

ALASKA LEGISLATURE COMMITTEE FILES 1997-1998 8672

9317 HOUSE LABOR & COMMERCE

1 * Sec. 54. AS 21.42.385 is repealed and reenacted to read:

2 Sec. 21.42.385. **Dental, vision, and hearing coverage.** (a) Except for a
3 fraternal benefit society, a health care insurer that offers, issues for delivery, delivers,
4 or renews in this state a health care insurance plan, including a Medicare supplement
5 policy to the extent not prohibited by 42 U.S.C. 1395, shall offer to each plan sponsor
6 or individual minimum dental, vision, and hearing coverage described in (b) of this
7 section. Coverage required under this subsection may be offered as a rider or in a
8 separate policy.

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

10 (1) be provided under contract with another health care insurer; and

11 (2) not be less than the dental, vision, and hearing coverage provided
12 on January 1, 1992, to an individual entitled to medical benefits under AS 39.35.535
13 (public employees' retirement system of Alaska).

14 (c) This section does not apply to a health care insurer that has written less
15 than \$300,000 in premiums in the previous calendar year. A health care insurer
16 exempt under this subsection shall disclose the exemption when offering, issuing for
17 delivery, delivering, or renewing a health care insurance plan or an excepted benefits
18 contract, and shall advise the individual covered under the plan that health care
19 insurers that have written more than \$300,000 in premiums in the previous calendar
20 year are required to offer coverage under (a) and (b) of this section.

21 (d) This section does not require an insurer who offers only group insurance
22 coverage under AS 21.54 to offer dental, vision, and hearing coverage to an individual.

23 * Sec. 55. AS 21.42.395(a) is repealed and reenacted to read:

24 (a) Except for a fraternal benefit society, a health care insurer that offers,
25 issues for delivery, delivers, or renews in this state a health care insurance plan shall
26 provide coverage for the costs of prostate cancer screening tests as required under the
27 schedule described in (b) of this section and shall provide coverage for the costs of
28 cervical cancer screening tests as required under (c) of this section. The coverage
29 required by this section is subject to standard policy provisions applicable to other
30 benefits, including deductible or copayment provisions. If a physician recommends
31 that a covered individual undergo prostate cancer screening by taking a prostate

1 antigen blood test, coverage may not be denied because the covered individual has
2 already had a digital rectal examination and the examination results were negative.

3 * Sec. 56. AS 21.42 is amended by adding a new section to read:

4 **Sec. 21.42.500. Definitions.** In AS 21.42.345 - 21.42.395,

5 (1) "copayment" means the portion of medical care expenses in excess
6 of the deductible to be paid by a covered individual;

7 (2) "deductible" means the portion of medical care expenses for which
8 a covered individual must pay before benefits become payable;

9 (3) "excepted benefits" has the meaning given in AS 21.54.160;

10 (4) "fraternal benefit society" has the meaning given in AS 21.84.900;

11 (5) "health care insurance plan" has the meaning given in
12 AS 21.54.500;

13 (6) "health care insurer" has the meaning given in AS 21.54.500;

14 (7) "placed for adoption" has the meaning given in AS 21.54.500.

15 * Sec. 57. AS 21.53.090 is amended to read:

16 **Sec. 21.53.090. Required regulations.** The director shall adopt regulations
17 regarding

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

20 (A) [(1)] terms of renewability;

21 (B) [(2)] initial and subsequent conditions of eligibility;

22 (C) [(3)] nonduplication of coverage provisions;

23 (D) [(4)] coverage of dependents;

24 (E) benefit triggers;

25 (F) [(5)] preexisting conditions and recurrent conditions;

26 (G) [(6)] termination of insurance;

27 (H) [(7)] continuation or conversion;

28 (I) [(8)] probationary periods, limitations, exceptions,
29 reductions, and elimination periods; [,] and

30 (J) requirements for replacement;

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

- 1 (3) nonforfeiture or minimum value requirements; and
2 (4) consumer protection standards, including standards for full and
3 fair disclosure setting out the manner and content of required disclosures.

4 * Sec. 58. AS 21.54 is amended by adding a new section to read:

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

7 * Sec. 59. AS 21.54 is amended by adding new sections to read:

8 **Article 2. Health Care Insurance Provisions.**

9 **Sec. 21.54.100. Unfair discrimination.** (a) A health care insurer that offers,
10 issues for delivery, delivers, or renews a health care insurance plan in the group market
11 may not establish rules for eligibility, including continued eligibility and waiting
12 periods under the plan, for an individual or dependent of an individual based on

13 (1) health status;

14 (2) medical condition, including physical and mental illnesses;

15 (3) claims experience;

16 (4) receipt of health care;

17 (5) medical history;

18 (6) genetic information;

19 (7) evidence of insurability, including conditions arising from acts of
20 domestic violence; or

21 (8) disability.

22 (b) A health care insurer may not require an individual, as a condition of
23 enrollment or continued enrollment under a health care insurance plan offered in the
24 group market, to pay a premium, contribution, or policy fee greater than a premium,
25 contribution, or policy fee for a similarly situated individual already enrolled in the
26 plan on the basis of a health status factor for the individual or a dependent of the
27 individual.

28 **Sec. 21.54.110. Preexisting condition exclusion.** (a) A health care insurance
29 plan offered, issued for delivery, delivered, or renewed in the group market may not
30 contain a preexisting condition exclusion that

31 (1) relates to a condition, regardless of cause, for which medical advice,

1 diagnosis, care, or treatment was recommended or received more than six months
2 before the enrollment date;

3 (2) considers genetic information as a condition for which a preexisting
4 condition exclusion may be imposed in absence of a diagnosis of the condition related
5 to the information;

6 (3) extends for more than 12 months after the enrollment date of a
7 covered individual; or

8 (4) excludes a condition relating to pregnancy.

