Disability Tables; the insurer shall indicate which morbidity table the insurer will use for all individual disability income policies issued in a calendar year;

(B) group disability income insurance issued

(i) after December 31, 1997, equal to the 1987 Commissioners' Group Disability Table; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(C) scheduled or fixed time period hospital, surgical, or maternity benefit policies issued

(i) after December 31, 1997, equal to the 1974 Medical Expense Table A from the Transactions of the Society of Actuaries, Volume XXX; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(D) cancer expense benefits for policies issued

(i) after December 31, 1997, equal to the 1985 National Association of Insurance Commissioners Cancer Claim Cost Tables; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(E) accidental death benefits for policies issued

(i) after December 31, 1997, equal to the 1959 accidental death benefit table; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998; or

(F) all other individual or group policy benefits equal to a morbidity table established for reserve determination by an actuary qualified to determine the morbidity table and approved by the director; the morbidity table must contain a pattern of incurred claims cost that reflects the underlying morbidity and may not be constructed for the primary purpose of minimizing reserves.

(h) The reserve method for return of premium or other deferred cash benefits must be a preliminary term method that is applied only in relation to the issue date of the policy and is a

(1) one-year preliminary term method if benefits are provided before the 20th policy anniversary; or

(2) two-year preliminary term method if the benefits are provided only on or after the 20th policy anniversary.

(i) The reserve method for long-term care insurance must be calculated on a

(1) two-year full preliminary term method for a policy or certificate issued on or before July 1, 1997; and

(2) one-year full preliminary term method for a policy or certificate issued after July 1, 1997.

(j) Reserve adjustments due to rate changes, revised assumptions, or other reasons for return of premium or other deferred cash benefits must be applied on the effective date of the adoption of the reserve adjustment.

(k) An alternative method or basis of determining policy reserves may be used

if the aggregate policy reserve is not less than the aggregate policy reserves determined under (c) - (j) of this section.

(l) An insurer shall annually review prospective policy liabilities on policies valued by tabular reserves to determine the continuing adequacy and reasonableness of the tabular reserves given future gross premiums. The insurer shall make adjustments to the tabular reserves if the tests indicate that the basis of the reserves is no longer adequate.

(m) Policy reserves that are valued based on the 1964 or 1985 Commissioners Individual Disability Tables must include a provision for a waiver of premium benefit with the minimum reserve for the benefit equal to the valuation net premium to be waived.

(n) Policy reserves for long-term care insurance may not be less than the net single premium for any nonforfeiture benefits provided by the policy or certificate.

Sec. 21.18.084. Claim reserves for health insurance. (a) Claim reserves are required for all incurred and unpaid claims on all health insurance policies.

(b) Claim expense reserves are required for the estimated expense of settlement of all incurred and unpaid claims.

(c) Claim reserves for prior valuation years must be tested for adequacy and reasonableness using claim runoff schedules in accordance with the statutory annual statement, including consideration of any residual unpaid liability. Claim reserve adequacy must be determined in the aggregate.

(d) Claim reserves must be determined as follows:

(1) for policies that require policy reserves under AS 21.18.082(a), based on a maximum interest rate equal to the maximum interest rate allowed under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the date the claim was incurred;

(2) for policies that do not require policy reserves under AS 21.18.082(b), based on a maximum interest rate equal to the maximum interest rate allowed under AS 21.18.110 for the valuation of single premium immediate annuities issued on the same date as the date the claim was incurred less 100 basis points;

(3) except as provided in (4) and (5) of this subsection, a morbidity

assumption for

(A) individual disability income insurance must be equal to the morbidity assumption used in determining policy reserves under AS 21.18.082(g)(5);

(B) group disability income insurance for policies issued

(i) after December 31, 1997, must be equal to the 1987 Commissioners Group Disability Table; and

(ii) before January 1, 1998, must be equal to the morbidity assumption in use by the insurer before January 1, 1998;

(C) accidental death benefits must be equal to the actual amount of claims incurred; and

(D) all other individual or group policy benefits must be equal to a morbidity table approved by the director and established for reserve determination by an actuary qualified to determine the morbidity table;

(4) for individual or group disability claims with a duration from disablement of less than two years, morbidity assumptions may be based on the insurer's experience if determined credible by the insurer or upon another basis designed to place a sound value on the liabilities as determined by the insurer;

(5) if approved by the director, reserves for group disability income claims with a duration from disablement of more than two years but less than five years may be based on the insurer's experience for which the insurer maintains control of underwriting and claim administration; request for approval to use this modified reserve basis must include

(A) an analysis of the credibility of the experience;

(B) a description of how all the insurer's experience is proposed to be used in setting the reserves;

(C) a description and quantification of the margins to be included;

(D) a summary of the financial impact that the proposed plan of modification would have on the insurer's last filed annual statement;

(E) a copy of the approval from the state of domicile; and

(F) all other information requested by the director;

(6) any generally accepted actuarial reserving method or other reasonable method approved by the director may be used; the method used to estimate liabilities may be an aggregate method; approximations based on groupings and averages may also be used.

(e) Claim reserves that are valued based on the 1964 or 1985 Commissioners' Individual Disability Tables must include a provision for a waiver of premium benefit with the minimum reserve for the benefit equal to the valuation net premium to be waived.

Sec. 21.18.086. Premium reserves for health insurance. (a) Unearned premium reserves must be established for the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(b) Due and unpaid premiums that are carried as an asset in the annual statement must be treated as premiums in force and are subject to the unearned premium reserve requirements of this section. Unpaid commissions, premium taxes, and costs of collection associated with due and unpaid premiums must be carried in the annual statement as an offsetting liability.

(c) Gross premiums paid in advance for a period of coverage starting after the next premium due date following the valuation date may be discounted to the valuation date and must be held as a separate liability in the annual statement or as an addition to the unearned premium reserve established in this section.

(d) The minimum unearned premium reserve for a policy is the pro rata unearned modal premium that applies to the valuation period beyond the date of valuation. If a policy reserve is required for a policy, the unearned modal premium is the valuation net modal premium on the policy reserve. If no policy reserve is required for a policy, the unearned modal premium is the gross modal premium for the policy.

(e) The sum of the unearned premium and policy reserves for all policies may not be less than the gross modal unearned premium reserve on all policies as of the date of valuation. The total unearned premium and policy reserves may not be less than the expected claims for the period after the valuation date represented by the

unearned premium reserve.

(f) An insurer may use approximations and estimates in determining premium reserves, including groupings, averages, and aggregate estimates. The approximations or estimates must be tested periodically and not less frequently than triennially to determine adequacy.

(g) Premium reserves based on the 1964 or 1985 Commissioners' Individual Disability Tables must include policies on premium waiver as in-force contracts and establish a minimum reserve for a waiver of premium benefit equal to the unearned modal valuation net premium being waived.

* **Sec. 16.** AS 21.21 is amended by adding a new section to read:

Sec. 21.21.410. Custodians. (a) A custodial agreement between an insurer and an institution holding the assets, securities, or investments of the insurer must provide that the custodian is obligated to indemnify the insurer for losses involving an insurance company asset or security in the custodian's custody resulting from the negligence or dishonesty of the custodian's officers, employees, or agents, or caused by burglary, robbery, holdup, theft, or mysterious disappearance, including loss by damage or destruction. The agreement must also provide that, in the event of a loss, an asset or security will be promptly replaced or the value of the asset or security and the value of a loss of rights or privileges resulting from the loss will be promptly replaced.

(b) The custodian for assets, securities, or investments of the insurer may only be a bank, trust company, or securities firm that is properly authorized by the insurer and approved by the director.

* **Sec. 17.** AS 21.27.010(f) is amended to read:

(f) A person who performs management services under a written contract for an admitted insurer is not required to be licensed as a managing general agent [,] if

(1) either

(A) the person is a United States manager of the United States branch of an alien admitted insurer; or

(B) the person's compensation is not based on the volume of premium written; and

(2) the person

(A) is a wholly-owned subsidiary of the admitted insurer;

(B) wholly owns the admitted insurer; or

(C) is a wholly-owned subsidiary of the insurance holding company subject to AS 21.22 that owns or controls the admitted insurer.

* **Sec. 18.** AS 21.27.010(i) is amended to read:

(i) A person licensed under AS 21.75 as an attorney-in-fact, or a person who meets the requirements for exemption from licensure under AS 21.75, is not required to be additionally licensed under this chapter while acting on behalf of subscribers and within the scope and authority of a subscribers agreement of a reciprocal insurer or exchange licensed under AS 21.75.

* **Sec. 19.** AS 21.27.040(a) is amended to read:

(a) Application for a license shall be made to the director upon forms prescribed by the director. As a part of or in connection with [,] the application, the applicant shall furnish information concerning the applicant's identity, personal history, experience, business record, purposes, [OF THE APPLICANT] and other pertinent facts [CONCERNING THE APPLICANT] that the director may reasonably require. The applicant shall declare under oath and subject to penalty of denial, nonrenewal, suspension, or revocation of a license issued by the director that the statements made in or in connection with the application are true, correct, and complete to the best of the applicant's knowledge and belief. Payment of an application fee established under AS 21.06.250 must be submitted with the application.

* **Sec. 20.** AS 21.27.370(b) is amended to read:

(b) A person [LICENSEE] may not be promised or paid, directly or indirectly, compensation for procuring an application or for placing a kind or class of insurance for which the person [LICENSEE] is not then licensed to procure or place or for insurance that the person [LICENSEE] is prohibited by this title from procuring or placing.