9 (b) A period of a preexisting condition exclusion permissible under (a) of this
10 section must be reduced by the aggregate of periods of creditable coverage, if any, as
11 determined in AS 21.54.120, applicable to the participant or beneficiary as of the
12 enrollment date. The aggregate of periods of creditable coverage is determined by
13 adding together all periods of creditable coverage before the enrollment date, excluding
14 periods of creditable coverage before a continuous break in coverage of more than 90
15 days. A waiting period or affiliation period may not be considered in determining the
16 90-day period. This subsection does not apply if an individual's most recent period
17 of creditable coverage ended on a date more than 90 days before the enrollment date.
18 This subsection does not preclude application of a waiting period to all new enrollees
19 under a health care insurance plan.

20 (c) A health care insurance plan offered, issued for delivery, delivered, or
21 renewed in this state in the group market may not apply a preexisting condition
22 exclusion to an individual who is (1) a newborn covered under creditable coverage as
23 of the last day of the 30-day period beginning with the date of birth; or (2) adopted
24 or placed for adoption before attaining 18 years of age and who is covered under
25 creditable coverage as of the last day of the 30-day period beginning with the date of
26 adoption or placement for adoption. This subsection does not apply to an individual
27 after the end of the first continuous 90-day period during all of which the individual
28 was not covered under creditable coverage.

29 (d) A health care insurance plan offered, issued for delivery, delivered, or
30 renewed in this state in the group market may exclude coverage for late enrollees for
31 the greater of 18 months or an 18-month preexisting condition exclusion. If both a

1 waiting period and a preexisting condition exclusion under (a) of this section are
2 applicable to a late enrollee, the combined period may not exceed 18 months from the
3 date the individual enrolls for coverage under a health care insurance plan.

4 **Sec. 21.54.120. Creditable coverage.** (a) A health care insurer that offers,
5 issues for delivery, delivers, or renews in this state a health care insurance plan in the
6 group market shall count a period of creditable coverage based on

7 (1) the standard method authorized by 42 U.S.C. 300gg (Health
8 Insurance Portability and Accountability Act of 1996) for determining creditable
9 coverage without regard to the specific benefits covered during the period; or

10 (2) an alternative method based on coverage of benefits within each of
11 several classes or categories of benefits specified in federal regulation if

12 (A) made on a uniform basis for all participants and
13 beneficiaries; and

14 (B) the insurer counts a period of creditable coverage with
15 respect to any class or category of benefits if any level of benefits is covered
16 within the class or category.

17 (b) A health care insurer that offers, issues for delivery, delivers, or renews in
18 this state a health care insurance plan in the group market shall provide a certification
19 of coverage

20 (1) at the time an individual ceases to be covered under a health care
21 insurance plan or becomes covered under a federal continuation provision;

22 (2) at the time an individual ceases to be covered under a federal
23 continuation provision; and

24 (3) upon request by an individual or on behalf of an individual with 24
25 months after the date coverage under the health care insurance plan or a federal
26 continuation provision ceases.

27 (c) A health care insurer that offers, issues for delivery, delivers, or renews in
28 this state a health care insurance plan in the group market shall establish periods of
29 creditable coverage with respect to an individual through certification under (b) of this
30 section or as specified in federal regulation.

31 (d) A health care insurer that offers, issues for delivery, delivers, or renews in

1 this state a health care insurance plan in the group market shall prominently state and
2 describe the effect of the health care insurer's election to count a period of creditable
3 coverage using a permissible alternative method

4 (1) in any disclosure statement concerning the health care insurance
5 plan or coverage;

6 (2) to each enrollee at the time of enrollment; and

7 (3) to each employer at the time of offer or sale of coverage.

8 (e) A health care insurer issuing a certification under (b) of this section shall
9 disclose information regarding coverage of classes and categories of health benefits
10 available under the health care insurer's plan at the request of an entity that

11 (1) enrolls an individual who has provided the certification of coverage;

12 (2) elects to count a period of creditable coverage according to a
13 permissible alternative method under (a)(2) of this section; and

14 (3) pays the health care insurer for the reasonable cost, if any, of
15 disclosing the information described in this subsection.

16 **Sec. 21.54.130. Renewability, termination, and modification of coverage.**

17 (a) Except for a multiple employer welfare arrangement, a health care insurer that
18 offers, issues for delivery, delivers, or renews in this state a health care insurance plan
19 in the group market shall renew or continue in force the coverage under the plan at the
20 option of the plan sponsor unless

21 (1) the plan sponsor has failed to pay premiums or contributions in
22 accordance with the terms of the health care insurance plan or the health care insurer
23 has not received timely premium payments;

24 (2) the plan sponsor has performed an act or practice that constitutes
25 fraud or made an intentional misrepresentation of material fact under the terms of the
26 coverage;

27 (3) the plan sponsor has failed to comply with a material plan provision
28 relating to minimum participation or employer contribution requirements;

29 (4) the health care insurer ceases to offer coverage in accordance with
30 (b) and (c) of this section;

31 (5) the health care insurer offers the plan only through a network plan

1 and there is no longer an enrollee in connection with the plan who lives, resides, or
2 works in the service area of the insurer or in the area for which the insurer is
3 authorized to transact business; or

4 (6) in the case of a plan that is made available only through a bona fide
5 association, the employer's membership in the association ceases and coverage is
6 terminated uniformly without regard to a health status factor of a covered individual.

7 (b) A health care insurer may discontinue offering a particular type of health
8 care insurance plan in the group market as permitted by this title if the insurer

9 (1) provides written notice of the decision to discontinue coverage to
10 all affected plan sponsors, participants, and beneficiaries and to the insurance
11 regulatory official in each state in which an affected covered employee or dependent
12 is known to reside; notice required under this paragraph must be given at least 180
13 days before the insurer fails to renew the health care insurance plan;

14 (2) provides written notice of the decision to discontinue coverage to
15 the director and to the insurance regulatory official in each state in which the insurer
16 is licensed at least 30 days before notice is given to the affected plan sponsors,
17 participants, and beneficiaries as described under (1) of this subsection;

18 (3) offers to each plan sponsor who is provided the particular type of
19 health care insurance plan the option to purchase another health care insurance plan
20 currently being offered by the insurer to plan sponsors in the same market in the state;
21 and

22 (4) acts uniformly without regard to the claims experience of those plan
23 sponsors or to any health status factor of a covered participant or beneficiary or a new
24 participant or beneficiary who may become eligible for coverage.

25 (c) A health care insurer may discontinue offering and renewing all health care
26 insurance plans in the group market as permitted by this title if the insurer

27 (1) provides written notice of the decision to discontinue coverage to
28 all affected plan sponsors, participants, and beneficiaries and to the insurance
29 regulatory official in each state in which an affected covered employee or dependent
30 is known to reside; notice required under this paragraph must be given at least 180
31 days before discontinuation of the plans;

1 (2) provides written notice of the decision to discontinue coverage to
2 the director and to the insurance regulatory official in each state in which the insurer
3 is licensed at least 30 days before the notice is given to the affected plan sponsors,
4 participants, and beneficiaries as described under (1) of this subsection; and

5 (3) does not issue a health care insurance plan in the group market in
6 this state for five years from the date the last group health care insurance plan was
7 discontinued.

8 (d) A health care insurer may modify a large employer's health care insurance
9 plan at the time of plan renewal.

10 (e) Except for coverage available only through a bona fide association, a health
11 care insurer may modify a small employer's health care insurance plan consistent with
12 this title at the time of plan renewal only if the modification is uniform for all small
13 employers with the same health care insurance plan.

14 (f) If a covered employee or dependent has committed a fraudulent act or
15 made an intentional misrepresentation of a material fact in regard to a health care
16 insurance plan, a health care insurer may terminate the coverage of the employee or
17 the dependent under the plan.

18 (g) For purposes of this section, a plan sponsor includes an employer member
19 of a bona fide association for a health care insurance plan made available by the health
20 care insurer only through a bona fide association.

21 **Sec. 21.54.140. Renewability of coverage for a multiple employer welfare**
22 **arrangement.** A health benefit plan that is a multiple employer welfare arrangement
23 subject to this title may not deny an employer whose employees are covered under the
24 plan continued access to the same or a different plan according to the terms of the
25 plan, except

- 26 (1) for nonpayment of contributions;
27 (2) for fraud or other intentional misrepresentation of material fact by
28 the employer;
29 (3) for noncompliance with material plan provisions;
30 (4) where the plan is ceasing to offer any coverage in a geographic
31 area;

1 (5) for a health benefit plan that offers benefits through a network plan
2 if

3 (A) there is no longer an individual enrolled through the
4 employer who lives, resides, or works in the service area of the network plan;
5 and

6 (B) the multiple employer welfare arrangement applies this
7 paragraph without regard to the claims experience of the employer or a health
8 status factor in relation to an individual or an individual's dependent; and

9 (6) for failure to meet the terms of an applicable collective bargaining
10 agreement to renew a collective bargaining or other agreement requiring or authorizing
11 contributions to the plan or to employ employees covered by a collective bargaining
12 agreement.

13 **Sec. 21.54.150. Mental health benefits.** (a) Except as provided in (d) of this
14 section, a health care insurance plan sold in the large employer group market that
15 provides both medical and surgical benefits and mental health benefits shall meet the
16 following requirements:

17 (1) if the plan does not include an aggregate lifetime limit on
18 substantially all medical and surgical benefits, the plan may not provide for an
19 aggregate lifetime limit on mental health benefits;

20 (2) if the plan includes an aggregate lifetime limit on substantially all
21 medical and surgical benefits, the plan must

22 (A) include the mental health benefits within the aggregate
23 lifetime limit and may not distinguish in the application of the limit between
24 medical and surgical benefits and mental health benefits; or

25 (B) provide an aggregate lifetime limit for mental health
26 benefits that is not less than the aggregate lifetime limit for medical and
27 surgical benefits;

28 (3) if the plan includes different aggregate lifetime limits or none on
29 different categories of medical and surgical benefits, the plan must provide for
30 aggregate lifetime limits on mental health benefits consistent with federal law;

31 (4) if the plan does not include an annual limit on substantially all

1 medical and surgical benefits, the plan may not provide for an annual limit on mental
2 health benefits;

3 (5) if the plan includes an annual limit on substantially all medical and
4 surgical benefits, the plan must

5 (A) include the mental health benefits with the annual limit and
6 may not distinguish in the application of the limit between medical and surgical
7 benefits and mental health benefits; or

8 (B) provide an annual limit for mental health benefits that is not
9 less than the annual limit for medical and surgical benefits; and

10 (6) if the plan includes different annual limits or none on different
11 categories of medical and surgical benefits, the plan must provide for annual limits on
12 mental health benefits consistent with federal law.

13 (b) Except as provided otherwise in this title, a health care insurance plan is
14 not required to provide mental health benefits.

15 (c) Except as otherwise provided in this title, this section does not affect the
16 terms and conditions relating to the amount, duration, or scope of mental health
17 benefits under a health care insurance plan that provides mental health benefits,
18 including cost sharing, limits on number of visits or days of coverage, and
19 requirements relating to medical necessity.

20 (d) This section does not apply if application of this section would result in
21 an increase in the cost under the health care insurance plan of at least one percent.