* **Sec. 21.** AS 21.27.390(b) is amended to read:

(b) Except as otherwise provided by law, a [A] temporary license may not be in effect for more than 90 consecutive days [,] and may not be renewed or reissued

for more than one additional 90-day period.

* Sec. 22. AS 21.27.405(b) is amended to read:

(b) If the director determines that a person has violated this chapter, the director shall serve an order upon the person charged requiring that person to cease and desist from engaging in the act or practice. [SERVICE REQUIRED UNDER THIS SUBSECTION SHALL BE BY MAIL WITH A CERTIFICATE OF MAILING FROM THE UNITED STATES POSTAL SERVICE.] A person aggrieved by the cease and desist order may demand a hearing under AS 21.06.170 - 21.06.240.

* Sec. 23. AS 21.27.440(a) is amended to read:

(a) In addition to any other penalty provided by law, a person that the director determines under AS 21.06.170 - 21.06.240 has violated the provisions of this chapter is subject to

(1) a civil penalty equal to the compensation promised, paid, or to be paid, directly or indirectly, to a <u>person</u> [LICENSEE] in regard to each violation;

(2) either a civil penalty of not more than $10,000 for each violation or a civil penalty of not more than $25,000 for each violation if the director determines that the person wilfully violated the provisions of this chapter; and

(3) denial, nonrenewal, suspension, or revocation of a license.

* Sec. 24. AS 21.27.640(b)(5) is amended to read:

(5) provide in or with its application

(A) all basic organizational documents of the third-party administrator, including articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, and other applicable documents and all endorsements to the required documents;

(B) the bylaws, rules, regulations, or similar documents regulating the internal affairs of the administrator;

(C) the names, mailing addresses, physical addresses, official positions, and professional qualifications of persons who are responsible for the conduct of affairs of the third-party administrator; including the members of the board of directors, board of trustees, executive committee, or other governing

board or committee; the principal officers in the case of a corporation or the partners or members in the case of partnership or association; shareholders holding directly or indirectly 10 percent or more of the voting securities of the third-party administrator; and any other person who exercises control or influence over the affairs of the third-party administrator;

(D) certified financial statements for the prior two years, **or for each year and partial year that the applicant has been in business if less than two years,** prepared by an independent certified public accountant **establishing** [THAT ESTABLISH] that the applicant is solvent, that the applicant's system of accounting, internal control, and procedure is operating effectively to provide reasonable assurance that money is promptly accounted for and paid to the person entitled to the money, and any other information that the director may require to review the current financial condition of the applicant; and

(E) a statement describing the business plan, including information on staffing levels and activities proposed in this state and in other jurisdictions and providing details establishing the third-party administrator's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims handling, underwriting, and record keeping;

* Sec. 25. AS 21.34.040(c)(4) is amended to read:

(4) a Lloyd's **syndicate** or **an insurer belonging to a** [OTHER] similar group, including incorporated and individual unincorporated **insurers** [UNDERWRITERS], may qualify if it maintains a trust fund **jointly and severally with the other members of the group** in an amount not less than $50,000,000, as security to the full amount, for the protection of all **policyholders** [ITS POLICY HOLDERS] and creditors of each member of the group in the United States; the incorporated members may not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; the trust fund must consist of instruments of substantially the same character and quality as those that are eligible investments for the capital and statutory reserves of

admitted insurers authorized to write like kinds of insurance in this state or of irrevocable, clean, and unconditional letters of credit; the trust fund must have an expiration date that at no time is less than five years;

* **Sec. 26.** AS 21.34.040(c)(5) is amended to read:

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

* **Sec. 27.** AS 21.34.180(b) is amended to read:

(b) The surplus lines tax is due on the **date specified by the director and may** [SECOND DAY OF MARCH FOLLOWING THE CALENDAR YEAR IN WHICH THE PREMIUM IS WRITTEN. THE TAX SHALL] be paid **by electronic or other means as specified by the director. The tax shall be** [TO AND] reported on forms prescribed by the director [,] or, upon the director's order, paid to and reported on forms prescribed by the surplus lines association.

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

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

* **Sec. 29.** AS 21.36.095(e) is amended to read:

(e) In this section, "insurer" includes

(1) an insurer, as defined in AS 21.90.900;

(2) a group health plan, as defined in 29 U.S.C. 1167(l) (Employee Retirement Income Security Act of 1974);

(3) a health maintenance organization, as defined in AS 21.86.900;

(4) a hospital service corporation or medical service corporation, as defined in AS 21.87.330;

(5) **Comprehensive Health Insurance Association, established in** AS 21.55.010 [A WRITING CARRIER, AS DEFINED IN AS 21.55.500]; and

(6) an entity offering a service benefit plan, as referred to in 42 U.S.C. 1396g-1.

* **Sec. 30.** AS 21.36 is amended by adding a new section to read:

Sec. 21.36.185. Maintenance of complaint handling records. An insurer shall maintain a complete record of all the complaints received by the insurer since the date of the insurer's last market conduct examination under AS 21.06.120 or for four years, whichever occurs first. This record must indicate the total number of complaints, the classification of each complaint by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this section, "complaint" means any written communication primarily expressing a grievance.

* Sec. 31. AS 21.36.240 is amended to read:

Sec. 21.36.240. Failure to renew. An insurer may only [NOT] fail to renew a personal insurance policy **on the policy's annual anniversary** [IN FORCE FOR LESS THAN 12 MONTHS]. An insurer may not fail to renew a policy unless a written notice of nonrenewal is mailed to the named insured as required by AS 21.36.260 at least 20 days for a personal insurance policy, and at least 45 days for a business or commercial insurance policy, before the expiration date of the policy or of the anniversary date of a policy written for a term longer than one year or with no fixed expiration date. If notice of nonrenewal is not given as required by this section, the existing policy shall continue until the insurer provides notice for the time period required by this section for that policy. This section does not apply

(1) if the insurer has in good faith manifested its willingness to renew;

(2) in case of nonpayment of premium for the expiring policy; or

(3) if the insured fails to pay the premium as required by the insurer for renewal.

* Sec. 32. AS 21.36.290 is amended to read:

Sec. 21.36.290. Policy period. (a) A [EXCEPT AS DESCRIBED IN (b) OF THIS SECTION, A] policy with a policy period or term [OF LESS THAN 12 MONTHS SHALL, FOR THE PURPOSES OF AS 21.36.210 - 21.36.310, BE CONSIDERED TO BE WRITTEN FOR A POLICY PERIOD OR TERM OF 12 MONTHS EXCEPT IN CASE OF CANCELLATION UNDER ANY OF THE CIRCUMSTANCES SPECIFIED IN AS 21.36.210, AND A POLICY WRITTEN FOR A TERM] longer than one year or a policy with no fixed expiration date shall be considered to be written for successive policy periods or terms of one year, and termination by an insurer effective on an anniversary date of the policy shall be considered a failure to renew.

(b) The rate for [FOR DETERMINING THE APPROPRIATE RATE OR PREMIUM,] a personal automobile insurance policy may not be changed more frequently than once every [WITH A POLICY PERIOD OR TERM OF LESS THAN SIX MONTHS SHALL, FOR THE PURPOSES OF AS 21.36.210 - 21.36.310, BE CONSIDERED TO BE WRITTEN FOR A POLICY PERIOD OR TERM OF] six months.

* **Sec. 33.** AS 21.36.390 is repealed and reenacted to read:

Sec. 21.36.390. Notice to director. (a) An insurer or licensee that has reason to believe that a fraudulent claim has been made against it shall send the director a report disclosing information that the director may require.

(b) An insurer or licensee that has reason to believe that an insurance producer with which it is doing business is involved in a defalcation, embezzlement, or violation of the provisions of AS 21.36.360 shall immediately send the director a report disclosing the basis for that belief and any other information that the director may require.

(c) An insurer or licensee, its employee or agent, or another person acting in good faith is not civilly liable for damages resulting from the filing of the report or the furnishing of information required by this section or by the director.

(d) The director shall investigate facts reported under this section and shall refer facts indicating a violation of law to the appropriate prosecutor or agency.

* **Sec. 34.** AS 21.39.045(b) is amended to read:

(b) The director shall accept a rate filing for workers' compensation insurance if the filing includes a reasonable method of recognizing differences in rates of pay <u>for the construction industry,</u> and the method uses a credit scale that begins at an amount equal to the average weekly wage in this state <u>for the construction industry</u> as determined by the Department of Labor.

* Sec. 35. AS 21.42.130 is amended to read:

Sec. 21.42.130. Grounds for disapproval. The director shall disapprove a form filed under AS 21.42.120 or withdraw a previous approval of the form [,] only if the form

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

(2) contains or incorporates by reference, where incorporation is permissible, an inconsistent, ambiguous, or misleading clause, or exception and condition that deceptively affects the risk purported to be assumed in the general coverage of the contract;

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

(4) is printed or otherwise reproduced in a manner that renders a provision of the form substantially illegible;

(5) provides benefits for Medicare <u>supplement</u> [SUPPLEMENTAL AND INDIVIDUAL HEALTH] insurance that are unreasonable in relation to the premium charged.