22 **Sec. 21.54.160. "Excepted benefits" defined.** "Excepted benefits" means
23 benefits under one or more or any combination of the following:

24 (1) benefits under

25 (A) coverage only for accident, disability income insurance, or
26 both;

27 (B) coverage issued as a supplement to liability insurance;

28 (C) liability insurance, including general liability insurance and
29 automobile liability insurance;

30 (D) workers' compensation or substantially similar insurance;

31 (E) automobile medical payment insurance;

1 (F) credit-only insurance;
2 (G) coverage for on-site medical clinics; or
3 (H) other similar insurance coverage, as specified in federal law,
4 under which benefits for medical care are secondary or incidental to other
5 insurance benefits;

6 (2) if offered as a separate insurance policy and otherwise not an
7 integral part of a health care insurance plan, benefits under

8 (A) limited scope dental or vision coverage;

9 (B) coverage for long-term care, nursing home care, home
10 health care, community-based care, or any combination; or

11 (C) other similar limited benefits as specified in federal law;

12 (3) if offered as independent noncoordinated benefits, benefits under
13 coverage only for a specified disease or illness, or hospital indemnity or other fixed
14 indemnity insurance; as used in this paragraph, "independent, noncoordinated benefits"
15 means benefits that are provided under a separate policy if

16 (A) there is no coordination between the provision of the
17 benefits and an exclusion of benefits under a health care insurance plan
18 maintained by the same plan sponsor; and

19 (B) the benefits are paid with respect to an event without regard
20 to whether benefits are provided for the event under a health care insurance
21 plan maintained by the same plan sponsor;

22 (4) if offered as a separate insurance policy, benefits under

23 (A) Medicare supplement health insurance as defined in 42
24 U.S.C. 1345ss(g)(1) (Social Security Act);

25 (B) coverage supplemental to the coverage provided under 10
26 U.S.C. 1071 - 1090; or

27 (C) similar supplemental coverage provided to coverage under
28 a health benefit plan.

29 **Sec. 21.54.170. Determination of size of employer.** The determination of
30 whether an employer is a large or small employer is subject to the following:

31 (1) the size of an employer that was not in existence throughout the

1 preceding calendar year must be based on the average number of employees that the
2 employer is reasonably expected to employ on the business days in the current
3 calendar year;

4 (2) all persons treated as a single employer under 26 U.S.C. 414(b), (c),
5 (m), or (o) must be treated as one employer; and

6 (3) a reference to a large or small employer includes by reference any
7 predecessor of that employer.

8 Article 3. Definitions.

9 Sec. 21.54.500. Definitions. In this chapter,

10 (1) "aggregate lifetime limit" means a dollar limit on the total amount
11 that may be paid for benefits under a health care insurance plan offered in the group
12 market with respect to an individual or unit of coverage;

13 (2) "annual limit" means a dollar limit on the total amount that may be
14 paid for benefits in a 12-month period under the plan with respect to an individual or
15 unit of coverage;

16 (3) "beneficiary" has the meaning given under 29 U.S.C. 1002(8)
17 (Employee Retirement Income Security Act of 1974);

18 (4) "bona fide association" means an association that

19 (A) has been actively in existence for five years;

20 (B) has been formed and maintained in good faith for purposes
21 other than obtaining insurance;

22 (C) does not condition membership in the association on a
23 health status factor relating to an individual;

24 (D) makes health care insurance available to all members and
25 dependents of members regardless of a health status factor in relation to the
26 member or dependent;

27 (E) does not offer a health care insurance plan to an individual
28 other than in connection with a member of the association; and

29 (F) meets any other requirement established by the director in
30 regulations;

31 (5) "certification of coverage" means a written certification of

1 (A) the period of creditable coverage of an individual under a
2 health benefit plan or health care insurance plan offered in the group market,
3 including coverage under a federal continuation provision; and

4 (B) the waiting period imposed with respect to the individual
5 for coverage under the health benefit plan or health care insurance plan offered
6 in the group market;

7 (6) "church plan" has the meaning given under 29 U.S.C. 1002(33)
8 (Employee Retirement Income Security Act of 1974);

9 (7) "creditable coverage" means, with respect to an individual,
10 coverage, excluding excepted benefits, calculated as required under AS 21.54.120 and
11 applicable under

12 (A) a health care insurance plan offered in the group market:

13 (B) a health benefit plan;

14 (C) 42 U.S.C. 1395c or 1395j (Part A or Part B of Title XVIII
15 of the Social Security Act):

16 (D) 42 U.S.C. 1396 (Title XIX of the Social Security Act),
17 other than coverage consisting solely of benefits under 42 U.S.C. 1396s;

18 (E) 10 U.S.C. 1071 - 1090;

19 (F) a medical care program of the Indian Health Service or of
20 a tribal organization;

21 (G) AS 21.55;

22 (H) 5 U.S.C. 8901 - 8914;

23 (I) a public health plan as defined under federal law; or

24 (J) a health benefit plan under 22 U.S.C. 2504(e) (Peace Corps
25 Act);

26 (8) "employee" has the meaning given under 29 U.S.C. 1002(6)
27 (Employee Retirement Income Security Act of 1974);

28 (9) "employer" has the meaning given under 29 U.S.C. 1002(5)
29 (Employee Retirement Income Security Act of 1974); for purposes of this chapter,
30 "employer" includes a large or small employer, including a person, firm, corporation,
31 partnership, association, or political subdivision, that is actively engaged in business;

1 (10) "enrollment date" means the date of enrollment of an individual
2 in a health benefit plan or health care insurance plan offered in the group market or
3 the first day of the waiting period for enrollment, whichever occurs first;

4 (11) "federal continuation provision" means a "COBRA continuation
5 provision" as defined in 42 U.S.C. 300gg-91(d) (Health Insurance Portability and
6 Accountability Act of 1996);

7 (12) "federal governmental plan" means a governmental plan
8 established or maintained for employees of the United States government or by an
9 agency or instrumentality of the United States government;

10 (13) "governmental plan" has the meaning given under 29 U.S.C.
11 1002(32) Employee Retirement Income Security Act of 1974);

12 (14) "group market" means the health care insurance market in which
13 individuals obtain health care insurance coverage on behalf of themselves and their
14 dependents through a health benefit plan maintained by a large or small employer;
15 "group market" includes a health benefit plan for a small employer in the group market
16 that includes an arrangement under which

17 (A) a portion of the premium or benefits is paid by a small
18 employer;

19 (B) a covered individual or dependent is reimbursed, through
20 wage adjustments or otherwise, by or on behalf of a small employer for all or
21 a portion of the premium; or

22 (C) the health benefit plan is treated by the employer or any of
23 the eligible employees or dependents as part of a plan or program for the
24 purposes of 26 U.S.C. 106 or 26 U.S.C. 162 (Internal Revenue Code);

25 (15) "health benefit plan" means an employee welfare benefit plan as
26 defined in 29 U.S.C. 1002(1) (Employee Retirement Income Security Act of 1974),
27 and includes a plan, fund, or program established or maintained by a partnership, to
28 the extent that the plan, fund, or program provides medical care, including items and
29 services paid for as medical care to employees, present or former partners, or their
30 dependents, as defined under the terms of the plan, fund, or program, directly or
31 through insurance, reimbursement, or other method;

1 (16) "health care insurance plan" means a health care insurance policy
2 or contract provided by a health care insurer but does not include an excepted benefits
3 policy or contract;

4 (17) "health care insurer" means a person transacting the business of
5 health care insurance, including an insurance company licensed under AS 21.09, a
6 hospital or medical service corporation licensed under AS 21.87, a fraternal benefit
7 society licensed under AS 21.84, a health maintenance organization licensed under
8 AS 21.86, a multiple employer welfare arrangement, a church plan, and a
9 governmental plan, except for a nonfederal governmental plan that elects to be
10 excluded under 40 U.S.C. 300gg-21(b)(2) (Health Insurance Portability and
11 Accountability Act of 1996);

12 (18) "health status factor" means any of the factors described in
13 AS 21.54.100(a);

14 (19) "large employer" means an employer that employed an average of
15 at least 51 employees on the business days during the preceding calendar year and that
16 employs at least two employees on the first day of a health benefit plan year;

17 (20) "late enrollee" means a participant or beneficiary who requests
18 enrollment in an employer's health care insurance plan following the initial enrollment
19 period for which the participant or beneficiary was eligible to enroll under the terms
20 of a health care insurance plan, except that a participant or beneficiary may not be
21 considered a late enrollee if

22 (A) the individual requests enrollment within 30 days after the
23 termination of the creditable coverage or the exhaustion of coverage and

24 (i) was covered under creditable coverage at the time of
25 the initial enrollment;

26 (ii) has lost creditable coverage as a result of the
27 termination of employer contribut. toward coverage or the
28 termination of eligibility, including death, divorce, dissolution of
29 marriage, legal separation, or a reduction in number of hours of
30 employment; or

31 (iii) had coverage under a federal continuation provision

1 and the coverage under that provision was exhausted;

2 (B) the individual is employed by an employer who offers
3 multiple health care insurance plans and the individual elects a different health
4 care insurance plan during an open enrollment period; or

5 (C) a court has ordered coverage to be provided for a spouse
6 or minor child under a covered employee's plan and request for enrollment is
7 made within 30 days after issuance of the court order;

8 (21) "medical and surgical benefits" means benefits provided for
9 medical or surgical services, but does not include mental health benefits;

10 (22) "mental health benefits" means benefits provided for mental health
11 services as defined under the terms of the health care insurance plan, but does not
12 include benefits for treatment of substance abuse or chemical dependency;

13 (23) "network plan" means a health care insurance plan offered in the
14 group market or by an insurer under which the financing and delivery of medical care,
15 including items and services paid for as medical care, are provided in whole or in part
16 through a defined set of providers under contract with the insurer;

17 (24) "participant" has the meaning given under 29 U.S.C. 1002(7)
18 (Employee Retirement Income Security Act of 1974); "participant" includes a

19 (A) partner in relation to a partnership; or

20 (B) self-employed individual if the individual or the individual's
21 beneficiaries are or may become eligible to receive benefits under a health
22 benefit plan maintained by the self-employed individual;

23 (25) "placed for adoption" means the assumption and retention by an
24 individual of a legal obligation for total or partial support of a child in anticipation of
25 adopting the child;

26 (26) "plan sponsor" has the meaning given under 29 U.S.C.
27 1002(16)(B) (Employee Retirement Income Security Act of 1974);

28 (27) "preexisting condition exclusion" means a limitation or exclusion
29 of benefits relating to a physical or mental condition that was present before the
30 enrollment date, regardless of whether medical advice, diagnosis, care, or treatment
31 was recommended or received before the enrollment date;

1 (28) "small employer" means an employer that employed an average
2 of at least two but not more than 50 employees on the business days during the
3 preceding calendar year and that employs at least two employees on the first day of
4 a health benefit plan year;

5 (29) "waiting period" means the period that must pass before an
6 individual who is a potential participant or beneficiary in a health care insurance plan
7 offered in the group market is eligible to be covered for benefits under the terms of
8 the plan.

9 * Sec. 60. AS 21.55.100(a) is amended to read:

10 (a) The association shall make available to residents who are high risks or to
11 federally defined eligible individuals an individual state plan of health insurance.
12 The association shall offer three alternatives related to deductibles as described in
13 AS 21.55.120 and may offer additional deductible alternatives.