* Sec. 36. AS 21.42 is amended by adding a new section to read:

Sec. 21.42.205. Coordination of benefits. (a) Unless prohibited by federal law, an insurer authorized under AS 21.09 to offer, issue for delivery, deliver, or renew an individual or group health insurance policy for major medical coverage on an expense incurred basis; a health maintenance organization authorized under AS 21.86 to offer a contract to provide major medical health care services on a prepaid basis; or a service corporation authorized under AS 21.87 to offer or renew an individual or group subscriber's contract for major medical coverage shall include a coordination of benefits provision in a major medical policy or contract.

(b) The director may adopt regulations to implement this section.

* **Sec. 37.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.265. Effective date of coverage. Unless otherwise provided by law, the effective date of a change relating to coverage under an insurance contract as a result of a change to this title is the issue date for a new policy or the renewal date for a renewal policy.

* **Sec. 38.** AS 21.54 is amended by adding a new section to read:

Sec. 21.54.015. Rate requirements. Rates charged for a group health insurance policy may not be excessive, inadequate, or unfairly discriminatory.

* **Sec. 39.** AS 21.66.110(a) is amended to read:

(a) **Each** [ANNUALLY EACH] title insurance company shall pay [ON OR BEFORE MARCH 1,] a tax of one percent of the amount of gross title insurance premiums received by it, including as premium income received from guaranteed certificates of title and other guarantees of title [DURING THE PRECEDING CALENDAR YEAR] covering property in this state, as shown by its annual statement to the director. **The director shall specify the due dates and the method of payment.**

* **Sec. 40.** AS 21.66.390(a) is amended to read:

(a) A title insurance company shall make rates that are not excessive or inadequate, [AND] that do not unfairly discriminate between risks in this state that involve essentially the same exposure to loss and expense elements, and that give due consideration to

(1) the desirability for stability of rate structures;

(2) the necessity of assuring the financial solvency of title insurance companies in periods of economic depression by encouraging growth in assets of title insurance companies in periods of high business activity; [AND]

(3) the necessity for assuring a reasonable margin of underwriting and operating profit**; and**

(4) investment income.

* **Sec. 41.** AS 21.69.310(a) is amended to read:

(a) Meetings of stockholders or members of a domestic insurer shall be held in the city or town of its principal office or place of business in this state. **The**

meetings may be held, for good cause, in another location within the state upon approval of the director.

* **Sec. 42.** AS 21.69.520(a) is amended to read:

(a) Subject to the director's prior written approval, a [A] domestic stock or mutual insurer may borrow money to defray the expenses of its organization or [,] provide it with surplus funds [, OR FOR ANY PURPOSE OF ITS BUSINESS,] upon a written agreement that the money is required to be repaid only out of the insurer's surplus in excess of that stipulated in the agreement. The agreement may provide for interest not exceeding six per cent a year, which interest may or may not constitute a liability of the insurer as to its funds other than the excess of surplus, as stipulated in the agreement. A commission or promotion expense may not be paid in connection with the loan.

* **Sec. 43.** AS 21.75.045(a) is amended to read:

(a) A person may not act in the capacity of attorney-in-fact for a subscriber regarding a subject that is resident, located, or to be performed in this state or for a reciprocal insurer licensed to do business in this state unless the person is licensed under this chapter. The director may adopt regulations that establish qualifications for being licensed as an attorney-in-fact. The attorney-in-fact for a [DOMESTIC] reciprocal insurer [TRANSACTING ALL OF ITS INSURANCE ACTIVITIES ON A SUBJECT RESIDENT, LOCATED, AND TO BE PERFORMED IN THIS STATE] is exempt from licensing under this title if the attorney-in-fact

(1) is a wholly-owned subsidiary of the reciprocal; and

(2) does not act as attorney-in-fact for another unaffiliated reciprocal insurer.

* **Sec. 44.** AS 21.76.020(b) is amended to read:

(b) By October 1 of each year, the administrator of a joint insurance arrangement shall prepare and deliver to the Legislative Budget and Audit Committee and the director a report showing the true and correct financial condition of the joint insurance arrangement. The report must

(1) be attested to by the administrator and the board of directors;

(2) include an analysis, certified by a member of the American

Academy of Actuaries, of the sufficiency of the loss reserves; and

(3) be certified by a certified public accountant.

* Sec. 45. AS 21.76.080(e) is amended to read:

(e) Within 150 [60] days of the end of the fiscal year, the administrator shall furnish a detailed report of the operation and condition of the fund to the board of directors and the director of the division of insurance. [THE REPORT FURNISHED TO THE DIRECTOR OF INSURANCE SHALL BE

(1) FILED IN THE GENERAL FORM AND CONTEXT ACCEPTABLE TO THE DIRECTOR;

(2) IN ACCORDANCE WITH ACCOUNTING PRINCIPLES ESTABLISHED UNDER THIS TITLE; AND

(3) AVAILABLE FOR PUBLIC INSPECTION.]

* Sec. 46. AS 21.78.293(b) is amended to read:

(b) The court shall review and adopt [MAY APPROVE, DISAPPROVE, OR MODIFY] the receiver's report on claims by approving those claims that are supported by substantial evidence and disapproving allowed claims that are not supported by substantial evidence. Claims in a report that are not disapproved [MODIFIED] by the court within a period of 120 [60] days following submission by the receiver shall be treated by the receiver as allowed claims.

* Sec. 47. AS 21.87.140(c) is amended to read:

(c) Each service agreement shall further effectively provide in substance that

(1) the participant provider shall be compensated for services rendered to a subscriber in accordance with terms [A SCHEDULE OF FEES] contained in the agreement or attached to and made a part of the agreement [,] and that the participant provider may not request or receive from the service corporation compensation for the services that [WHICH] is not in accord with the terms [SCHEDULE];

(2) compensation for services may be prorated and settled under the circumstances and in the manner referred to in AS 21.87.300;

(3) if the participant provider withdraws from the agreement, the withdrawal may not be effective as to a subscriber's contract in force on the date of the withdrawal until the termination of the subscriber's contract or the next anniversary

of the subscriber's contract, whichever date is the earlier.

* Sec. 48. AS 21.87.150(c) is amended to read:

(c) Each service agreement must further effectively in substance provide that

(1) the participant hospitals shall be compensated for services rendered to a subscriber in accordance with terms [A SCHEDULE OF CHARGES] contained in the agreement or attached to and made a part of the agreement [,] and that the hospital may not request or receive from the service corporation compensation for the services that is not in accord with the terms [SCHEDULE];

(2) compensation for services may be prorated and settled under the circumstances and in the manner referred to in AS 21.87.300;

(3) if the participant hospital withdraws from the agreement, the withdrawal may not be effective as to a subscriber's contract in force on the date of the withdrawal until the termination of the subscriber's contract or the next anniversary of the subscriber's contract, whichever date is the earlier.

* Sec. 49. AS 21.87.180(a) is amended to read:

(a) A service corporation may not issue or use a basic form of service agreement or subscriber's contract, or application, identification, supplement, or endorsement to be connected with the agreement or contract, until the form has been filed with and approved by the director. This provision does not apply to riders [AGREEMENTS, CONTRACTS, APPLICATIONS, IDENTIFICATION SUPPLEMENTS], endorsements, or other forms of unique character designed for and used with relation to a particular subject [SET OF CIRCUMSTANCES].

* Sec. 50. AS 21.87.190(b) is amended to read:

(b) The service corporation shall, before use, file with the director (1) a schedule of subscription rates, fees, or payments of any kind to be charged subscribers; (2) every rating manual, schedule, plan, rule, or formula; and (3) [SHALL FILE] before use, any modification to the rating manual, schedule, plan, rule, or formula. Each filing must state the effective date and must provide a comprehensive description of the coverage. The director may withhold the rating formula from public inspection for as long as the director determines that withholding the rating formula is necessary to protect the service corporation against unwarranted

injury or is in the public interest [EVERY PROPOSED CHANGE OR MODIFICATION IN THE RATES, FEES, OR PAYMENTS].

* **Sec. 51.** AS 21.87.200 is repealed and reenacted to read:

Sec. 21.87.200. Reserves. In addition to the surplus fund provided for in AS 21.87.210, each service corporation shall establish and maintain unimpaired reserves and liabilities required under AS 21.18.050.

* **Sec. 52.** AS 21.89.020(g) is amended to read:

(g) An insurance company offering automobile liability insurance in this state shall offer a short term policy valid for no more than seven days. The coverage available for the short term policy must be comparable to coverage available for longer term policies. The provisions of AS 21.36.210 - 21.36.310 do not apply to short term policies issued under this subsection.

* **Sec. 53.** AS 21.90.900(29) is amended to read:

(29) "policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements, and papers attached to it and a part of it; for a group, trust, association, or similar entity, it also means a certificate or other evidence of insurance that establishes the written contract of or written agreement for or effecting insurance for an insured or other beneficiary of the entity;

* **Sec. 54.** AS 21.90.900 is amended by adding a new paragraph to read:

(41) "certified financial statement" means a financial statement upon which an independent certified public accountant, or an accountant holding a substantially equivalent designation as determined by the director, renders or disclaims an opinion after performance of an audit.

* **Sec. 55.** AS 21.81 is repealed.

* **Sec. 56.** Sections 4, 5, 25 - 28, and 39 of this Act take effect January 1, 1998.

* **Sec. 57.** Except as provided in sec. 56 of this Act, this Act takes effect on July 1, 1997.