14 * Sec. 61. AS 21.55.100(c) is amended to read:

15 (c) The association may not refuse to offer coverage under a state plan to
16 residents who are high risks, or to federally defined eligible individuals, [AND] who
17 are eligible under this chapter. The association may not refuse coverage under a state
18 plan to residents who are high risks, or to federally defined eligible individuals, who
19 [.] are eligible under this chapter, apply for coverage, and pay the required premium.

20 * Sec. 62. AS 21.55.100(d) is amended to read:

21 (d) The association may make available to residents who are high risks and
22 to federally defined eligible individuals coverage through a health maintenance
23 organization or other managed care arrangement as approved by the director.

24 * Sec. 63. AS 21.55.130 is amended by adding a new subsection to read:

25 (d) A state plan issued to a federally defined eligible individual may not
26 impose a preexisting condition exclusion.

27 * Sec. 64. AS 21.55.300(a) is amended to read:

28 (a) Except as provided in this section, a state resident who is a high risk or
29 a federally defined eligible individual is eligible to enroll in a state plan described
30 in AS 21.55.100.

31 * Sec. 65. AS 21.55.300(b) is amended to read:

1 (b) Except for a federally defined eligible individual, a [A] person may not
2 be covered by the state plan

3 (1) while covered by another health insurance policy or subscriber
4 contract; or

5 (2) if the person is eligible to be covered by a plan subject to the
6 requirements of AS 21.56.110 - 21.56.250.

7 * Sec. 66. AS 21.55.310 is amended to read:

8 **Sec. 21.55.310. Enrollment by an eligible person.** A person may enroll in
9 a state plan by applying to the writing carrier. The application must include the
10 following:

11 (1) name, address, age, and length of residency of the applicant;

12 (2) a designation of the plan desired, including deductible option
13 chosen;

14 (3) information relevant to whether the person is a high risk or a
15 federally defined eligible individual; and

16 (4) payment of the first premium.

17 * Sec. 67. AS 21.55.500(9) is repealed and reenacted to read:

18 (9) "resident" means

19 (A) except for a federally defined eligible individual and an
20 individual who is absent from the state for more than 90 consecutive days for
21 reasons other than for medical treatment or education, an individual who

22 (i) is physically present in the state, has lived in the
23 state for at least the 12 consecutive months immediately preceding the
24 application for a state plan, and intends to remain permanently in the
25 state; or

26 (ii) is not physically present in the state if the person
27 lived in the state for at least nine of the 12 months immediately
28 preceding application for a state plan and the person's absence from the
29 state is for medical treatment or education;

30 (B) for a federally defined eligible individual, an individual who
31 is legally domiciled in this state.

1 * Sec. 68. AS 21.55.500 is amended by adding new paragraphs to read:

2 (14) "creditable coverage" has the meaning given in AS 21.54.500;

3 (15) "federal continuation provision" has the meaning given in
4 AS 21.54.500;

5 (16) "federally defined eligible individual" means an individual

6 (A) with an aggregate of all periods of creditable coverage as
7 provided under AS 21.54.110(b) that is greater than 18 months as of the date
8 that the individual seeks coverage under this chapter;

9 (B) whose most recent prior creditable coverage was under a
10 health benefit plan or health care insurance plan offered in the group market;

11 (C) who is not eligible for coverage under a health benefit plan,
12 42 U.S.C. 1395c or 42 U.S.C. 1395j (Part A or Part B of Title XVIII of the
13 Social Security Act), or a state plan under 42 U.S.C. 1396 (Title XIX of the
14 Social Security Act), and who does not have other health care insurance
15 coverage;

16 (D) whose most recent coverage within the period of aggregate
17 creditable coverage as provided under AS 21.54.110(b) was not terminated
18 based on a factor relating to nonpayment of premiums or fraud;

19 (E) who, having been offered and having elected continuation
20 coverage under a federal continuation provision or a similar state program, has
21 exhausted coverage under the continuation provision or program;

22 (17) "group market" has the meaning given in AS 21.54.500;

23 (18) "health benefit plan" has the meaning given in AS 21.54.500;

24 (19) "health care insurance plan" has the meaning given in
25 AS 21.54.500;

26 (20) "health care insurer" has the meaning given in AS 21.54.500;

27 (21) "preexisting condition exclusion" has the meaning given in
28 AS 21.54.500.

29 * Sec. 69. AS 21.56.010 is amended to read:

30 **Sec. 21.56.010. Creation; membership.** A nonprofit incorporated legal entity
31 to be known as the Small Employer Health Reinsurance Association is established.

1 Membership consists of all health care insurers [LICENSED TO TRANSACT
2 HEALTH INSURANCE IN THE STATE THAT OFFER A HEALTH BENEFIT
3 PLAN]. All members shall maintain membership in the reinsurance association as
4 a condition of transacting [DOING] health care insurance business [, OR BEING
5 ABLE TO OFFER SUBSCRIBER CONTRACTS,] in the state.

6 * Sec. 70. AS 21.56.020(a) is amended to read:

7 (a) The board of directors of the reinsurance association consists of nine
8 individuals selected by participating members, subject to approval by the director. The
9 director shall endeavor to appoint at least six board members who are also small
10 employer insurers. If the director is unable to appoint six board members who are also
11 small employer insurers, the director may fill the remaining seats with any insurer. In
12 selecting members of the board, the director shall consider, among other things,
13 whether all types of participating members are fairly represented.

14 * Sec. 71. AS 21.56.020(b) is amended to read:

15 (b) To the extent possible, one board member shall represent a health
16 maintenance organization, one board member shall represent a hospital or medical
17 service corporation, one board member's principal health insurance business shall be
18 in the small employer group market, and one board member's principal health
19 insurance business shall be in the large employer group market. Members of the
20 board may be reimbursed from the reinsurance association for expenses incurred by
21 them as members, but may not otherwise be compensated by the reinsurance
22 association for their services. The costs of conducting meetings of the reinsurance
23 association and its board of directors shall be borne by the reinsurance association.