0-LS0850\B
Ford
4/17/97

CS FOR HOUSE BILL NO. 218(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

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

A BILL

FOR AN ACT ENTITLED

"An Act relating to regulation and examination of insurers and insurance agents; relating to kinds of insurance; relating to payment of insurance taxes and to required insurance reserves; relating to insurance policies; relating to regulation of capital, surplus, and investments by insurers; relating to hospital and medical service corporations; relating to the portability and availability of health care insurance; making amendments to the insurance statutes to conform to federal requirements regarding health insurance; relating to the repeal of certain small employer health care insurance provisions; repealing delayed provisions relating to dental, vision, and hearing insurance in secs. 3 and 4, ch. 101, SLA 1992; repealing delayed provisions relating to small employer health care insurance in secs. 4, 7, 9, and 12, ch. 39, SLA 1993; repealing the delayed effective date in sec. 5, ch. 101, SLA 1992, and in sec. 13, ch. 39, SLA 1993; and providing for

is reasonably possible, the director shall prepare and deliver an annual report to the commissioner, who shall notify the legislature that the report is available, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in this state, with a summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose **certificate of authority was surrendered, suspended, or revoked** [BUSINESS WAS CLOSED] during the year **and** [,] the cause of **surrender, suspension, or revocation** [THE CLOSING, AND THE AMOUNT OF ASCERTAINABLE ASSETS AND LIABILITIES OF EACH CLOSED BUSINESS];

(3) the name of each insurer **authorized to do business in this state** against which delinquency or similar proceedings were instituted [,] and**, if against an insurer domiciled in this state,** a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipt and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance [,] or the office of director;

(7) other pertinent information and matters the director considers proper.

*** Sec. 5.** AS 21.06.160(a) is amended to read:

(a) Each person examined, other than [AS TO] examinations under AS 21.06.130, shall pay **a reasonable rate calculated on** [ALL THE COSTS OF, AND EXPENSES INCURRED BY DIVISION STAFF EXAMINERS, INCLUDING] salary, [AND] benefit costs, **and estimated division overhead** for time spent directly or indirectly related to the examination**. Each person examined, other than examinations under AS 21.06.130, shall pay actual out-of-pocket business expenses, including travel expenses, incurred by division staff examiners** [,] and shall pay the compensation of a contract examiner, to be set at a reasonable customary

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

0-LS0850\B
Ford
4/17/97

CS FOR HOUSE BILL NO. 218(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTIETH LEGISLATURE - FIRST SESSION

BY THE HOUSE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

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

A BILL

FOR AN ACT ENTITLED

"An Act relating to regulation and examination of insurers and insurance agents; relating to kinds of insurance; relating to payment of insurance taxes and to required insurance reserves; relating to insurance policies; relating to regulation of capital, surplus, and investments by insurers; relating to hospital and medical service corporations; relating to the portability and availability of health care insurance; making amendments to the insurance statutes to conform to federal requirements regarding health insurance; relating to the repeal of certain small employer health care insurance provisions; repealing delayed provisions relating to dental, vision, and hearing insurance in secs. 3 and 4, ch. 101, SLA 1992; repealing delayed provisions relating to small employer health care insurance in secs. 4, 7, 9, and 12, ch. 39, SLA 1993; repealing the delayed effective date in sec. 5, ch. 101, SLA 1992, and in sec. 13, ch. 39, SLA 1993; and providing for

an effective date."

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

*** Section 1.** PURPOSE. The purpose of secs. 3, 11, 12, 31 - 34, 43 - 57, 59 - 90, 99 - 102, 108, ~~and~~ 110 - 116 of this Act is to implement the minimum federal standards for health care insurance enacted under P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996).

*** Sec. 2.** AS 21.06.030 is amended by adding a new subsection to read:

(h) A volunteer member of an advisory committee who has been appointed by the director under a provision of this title to assist and advise the director on issues or matters concerning a specific area of insurance is not entitled to payment of per diem or travel expenses authorized under AS 39.20.180.

*** Sec. 3.** AS 21.06.085 is amended to read:

Sec. 21.06.085. Uniform data and procedures for health claims. (a) The director shall adopt by regulation uniform claims forms, uniform standards, and uniform procedures for the processing of data relating to billing for and payment of health care services provided to state residents. A health <u>care</u> insurer shall use the uniform claims forms and comply with the uniform standards and procedures established under this section.

(b) In this section,

(1) "health care services" has the meaning given in AS 21.86.900;

(2) ["HEALTH INSURANCE" HAS THE MEANING GIVEN IN AS 21.12.050;

(3)] "health <u>care</u> insurer" **<u>has the meaning given in AS 21.54.500</u>** [MEANS AN INSURER TRANSACTING THE BUSINESS OF HEALTH INSURANCE, A HEALTH MAINTENANCE ORGANIZATION UNDER AS 21.86, A HOSPITAL SERVICE CORPORATION UNDER AS 21.87, A MEDICAL SERVICE CORPORATION UNDER AS 21.87, OR A COMBINED MEDICAL SERVICE AND HOSPITAL SERVICE CORPORATION UNDER AS 21.87].

*** Sec. 4.** AS 21.06.110 is amended to read:

Sec. 21.06.110. Director's annual report. As early in each calendar year as

is reasonably possible, the director shall prepare and deliver an annual report to the commissioner, who shall notify the legislature that the report is available, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in this state, with a summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose **certificate of authority was surrendered, suspended, or revoked** [BUSINESS WAS CLOSED] during the year **and** [,] the cause of **surrender, suspension, or revocation** [THE CLOSING, AND THE AMOUNT OF ASCERTAINABLE ASSETS AND LIABILITIES OF EACH CLOSED BUSINESS];

(3) the name of each insurer **authorized to do business in this state** against which delinquency or similar proceedings were instituted [,] and**, if against an insurer domiciled in this state,** a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipt and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance [,] or the office of director;

(7) other pertinent information and matters the director considers proper.

* **Sec. 5.** AS 21.06.160(a) is amended to read:

(a) Each person examined, other than [AS TO] examinations under AS 21.06.130, shall pay **a reasonable rate calculated on** [ALL THE COSTS OF, AND EXPENSES INCURRED BY DIVISION STAFF EXAMINERS, INCLUDING] salary, [AND] benefit costs, **and estimated division overhead** for time spent directly or indirectly related to the examination**. Each person examined, other than examinations under AS 21.06.130, shall pay actual out-of-pocket business expenses, including travel expenses, incurred by division staff examiners** [,] and shall pay the compensation of a contract examiner, to be set at a reasonable customary

rate, for conducting the examination [,] upon presentation of a detailed account of the charges and expenses by the director or under an order of the director. The accounting may either be presented periodically during the course of the examination or at the termination of the examination. A person may not pay and an examiner may not accept additional compensation for an examination.

*** Sec. 6.** AS 21.09.210(b) is amended to read:

(b) Each insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall pay a tax on the total direct premium income received during the year ending on the preceding December 31 and paid for the insurance of property or risks resident or located in the state, other than wet marine and transportation insurance, after deducting from the total direct premium income the applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to their policies. No deductions may be made of cash surrender value of policies. Considerations received on annuity contracts are not included in the direct premium income and are not subject to tax. The tax shall be paid to the director **at least** annually **but not more often than once each quarter** on **the dates specified by the director. The method of payment must be by the electronic or other payment method specified by the director. The tax** [OR BEFORE MARCH 1, AND] is computed at the rate of

(1) for domestic and foreign insurers, except hospital and medical service corporations, 2.7 percent;

(2) for hospital and medical service corporations, six percent of their gross premiums less claims paid.

*** Sec. 7.** AS 21.09.210(d) is amended to read:

(d) An authorized insurer shall, with respect to all wet marine and transportation contracts written in this state during the preceding calendar year, [ON OR BEFORE MARCH 1 OF EACH YEAR,] pay to the director a tax of three-quarters of one percent on its gross underwriting profit. **The director shall specify the dates that payment is due and the electronic or other method by which payment is to**

be made. The gross underwriting profit is computed by deducting, from the net premiums on wet marine and transportation insurance contracts, the net losses paid during the calendar year under the contracts. In the case of an insurer issuing participating contracts, the gross underwriting profit may not include, for computation of the tax prescribed by this section, the amounts refunded or paid as participation dividends by the insurers to the holders of the contracts. In this subsection,

(1) "net losses" means gross losses less salvage and recoveries on reinsurance ceded;

(2) "net premiums" means gross premiums less all return premiums and premiums for reinsurance.

* **Sec. 8.** AS 21.09 is amended by adding a new section to read:

Sec. 21.09.245. Required notice. (a) If an insurer intends to change the insurer's name, domicile, or other information provided on the certificate of authority, the insurer shall file a notice of the change with the director within 30 days before or after the intended change takes effect.

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

(c) Failure by an insurer to provide notification required by this section may result in a civil penalty of up to $1,000 and, additionally, a civil penalty of up to $50 for each day that the information is withheld from the director.

* **Sec. 9.** AS 21.09 is amended by adding a new section to read:

Sec. 21.09.320. Maintenance of records. (a) An insurer domiciled in a jurisdiction other than this state shall keep at its principal place of business a complete record of its assets, transactions, and affairs in accordance with the methods and systems that are customary or suitable to the kind of insurance transacted.

(b) To meet the requirements of (a) of this section, the insurer shall keep the records specified in AS 21.69.390(d) for 10 years from the date the record was created or as required by the record maintenance requirements of the insurer's domicile jurisdiction, whichever is longer.

* **Sec. 10.** AS 21.12.020(a)(4)(A)(iii) is amended to read:

(iii) in the case of a single assuming insurer, the trust shall consist of trust money representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, include a trust surplus of not less than $20,000,000; the single assuming insurer shall make available to the director an annual certification of the insurer's solvency [BY THE INSURER'S DOMICILIARY REGULATOR AND] by an independent certified public accountant or an accountant holding a substantially equivalent designation as determined by the director;

* **Sec. 11.** AS 21.12.050 is amended to read:

Sec. 21.12.050. Health and health care insurance defined. Health insurance is insurance of human beings (1) against bodily injury, disablement, or death by accident or accidental means; (2) against the resulting expenses of the injury, disablement, or death; (3) against disablement or expense resulting from sickness or childbirth; (4) against expense incurred in prevention of sickness; (5) for dental care; and (6) **including every insurance** that applies to injury, disablement, or death. Transaction of health insurance includes disability insurance **and stop-loss insurance** but does not include workers' compensation insurance. **Health care insurance described in (b) of this section is a type of health insurance under this subsection.**

* **Sec. 12.** AS 21.15.050 is amended by adding new subsections to read:

(b) Health care insurance means that part of health insurance that provides benefits for medical care whether provided directly, through reimbursement, or other method.

(c) In this section, "stop-loss insurance" means insurance purchased by a self-insured employer to cover benefits the employer incurs in excess of a preset limit.

* **Sec. 13.** AS 21.14.010(a) is amended to read:

(a) A life and health domestic insurer, property and casualty domestic insurer, or other insurer required by the director shall, on or before March 1, submit to the director a report of its risk based capital covering the previous calendar year [, IF REQUIRED BY THE DIRECTOR]. The report must be in a form and contain the

information required by risk based capital instructions. A domestic insurer required to submit a report under this subsection shall file the report with

(1) the National Association of Insurance Commissioners; and

(2) the insurance regulatory agency in each state in which the insurer is authorized to transact business [,] if the insurance regulatory agency has requested the report in writing from the insurer; a report requested under this paragraph shall be delivered

(A) not later than 15 days from the receipt of a request if the report has already been filed with the director; or

(B) at the time the report is filed with the director, if the report has not yet been filed with the director.

* **Sec. 14.** AS 21.14.200(18) is amended to read:

(18) "risk based capital instructions" means risk based capital instructions for a life and health insurer or for a property and casualty insurer adopted by **order of** [REGULATION BY] the director **after an open meeting as provided** under **AS 44.62.310** [AS 21.14.010];

* **Sec. 15.** AS 21.18.050 is amended to read:

Sec. 21.18.050. Reserves and liabilities, in general. In a determination of the financial condition of an insurer, capital stock and liabilities to be charged against its assets shall include

(1) the amount of its capital stock outstanding, if any;

(2) the amount, estimated consistent with the provisions of this title, necessary to pay all of its unpaid losses and claims incurred on or before the date of statement, whether reported or unreported, together with the expenses of adjustment or settlement;

(3) with reference to life and health insurance and annuity contracts,

(A) the amount of reserves on life insurance policies and annuity contracts in force, valued according to the tables of mortality, rates of interest, and methods adopted under this title that are applicable;

(B) reserves for disability benefits, for both active and disabled lives;

(C) reserves for accidental death benefits;

(D) additional reserves that may be required by the director, consistent with practice formulated or approved by the National Association of Insurance Commissioners, on account of the insurance;

(4) with reference to health insurance, the amount of reserves required under AS 21.18.080 - 21.18.086 [AS 21.18.080];

(5) with reference to insurance other than specified in (3) and (4) of this section, and other than title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with this chapter;

(6) taxes, expenses, and other obligations due or accrued at the date of the statement.

* **Sec. 16.** AS 21.18.080 is repealed and reenacted to read:

Sec. 21.18.080. Reserve standards for health insurance. (a) The adequacy of health insurance reserves must be determined based on the sum of policy reserves determined under AS 21.18.082, claim reserves determined under AS 21.18.084, and premium reserves determined under AS 21.18.086.

(b) Reserve adequacy must be determined by a prospective gross premium valuation. For policies in force, in a claims status, or in a continuation of benefits status on the valuation date, the gross premium valuation must take into account the present value of all expected benefits unpaid, all expected expenses unpaid, and all unearned or expected premiums, including expected future premium increases.

(c) A gross premium valuation must be performed whenever there is an indication that reserves and future premiums may be insufficient to cover future claims for a particular block of policies or for the entire health insurance block. If a reserve inadequacy is determined to exist, the loss must be immediately recognized and reserves increased to account for the inadequacy. The increased reserves will be considered minimum reserves.

* **Sec. 17.** AS 21.18 is amended by adding new sections to read:

Sec. 21.18.082. Policy reserves for health insurance. (a) Except as provided in (b) of this section, policy reserves are required for all individual and group health

insurance policies or groups of policies

(1) with level premiums or with a gross premium pricing structure at time of issue that results in future benefits exceeding the corresponding future valuation net premiums at any time; or

(2) for which gross premiums are restricted by contract, regulation, or another reason that results in future gross premiums, reduced by expenses for administration, commissions, and taxes, being insufficient to cover future claims.

(b) Policy reserves are not required for health insurance policies that cannot be continued after one year from the date of issue.

(c) The structure of valuation net premiums used under a health insurance policy must be consistent with the structure of gross premiums on the date the policy is issued.

(d) For return of premium benefits, deferred cash benefits, policies with premium rates that are not guaranteed, and where the effects of insurer underwriting by policy duration are specifically used in the valuation morbidity standard, termination rates that exceed the mortality rates in the tables required in (g)(2) of this section may be used but may not exceed the lesser of

(1) 80 percent of the total termination rate used in the calculation of gross premiums; or

(2) eight percent.

(e) The methods and procedures used to determine health insurance policy reserves must be consistent with the methods and procedures used to determine claim reserves for a health insurance policy.

(f) Negative reserves on a benefit may be offset against positive reserves for other benefits in the same policy, but the total policy reserve with respect to all benefits combined may not be less than zero.

(g) Except as provided in (d) and (h) - (k) of this section, policy reserves for policies issued after July 1, 1997, must be determined based on

(1) a maximum interest rate equal to the maximum interest rate allowed under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the health insurance policy;

(2) a termination assumption equal to the mortality table allowed under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the health insurance policy or equal to a mortality table approved by the director for use in determining the policy reserves;

(3) for long-term care policies issued after July 1, 1997,

(A) a mortality assumption equal to the 1983 Group Annuity Mortality Table without projection;

(B) a lapse assumption for policy durations one through four equal to the lesser of 80 percent of the voluntary lapse rate used in the calculation of gross premiums or eight percent; and

(C) a lapse assumption for policy durations five and later of 100 percent of the voluntary lapse rate used in the calculation of the gross premiums or four percent;

(4) a two-year full preliminary term method under which the terminal reserve is zero on the first and second policy anniversary dates;

(5) a morbidity assumption for

(A) individual disability income insurance issued (i) after December 31, 1997, equal to Tables A or B of the 1985 Commissioners' Individual Disability Tables for policies; and (ii) before January 1, 1998, equal to the 1964 or 1985 Commissioners' Individual Disability Tables; the insurer shall indicate which morbidity table the insurer will use for all individual disability income policies issued in a calendar year;

(B) group disability income insurance issued

(i) after December 31, 1997, equal to the 1987 Commissioners' Group Disability Table; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(C) scheduled or fixed time period hospital, surgical, or maternity benefit policies issued

(i) after December 31, 1997, equal to the 1974 Medical Expense Table A from the Transactions of the Society of Actuaries,

Volume XXX; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(D) cancer expense benefits for policies issued

(i) after December 31, 1997, equal to the 1985 National Association of Insurance Commissioners Cancer Claim Cost Tables; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998;

(E) accidental death benefits for policies issued

(i) after December 31, 1997, equal to the 1959 accidental death benefit table; and

(ii) before January 1, 1998, equal to the morbidity assumption in use by the insurer before January 1, 1998; or

(F) all other individual or group policy benefits equal to a morbidity table established for reserve determination by an actuary qualified to determine the morbidity table and approved by the director; the morbidity table must contain a pattern of incurred claims cost that reflects the underlying morbidity and may not be constructed for the primary purpose of minimizing reserves.

(h) The reserve method for return of premium or other deferred cash benefits must be a preliminary term method that is applied only in relation to the issue date of the policy and is a

(1) one-year preliminary term method if benefits are provided before the 20th policy anniversary; or

(2) two-year preliminary term method if the benefits are provided only on or after the 20th policy anniversary.

(i) The reserve method for long-term care insurance must be calculated on a

(1) two-year full preliminary term method for a policy or certificate issued on or before July 1, 1997; and

(2) one-year full preliminary term method for a policy or certificate issued after July 1, 1997.

(j) Reserve adjustments due to rate changes, revised assumptions, or other reasons for return of premium or other deferred cash benefits must be applied on the effective date of the adoption of the reserve adjustment.

(k) An alternative method or basis of determining policy reserves may be used if the aggregate policy reserve is not less than the aggregate policy reserves determined under (c) - (j) of this section.

(l) An insurer shall annually review prospective policy liabilities on policies valued by tabular reserves to determine the continuing adequacy and reasonableness of the tabular reserves given future gross premiums. The insurer shall make adjustments to the tabular reserves if the tests indicate that the basis of the reserves is no longer adequate.