24 * Sec. 72. AS 21.56.030 is amended to read:

25 **Sec. 21.56.030. General powers.** The reinsurance association may

- 26 (1) exercise the powers granted to insurers under the laws of the state,
27 except that the reinsurance association may not issue insurance;
- 28 (2) sue or be sued;
- 29 (3) enter into contracts with insurers, similar reinsurance associations
30 in other states, or with other persons for the performance of administrative functions;
- 31 (4) establish administrative and accounting procedures for the operation

1 of the reinsurance association;

2 (5) take legal action as necessary to avoid the payment of improper
3 claims against the reinsurance association;

4 (6) define the array of health coverage products for which reinsurance
5 will be provided and issue reinsurance policies;

6 (7) establish rules, conditions, and procedures pertaining to the
7 reinsurance of members' risks by the reinsurance association;

8 (8) establish actuarial functions appropriate to the operation of the
9 reinsurance association;

10 (9) assess members under the provisions of this chapter and make
11 advance interim assessments as may be reasonable and necessary for organizational
12 and interim operating expenses; interim assessments shall be credited as offsets against
13 regular assessments due following the close of the calendar year;

14 (10) appoint appropriate legal, actuarial, and other committees as are
15 necessary to provide technical assistance in the operation of the reinsurance
16 association, design of a policy or contract, or to assist in other functions of the
17 reinsurance association;

18 (11) borrow money to accomplish the purposes of the reinsurance
19 association; notes or other evidence of indebtedness of the reinsurance association that
20 are not in default are investments for insurers and may be carried as admitted assets.

21 * Sec. 73. AS 21.56.040 is amended to read:

22 **Sec. 21.56.040. Plan of operation.** (a) The reinsurance association shall
23 submit to the director a plan of operation and amendments necessary or suitable to
24 assure the fair, reasonable, and equitable administration of the reinsurance association.
25 The director may, after notice and hearing, approve the plan of operation if the director
26 determines it to be suitable to assure the fair, reasonable, and equitable administration
27 of the program on a proportionate basis under the provisions of this section and it does
28 not shift program costs to other insured persons or the state. The plan of operation
29 and amendments become effective upon approval in writing by the director.

30 (b) All members of the reinsurance association shall comply with the plan of
31 operation.

1 (c) The plan of operation must establish procedures for

2 (1) handling and accounting of program assets and money of the
3 reinsurance association and for an annual fiscal report to the director;

4 (2) reinsuring risks under the provisions of this section;

5 (3) collecting assessments from all members to provide for claims
6 reinsured by the reinsurance association and for administrative expenses incurred or
7 estimated to be incurred by the reinsurance association;

8 (4) selection of an administering insurer and establishing the
9 administering insurer's powers and duties;

10 (5) effectuating a methodology for applying the dollar thresholds
11 contained in this section for insurers that pay or reimburse health care providers by
12 capitation or salary; and

13 (6) provisions necessary or proper for the execution of the powers and
14 duties of the reinsurance association.

15 * Sec. 74. AS 21.56.050 is amended to read:

16 **Sec. 21.56.050. Health care reinsurance.** (a) A member may reinsure health
17 care coverage of an eligible employee of a small employer or a dependent of an
18 eligible employee of a small employer with the reinsurance association only under the
19 following provisions:

20 (1) regarding a small employer basic or standard health care insurance
21 [BENEFIT] plan, the reinsurance association shall reinsure the level of coverage
22 provided;

23 (2) regarding a health care plan other than a small employer health care
24 insurance [BENEFIT] plan, the reinsurance association shall reinsure the level of
25 coverage provided up to, but not exceeding, the level of coverage provided in a small
26 employer basic or standard health benefit plan;

27 (3) a small employer insurer may reinsure an entire employer group
28 within 60 days of the commencement of the group's coverage under a health care
29 insurance [BENEFIT] plan;

30 (4) a small employer insurer may reinsure an eligible employee or
31 dependent within a period of 60 days following the commencement of the coverage

1 with the small employer; a newly eligible employee or dependent of a reinsured small
2 employer may be reinsured within 60 days of the commencement of coverage;

3 (5) the reinsurance association may not reimburse a reinsuring insurer
4 regarding the claims of a reinsured employee or dependent until the insurer has paid
5 an initial level of claims for the employee or dependent of \$5,000 in a calendar year
6 for benefits covered by the reinsurance association;

7 (6) a small employer insurer may terminate reinsurance for one or more
8 of the reinsured employees or dependents of a small employer on any plan anniversary.

9 (b) Premium rates charged for coverage reinsured by the reinsurance
10 association shall be established as required under (c) of this section and adjusted as
11 follows:

12 (1) for whole group small employer reinsurance coverage, 1.5
13 multiplied by the base premium rate established by the reinsurance association for
14 eligible employees, and dependents of eligible employees, of a small employer all of
15 whose health insurance coverage is reinsured with the reinsurance association;

16 (2) for eligible employee or dependent health reinsurance coverage, 5.0
17 multiplied by the base premium rate established by the reinsurance association.

18 (c) If a health care insurance [BENEFIT] plan coverage for a small employer
19 is entirely or partially reinsured with the reinsurance association, the premium charged
20 to the small employer for a rating period for the coverage issued under this section
21 shall meet the premium rate requirements established under AS 21.56.120.