(m) Policy reserves that are valued based on the 1964 or 1985 Commissioners Individual Disability Tables must include a provision for a waiver of premium benefit with the minimum reserve for the benefit equal to the valuation net premium to be waived.

(n) Policy reserves for long-term care insurance may not be less than the net single premium for any nonforfeiture benefits provided by the policy or certificate.

Sec. 21.18.084. Claim reserves for health insurance. (a) Claim reserves are required for all incurred and unpaid claims on all health insurance policies.

(b) Claim expense reserves are required for the estimated expense of settlement of all incurred and unpaid claims.

(c) Claim reserves for prior valuation years must be tested for adequacy and reasonableness using claim runoff schedules in accordance with the statutory annual statement, including consideration of any residual unpaid liability. Claim reserve adequacy must be determined in the aggregate.

(d) Claim reserves must be determined as follows:

(1) for policies that require policy reserves under AS 21.18.082(a), based on a maximum interest rate equal to the maximum interest rate allowed under AS 21.18.110 for the valuation of whole life insurance issued on the same date as the date the claim was incurred;

(2) for policies that do not require policy reserves under

AS 21.18.082(b), based on a maximum interest rate equal to the maximum interest rate allowed under AS 21.18.110 for the valuation of single premium immediate annuities issued on the same date as the date the claim was incurred less 100 basis points;

(3) except as provided in (4) and (5) of this subsection, a morbidity assumption for

(A) individual disability income insurance must be equal to the morbidity assumption used in determining policy reserves under AS 21.18.082(g)(5);

(B) group disability income insurance for policies issued

(i) after December 31, 1997, must be equal to the 1987 Commissioners Group Disability Table; and

(ii) before January 1, 1998, must be equal to the morbidity assumption in use by the insurer before January 1, 1998;

(C) accidental death benefits must be equal to the actual amount of claims incurred; and

(D) all other individual or group policy benefits must be equal to a morbidity table approved by the director and established for reserve determination by an actuary qualified to determine the morbidity table;

(4) for individual or group disability claims with a duration from disablement of less than two years, morbidity assumptions may be based on the insurer's experience if determined credible by the insurer or upon another basis designed to place a sound value on the liabilities as determined by the insurer;

(5) if approved by the director, reserves for group disability income claims with a duration from disablement of more than two years but less than five years may be based on the insurer's experience for which the insurer maintains control of underwriting and claim administration; request for approval to use this modified reserve basis must include

(A) an analysis of the credibility of the experience;

(B) a description of how all the insurer's experience is proposed to be used in setting the reserves;

(C) a description and quantification of the margins to be

included;

(D) a summary of the financial impact that the proposed plan of modification would have on the insurer's last filed annual statement;

(E) a copy of the approval from the state of domicile; and

(F) all other information requested by the director;

(6) any generally accepted actuarial reserving method or other reasonable method approved by the director may be used; the method used to estimate liabilities may be an aggregate method; approximations based on groupings and averages may also be used.

(e) Claim reserves that are valued based on the 1964 or 1985 Commissioners Individual Disability Tables must include a provision for a waiver of premium benefit with the minimum reserve for the benefit equal to the valuation net premium to be waived.

Sec. 21.18.086. Premium reserves for health insurance. (a) Unearned premium reserves must be established for the period of coverage for which premiums, other than premiums paid in advance, have been paid beyond the date of valuation.

(b) Due and unpaid premiums that are carried as an asset in the annual statement must be treated as premiums in force and are subject to the unearned premium reserve requirements of this section. Unpaid commissions, premium taxes, and costs of collection associated with due and unpaid premiums must be carried in the annual statement as an offsetting liability.

(c) Gross premiums paid in advance for a period of coverage starting after the next premium due date following the valuation date may be discounted to the valuation date and must be held as a separate liability in the annual statement or as an addition to the unearned premium reserve established in this section.

(d) The minimum unearned premium reserve for a policy is the pro rata unearned modal premium that applies to the valuation period beyond the date of valuation. If a policy reserve is required for a policy, the unearned modal premium is the valuation net modal premium on the policy reserve. If no policy reserve is required for a policy, the unearned modal premium is the gross modal premium for the policy.

(e) The sum of the unearned premium and policy reserves for all policies may not be less than the gross modal unearned premium reserve on all policies as of the date of valuation. The total unearned premium and policy reserves may not be less than the expected claims for the period after the valuation date represented by the unearned premium reserve.

(f) An insurer may use approximations and estimates in determining premium reserves, including groupings, averages, and aggregate estimates. The approximations or estimates must be tested periodically and not less frequently than triennially to determine adequacy.

(g) Premium reserves based on the 1964 or 1985 Commissioners' Individual Disability Tables must include policies on premium waiver as in-force contracts and establish a minimum reserve for a waiver of premium benefit equal to the unearned modal valuation net premium being waived.

* **Sec. 18.** AS 21.21 is amended by adding a new section to read:

Sec. 21.21.410. Custodians. (a) A custodial agreement between an insurer and an institution holding the assets, securities, or investments of the insurer must provide that the custodian is obligated to indemnify the insurer for losses involving an insurance company asset or security in the custodian's custody resulting from the negligence or dishonesty of the custodian's officers, employees, or agents, or caused by burglary, robbery, holdup, theft, or mysterious disappearance, including loss by damage or destruction. The agreement must also provide that, in the event of a loss, an asset or security will be promptly replaced or the value of the asset or security and the value of a loss of rights or privileges resulting from the loss will be promptly replaced.

(b) The custodian for assets, securities, or investments of the insurer may only be a bank, trust company, or securities firm that is properly authorized by the insurer and approved by the director.

* **Sec. 19.** AS 21.27.010(f) is amended to read:

(f) A person who performs management services under a written contract for an admitted insurer is not required to be licensed as a managing general agent [,] if

(1) either

(A) the person is a United States manager of the United States branch of an alien admitted insurer; or

(B) the person's compensation is not based on the volume of premium written; and

(2) the person

(A) is a wholly-owned subsidiary of the admitted insurer;

(B) wholly owns the admitted insurer; **or**

(C) is a wholly-owned subsidiary of the insurance holding company subject to AS 21.22 that owns or controls the admitted insurer.

* **Sec. 20.** AS 21.27.010(i) is amended to read:

(i) A person licensed under AS 21.75 as an attorney-in-fact**, or a person who meets the requirements for exemption from licensure under AS 21.75,** is not required to be additionally licensed under this chapter while acting on behalf of subscribers and within the scope and authority of a subscribers agreement of a reciprocal insurer or exchange licensed under AS 21.75.

* **Sec. 21.** AS 21.27.040(a) is amended to read:

(a) Application for a license shall be made to the director upon forms prescribed by the director. As a part of or in connection with [,] the application, the applicant shall furnish information concerning the **applicant's** identity, personal history, experience, business record, purposes, [OF THE APPLICANT] and other pertinent facts [CONCERNING THE APPLICANT] that the director may reasonably require. The applicant shall declare under **oath and subject to** penalty of denial, nonrenewal, suspension, or revocation of a license issued by the director that the statements made in or in connection with the application are true, correct, and complete to the best of the applicant's knowledge and belief. Payment of an application fee established under AS 21.06.250 must be submitted with the application.

* **Sec. 22.** AS 21.27.370(b) is amended to read:

(b) A **person** [LICENSEE] may not be promised or paid, directly or indirectly, compensation for procuring an application or for placing a kind or class of insurance for which the **person** [LICENSEE] is not then licensed to procure or place or for insurance that the **person** [LICENSEE] is prohibited by this title from procuring or

placing.

* **Sec. 23.** AS 21.27.390(b) is amended to read:

(b) **Except as otherwise provided by law, a** [A] temporary license may not be in effect for more than 90 consecutive days [,] and may not be renewed or reissued for more than one additional 90-day period.

* **Sec. 24.** AS 21.27.405(b) is amended to read:

(b) If the director determines that a person has violated this chapter, the director shall serve an order upon the person charged requiring that person to cease and desist from engaging in the act or practice. [SERVICE REQUIRED UNDER THIS SUBSECTION SHALL BE BY MAIL WITH A CERTIFICATE OF MAILING FROM THE UNITED STATES POSTAL SERVICE.] A person aggrieved by the cease and desist order may demand a hearing under AS 21.06.170 - 21.06.240.

* **Sec. 25.** AS 21.27.440(a) is amended to read:

(a) In addition to any other penalty provided by law, a person that the director determines under AS 21.06.170 - 21.06.240 has violated the provisions of this chapter is subject to

(1) a civil penalty equal to the compensation promised, paid, or to be paid, directly or indirectly, to a **person** [LICENSEE] in regard to each violation;

(2) either a civil penalty of not more than $10,000 for each violation or a civil penalty of not more than $25,000 for each violation if the director determines that the person wilfully violated the provisions of this chapter; and

(3) denial, nonrenewal, suspension, or revocation of a license.

* **Sec. 26.** AS 21.27.640(b)(5) is amended to read:

(5) provide in or with its application

(A) all basic organizational documents of the third-party administrator, including articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement, and other applicable documents and all endorsements to the required documents;

(B) the bylaws, rules, regulations, or similar documents regulating the internal affairs of the administrator;

(C) the names, mailing addresses, physical addresses, official positions, and professional qualifications of persons who are responsible for the conduct of affairs of the third-party administrator; including the members of the board of directors, board of trustees, executive committee, or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of partnership or association; shareholders holding directly or indirectly 10 percent or more of the voting securities of the third-party administrator; and any other person who exercises control or influence over the affairs of the third-party administrator;

(D) certified financial statements for the prior two years, **or for each year and partial year that the applicant has been in business if less than two years,** prepared by an independent certified public accountant **establishing** [THAT ESTABLISH] that the applicant is solvent, that the applicant's system of accounting, internal control, and procedure is operating effectively to provide reasonable assurance that money is promptly accounted for and paid to the person entitled to the money, and any other information that the director may require to review the current financial condition of the applicant; and

(E) a statement describing the business plan, including information on staffing levels and activities proposed in this state and in other jurisdictions and providing details establishing the third-party administrator's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims handling, underwriting, and record keeping;

*** Sec. 27.** AS 21.34.040(c)(4) is amended to read:

(4) a Lloyd's **syndicate** or **an insurer belonging to a** [OTHER] similar group, including incorporated and individual unincorporated **insurers** [UNDERWRITERS], may qualify if it maintains a trust fund **jointly and severally with the other members of the group** in an amount not less than $50,000,000, as security to the full amount, for the protection of all **policyholders** [ITS POLICY HOLDERS] and creditors of each member of the group in the United States; the incorporated members may not be engaged in any business other than underwriting as

a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; the trust fund must consist of instruments of substantially the same character and quality as those that are eligible investments for the capital and statutory reserves of admitted insurers authorized to write like kinds of insurance in this state or of irrevocable, clean, and unconditional letters of credit; the trust fund must have an expiration date that at no time is less than five years;

*** Sec. 28.** AS 21.34.040(c)(5) is amended to read:

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

*** Sec. 29.** AS 21.34.180(b) is amended to read:

(b) The surplus lines tax is due on the **date specified by the director and may** [SECOND DAY OF MARCH FOLLOWING THE CALENDAR YEAR IN WHICH THE PREMIUM IS WRITTEN. THE TAX SHALL] be paid **by electronic or other means as specified by the director. The tax shall be** [TO AND] reported on forms prescribed by the director [,] or, upon the director's order, paid to and reported on forms prescribed by the surplus lines association.

*** Sec. 30.** AS 21.34.190(a) is amended to read:

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

*** Sec. 31.** AS 21.36.095(a) is amended to read:

(a) **A health care** [AN] insurer may not deny enrollment of a child under the

health **care** insurance of the child's parent on the ground that the child

(1) was born out of wedlock;

(2) is not claimed as a dependent on the parent's federal income tax return;

(3) does not reside with the parent; or

(4) does not reside in the **health care** insurer's service area.

*** Sec. 32.** AS 21.36.095(b) is amended to read:

(b) If a parent is required under AS 25.27.020(a)(9) or 25.27.060(c) to provide medical support for a child and the parent is eligible for family health **care insurance** coverage through an insurer, the parent's **health care** insurer

(1) shall allow the parent to enroll the child under the family **health care insurance** coverage without regard to restrictions relating to enrollment periods if the child is otherwise eligible;

(2) shall, if the parent fails to apply for enrollment of a child under (1) of this subsection, enroll the child under the parent's family **health care insurance** coverage upon application by the child's other parent or custodian, the child support enforcement agency, or the Department of Health and Social Services; and

(3) may not disenroll or eliminate **health care insurance** coverage of the child unless the insurer has received written evidence that

(A) the parent with the insurance coverage is no longer required by court order or administrative order to provide the child's medical support; or

(B) the child is or will be enrolled in comparable health **care insurance** coverage through another insurer that will take effect not later than the effective date of the disenrollment or elimination of coverage.

*** Sec. 33.** AS 21.36.095(c) is amended to read:

(c) **A health care** [AN] insurer who provides health **care insurance** coverage of a child through family health **care insurance** coverage of a parent who does not have sole physical custody of the child shall

(1) provide to the child's other parent or custodian the information that may be necessary for the child to obtain benefits through the family health **care**

insurance coverage.

(2) allow the child's other parent or custodian, or the child's health care provider with the parent's or custodian's approval, to submit claims for covered services without the approval of the parent whose **health care** insurance covers the child; and

(3) make payment on claims submitted under (2) of this subsection directly to the child's other parent or custodian, the health care provider, or a state agency to which the child's medical support rights have been assigned under AS 25.27.120 or AS 47.07.025.

* **Sec. 34.** AS 21.36.095(e) is repealed and reenacted to read:

(e) In this section, "health care insurer" has the meaning given in AS 21.54.500 and includes the Comprehensive Health Insurance Association as described in AS 21.55.010.

* **Sec. 35.** AS 21.36 is amended by adding a new section to read:

Sec. 21.36.185. Maintenance of complaint handling records. An insurer shall maintain a complete record of all the complaints received by the insurer since the date of the insurer's last market conduct examination under AS 21.06.120 or for four years, whichever occurs first. This record must indicate the total number of complaints, the classification of each complaint by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this section, "complaint" means any written communication primarily expressing a grievance.

* **Sec. 36.** AS 21.36.240 is amended to read:

Sec. 21.36.240. Failure to renew. An insurer may **only** [NOT] fail to renew a personal insurance policy **on the policy's annual anniversary** [IN FORCE FOR LESS THAN 12 MONTHS]. An insurer may not fail to renew a policy unless a written notice of nonrenewal is mailed to the named insured as required by AS 21.36.260 at least 20 days for a personal insurance policy, and at least 45 days for a business or commercial insurance policy, before the expiration date of the policy or of the anniversary date of a policy written for a term longer than one year or with no fixed expiration date. If notice of nonrenewal is not given as required by this section,

the existing policy shall continue until the insurer provides notice for the time period required by this section for that policy. This section does not apply

(1) if the insurer has in good faith manifested its willingness to renew;

(2) in case of nonpayment of premium for the expiring policy; or

(3) if the insured fails to pay the premium as required by the insurer for renewal.

*** Sec. 37.** AS 21.36.290 is amended to read:

Sec. 21.36.290. Policy period. (a) A [EXCEPT AS DESCRIBED IN (b) OF THIS SECTION, A] policy with a policy period or term [OF LESS THAN 12 MONTHS SHALL, FOR THE PURPOSES OF AS 21.36.210 - 21.36.310, BE CONSIDERED TO BE WRITTEN FOR A POLICY PERIOD OR TERM OF 12 MONTHS EXCEPT IN CASE OF CANCELLATION UNDER ANY OF THE CIRCUMSTANCES SPECIFIED IN AS 21.36.210, AND A POLICY WRITTEN FOR A TERM] longer than one year or a policy with no fixed expiration date shall be considered to be written for successive policy periods or terms of one year, and termination by an insurer effective on an anniversary date of the policy shall be considered a failure to renew.

(b) **The rate for** [FOR DETERMINING THE APPROPRIATE RATE OR PREMIUM,] a personal automobile insurance policy **may not be changed more frequently than once every** [WITH A POLICY PERIOD OR TERM OF LESS THAN SIX MONTHS SHALL, FOR THE PURPOSES OF AS 21.36.210 - 21.36.310, BE CONSIDERED TO BE WRITTEN FOR A POLICY PERIOD OR TERM OF] six months.

*** Sec. 38.** AS 21.36.390 is repealed and reenacted to read:

Sec. 21.36.390. Notice to director. (a) An insurer or licensee that has reason to believe that a fraudulent claim has been made against it shall send the director a report disclosing information that the director may require.

(b) An insurer or licensee that has reason to believe that an insurance producer with which it is doing business is involved in a defalcation, embezzlement, or violation of the provisions of AS 21.36.360 shall immediately send the director a report disclosing the basis for that belief and any other information that the director may

require.

(c) An insurer or licensee, its employee or agent, or another person acting in good faith is not civilly liable for damages resulting from the filing of the report or the furnishing of information required by this section or by the director.

(d) The director shall investigate facts reported under this section and shall refer facts indicating a violation of law to the appropriate prosecutor or agency.

* **Sec. 39.** AS 21.39.045(b) is amended to read:

(b) The director shall accept a rate filing for workers' compensation insurance if the filing includes a reasonable method of recognizing differences in rates of pay **for the construction industry,** and the method uses a credit scale that begins at an amount equal to the average weekly wage in this state **for the construction industry** as determined by the Department of Labor.

* **Sec. 40.** AS 21.42.130 is amended to read:

Sec. 21.42.130. Grounds for disapproval. The director shall disapprove a form filed under AS 21.42.120 or withdraw a previous approval of the form [,] only if the form

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

(2) contains or incorporates by reference, where incorporation is permissible, an inconsistent, ambiguous, or misleading clause, or exception and condition that deceptively affects the risk purported to be assumed in the general coverage of the contract;

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

(4) is printed or otherwise reproduced in a manner that renders a provision of the form substantially illegible;

(5) provides benefits for Medicare **supplement** [SUPPLEMENTAL AND INDIVIDUAL HEALTH] insurance that are unreasonable in relation to the premium charged.

* **Sec. 41.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.205. Coordination of benefits. (a) Unless prohibited by federal law, an insurer authorized under AS 21.09 to offer, issue for delivery, deliver, or renew

an individual or group health insurance policy for major medical coverage on an expense incurred basis; a health maintenance organization authorized under AS 21.86 to offer a contract to provide major medical health care services on a prepaid basis; or a service corporation authorized under AS 21.87 to offer or renew an individual or group subscriber's contract for major medical coverage shall include a coordination of benefits provision in a major medical policy or contract.

(b) The director may adopt regulations to implement this section.

* **Sec. 42.** AS 21.42 is amended by adding a new section to read:

Sec. 21.42.265. Effective date of coverage. Unless otherwise provided by law, the effective date of a change relating to coverage under an insurance contract as a result of a change to this title is the issue date for a new policy or the renewal date for a renewal policy.

* **Sec. 43.** AS 21.42.345 is repealed and reenacted to read:

Sec. 21.42.345. Required provision for coverage of dependents. (a) A health care insurance plan providing coverage for a dependent of a covered individual shall, as to the dependent's coverage, also provide that the health care insurance benefits applicable for dependents shall be payable with respect to

(1) a newly born child of a covered individual from the moment of birth;

(2) a child adopted by a covered individual from the date of adoption;

(3) a child placed with a covered individual for adoption from the date of placement for adoption; and

(4) a spouse from not later than the first day of the first month beginning after the date the request for enrollment is received, but the insurer may require that a request for enrollment be received within 31 days of the date of marriage.

(b) The coverage for a newly born child under this section shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(c) If payment of a specific charge is required to provide coverage for a child under this section, the policy or contract may require that notification of birth of a

newly born child, adopted child, or child placed for adoption and payment of the required premium or fees may be required to be furnished to the health care insurer within 31 days after the date of birth, adoption, or placement for adoption in order to have the coverage continue beyond the 31-day period.

(d) Under (a) - (c) of this section, a health care insurer shall offer coverage for a family member, including a newly born child, adopted child, or child placed for adoption, regardless of the marital status of the covered individual.

* **Sec. 44.** AS 21.42.347(a) is amended to read:

(a) **A health care** [AN] insurer who provides coverage for the costs of childbirth shall also provide coverage for the costs of hospitalization or medical care following childbirth for a period of not less than

(1) 48 hours after a vaginal birth; and

(2) 96 hours after a caesarean birth.

* **Sec. 45.** AS 21.42.347(b) is amended to read:

(b) Except as otherwise required to provide coverage specified under (a) of this section, this section does not affect a payment arrangement entered into between a hospital or **health care provider** [PHYSICIAN] and **a health care** [AN] insurer.

* **Sec. 46.** AS 21.42.347(d)(2) is repealed and reenacted to read:

(2) "health care insurer" has the meaning given in AS 21.54.500; "health care insurer" includes the Comprehensive Health Insurance Association as described in AS 21.55.010.

* **Sec. 47.** AS 21.42.353 is repealed and reenacted to read:

Sec. 21.42.353. Coverage for the costs of acupuncture treatment. Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan may offer coverage for services of an acupuncturist licensed under AS 08.06 if the plan covers acupuncture treatment by a health care provider who is subject to other provisions of AS 08.

* **Sec. 48.** AS 21.42.355 is amended to read:

Sec. 21.42.355. Coverage for cost of services provided by nurse midwives. (a) If **a health care insurance plan or an excepted benefits policy or contract** [AN INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY, SUBSCRIBER'S

CONTRACT, ENROLLEE CONTRACT, OR FRATERNAL BENEFIT SOCIETY CERTIFICATE] provides indemnity for the cost of services of a physician provided to women during pregnancy, childbirth, and the period after childbirth, indemnity in a reasonable amount shall also be provided for the cost of an advanced nurse practitioner who provides the same services. Indemnity may be provided under this subsection only if the advanced nurse practitioner is certified to practice as a nurse midwife in accordance with regulations adopted under AS 08.68.100(a), and the services provided are within the scope of practice authorized by that certification.

(b) If **a health care insurance plan or an excepted benefits policy or contract** [AN INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY, SUBSCRIBER'S CONTRACT, ENROLLEE CONTRACT, OR FRATERNAL BENEFIT SOCIETY CERTIFICATE] provides for furnishing those services required of a physician in the care of women during pregnancy, childbirth, and the period after childbirth, the contract shall also provide that an advanced nurse practitioner may furnish those same services instead of a physician. Services may be provided under this subsection only if the advanced nurse practitioner is certified to practice as a nurse midwife in accordance with regulations adopted under AS 08.68.100(a), and the services provided are within the scope of practice authorized by that certification.

* **Sec. 49.** AS 21.42.365 is repealed and reenacted to read:

Sec. 21.42.365. Coverage for treatment of alcoholism or drug abuse. (a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan, except for catastrophic illness insurance, providing coverage for five or more employees of an employer in the group market shall provide a covered employee or the employee's dependent the following coverage for treatment of alcoholism or drug abuse:

(1) benefits of at least $9,600 over two consecutive benefit years; and

(2) lifetime benefits of at least $19,200.

(b) The benefits described in (a) of this section shall be adjusted January 1, 1999, by the director and every three years thereafter to correspond with the change in the medical care component of the consumer price index for all urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor

Statistics, United States Department of Labor. The base year for the first adjustment shall be calendar year 1996.

(c) A health care insurer that offers a health care insurance plan providing coverage under this section may not

(1) require that a covered employee or the employee's dependent be responsible for a deductible or copayment that is different for the determination of benefits relating to treating alcoholism or drug abuse than for the determination of benefits for treating another covered illness;

(2) use a different claim payment methodology in determining the benefits relating to treating alcoholism or drug abuse than that used in determining the benefits for treating another covered illness;

(3) require prenotification of treatment or a second opinion unless the requirement is applicable to other covered major illnesses;

(4) limit coverage by provisions of the insurance contract that are not applicable to other covered major illnesses, including provisions concerning preexisting illnesses or provisions requiring that the exact date of onset be known;

(5) limit treatment services under the insurance contract to either an inpatient or outpatient service;

(6) exclude from coverage the cost of medically necessary treatment, including medical or psychiatric evaluation, activity or family therapy, counseling, or prescription drugs or supplies received at an approved treatment facility; or

(7) deny reimbursement for actual services rendered solely because treatment was interrupted or not completed.

(d) Notwithstanding (a) of this section, if an employer employs fewer than 20 permanent, full-time employees for each working day during each of at least 20 calendar workweeks in either the current calendar year or the preceding calendar year, a health care insurer is not required to provide the coverage specified in (a) of this section to the employer but shall offer that coverage to the employer as optional coverage.

(e) In this section,

(1) "alcoholism or drug abuse" means an illness characterized by

(A) a physiological or psychological dependency, or both, on alcoholic beverages or controlled substances as defined in AS 11.71.900; or

(B) habitual lack of self-control in using alcoholic beverages or controlled substances to the extent that the person's health is substantially impaired or the person's social or economic function is substantially disrupted;

(2) "approved treatment facility" means treatment in a facility that is either approved under AS 47.37.140 or located and licensed for treatment of alcoholism or drug abuse in another state;

(3) "catastrophic illness insurance" means a health care insurance plan that provides benefits for hospital and medical care with a lifetime maximum benefit per insured of at least $250,000 and that has a deductible of at least $5,000;

(4) "cost" means the least of the following:

(A) the actual charge for the treatment received for alcoholism or drug abuse;

(B) the usual, customary, and reasonable charge for the treatment as determined by the contract of coverage; or

(C) the charged agreed to by contract between the treatment provider and the health care insurer;

(5) "treatment" means medical care, including detoxification, as an inpatient or outpatient at an approved treatment facility.

* **Sec. 50.** AS 21.42.375(a) is repealed and reenacted to read:

(a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan shall provide coverage for low-dose mammography screening under the schedule described in (b) of this section if the plan covers mastectomies and prosthetic devices and reconstructive surgery incident to mastectomies.

* **Sec. 51.** AS 21.42.375(b) is amended to read:

(b) The minimum coverage required under (a) of this section includes

(1) a baseline mammogram for a **covered individual** [PERSON] who is at least 35 years of age but less than 40 years of age;

(2) one mammogram every two years for a **covered individual**

[PERSON] who is at least 40 years of age but less than 50 years of age;

(3) an annual mammogram for a **covered individual** [PERSON] who is at least 50 years of age;

(4) a mammogram at any age for a **covered individual** [PERSON] with a history of breast cancer or whose parent or sibling has a history of breast cancer, upon referral by a physician.

* **Sec. 52.** AS 21.42.375(c) is amended to read:

(c) The coverage required by this section

(1) must be included in the **health care insurance plan** [POLICY OR CONTRACT] on a basis that is not less favorable than for other radiological examinations;

(2) may be subject to standard policy provisions applicable to other benefits, such as deductible or copayment provisions.

* **Sec. 53.** AS 21.42.380 is repealed and reenacted to read:

Sec. 21.42.380. Coverage for treatment of phenylketonuria. (a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in this state a health care insurance plan shall provide coverage under the plan for the formulas necessary for the treatment of phenylketonuria. This subsection does not apply to a health care insurance plan that the director has determined by order should be excluded from this subsection.

(b) A health care insurer providing coverage under this section may impose reasonable contract limitations but may not refuse coverage based on a preexisting condition of phenylketonuria or require that an individual covered under the plan pay a higher deductible or copayment for the cost of treating phenylketonuria than for the cost of treating another condition or illness.

(c) In this section, "cost" means the lowest of the following:

(1) the actual charge for the treatment received for phenylketonuria;

(2) the usual, customary, and reasonable charge for the treatment as determined by the contract of coverage; or

(3) the charge agreed to by contract between the treatment provider and the health care insurer.