22 (d) On or before March 1 of each year, the board shall determine and report
23 to the director the reinsurance association's net loss for the previous calendar year,
24 including administrative expenses and incurred losses for the year, taking into account
25 investment income and other appropriate gains and losses. A net loss for the year
26 shall be recovered by assessments collected from reinsuring insurers. The board shall
27 establish, as part of the plan of operation, a formula by which to make assessments
28 against reinsuring insurers. The assessment formula must be based on each reinsuring
29 insurer's share of the total premiums earned in the preceding calendar year from health
30 care insurance [BENEFIT] plans delivered or issued for delivery to small employers
31 in this state by reinsuring carriers and each reinsuring insurer's share of the premiums

1 earned in the preceding calendar year from newly issued health care insurance
2 [BENEFIT] plans delivered or issued for delivery during the calendar year to small
3 employers in this state by reinsuring insurers. In determining an assessment, if any,
4 that is collected from a member, the following provisions apply:

5 (1) the formula established under this subsection may not result in a
6 reinsuring insurer having an assessment share that is less than 50 percent or more than
7 150 percent of an amount that is based on the proportion of the reinsuring insurer's
8 total premiums earned in the preceding calendar year from health care insurance
9 [BENEFIT] plans delivered or issued for delivery to small employers in this state by
10 reinsuring insurers to total premiums earned in the preceding calendar year from health
11 care insurance [BENEFIT] plans delivered or issued for delivery to small employers
12 in this state by all reinsuring carriers;

13 (2) the board may, with approval of the director, change the assessment
14 formula established under this section from time to time, as appropriate; the board may
15 provide for the shares of the assessment base attributable to premiums from all health
16 care insurance [BENEFIT] plans and to premiums from newly issued health care
17 insurance [BENEFIT] plans to vary during a transition period;

18 (3) subject to the approval of the director, the board shall make an
19 adjustment to the assessment formula for reinsuring carriers that are approved health
20 maintenance organizations that are federally qualified under 42 U.S.C. 300, to the
21 extent, if any, that restrictions are imposed on those organizations that are not imposed
22 on other small employer insurers [CARRIERS];

23 (4) annually before March 1, the board shall determine and file with
24 the director an estimate of the assessments needed to fund losses incurred by the
25 reinsurance association in the previous calendar year;

26 (5) if the board determines that the assessments needed to fund the
27 losses incurred by the reinsurance association in the previous calendar year will
28 exceed five percent of total premiums earned in the previous year from health care
29 insurance [BENEFIT] plans delivered or issued for delivery to small employers in this
30 state by reinsuring insurers, the board shall evaluate the operation of the program and
31 report its findings, including any recommendations for changes to the plan of

1 operation, to the director within 90 days following the end of the calendar year in
2 which the losses were incurred; the evaluation must include an estimate of future
3 assessments, the administrative costs of the program, the appropriateness of the
4 premiums charged, and the level of insurer retention under the program and the costs
5 of coverage for small employers; if the board fails to file a report with the director
6 within 90 days following the end of the applicable calendar year, the director may
7 evaluate the operations of the program and implement amendments to the plan of
8 operation the director determines necessary to reduce future losses and assessments;

9 (6) if assessments exceed net losses of the reinsurance association, the
10 excess shall be held in an interest bearing account and used by the board to offset
11 future losses or to reduce reinsurance association premiums; in this paragraph, "future
12 losses" include a reserve for incurred but not reported claims;

13 (7) the board shall annually determine a member's proportion of
14 participation in the reinsurance association based on annual statements and other
15 reports determined necessary by the board and filed by the member with the board; an
16 insurer shall report to the board a claim payment made and administrative expense
17 incurred in this state on a semi-annual basis on a form prescribed by the director;

18 (8) the plan of operation must include a provision for the imposition
19 of an interest penalty for late payment of assessments;

20 (9) a member may request a deferment from the director, in whole or
21 in part, from an assessment issued by the board; the director may defer, in whole or
22 in part, the assessment of a member if, in the opinion of the director payment of the
23 assessment would endanger the ability of the member to fulfill the member's
24 contractual obligations;

25 (10) in the event an assessment against a member is deferred in whole
26 or in part, the amount by which the assessment is deferred may be assessed against the
27 other members in a manner consistent with the basis for assessments set out in this
28 subsection; the member receiving a deferment shall remain liable to the reinsurance
29 association for the amount deferred; the director may attach conditions to a deferment;
30 a member receiving a deferment may not reinsure an individual or group, as provided
31 under this section until the assessment is paid.

1 (e) The board, as part of the plan of operation, shall establish a methodology
2 for determining premium rates to be charged by the program for reinsuring small
3 employers and individuals under this section. The methodology must include a system
4 for classification of small employers that reflects the types of case characteristics
5 commonly used by small employer insurers in the state. The methodology must
6 provide for the development of base reinsurance premium rates that shall be multiplied
7 by the factors set out in (b) of this section to determine the premium rates for the
8 reinsurance association. The base reinsurance premium rates shall be established by
9 the board, subject to the approval of the director, and shall be set at levels that
10 reasonably approximate gross premiums charged to small employers by small employer
11 insurers for health care insurance [BENEFIT] plans with benefits similar to the
12 standard health care insurance [BENEFIT] plan. The board shall review the
13 methodology established under this subsection to ensure that the methodology
14 reasonably reflects the claims experience of the program. Changes to the methodology
15 may be proposed by the board [,] and are subject to approval by the director. In this
16 subsection, "gross premiums" means the premium charged for insurance before
17 reducing the premium for a dividend or rate credit.

18 * Sec. 75. AS 21.56.060 is amended to read:

19 **Sec. 21.56.060. Health care insurance [BENEFIT] plan committee.** (a)
20 The health care insurance [BENEFIT] plan committee is established in the
21 reinsurance association. The committee is composed of seven members selected by
22 the director as follows:

- 23 (1) three members who are representatives of participating insurers;
- 24 (2) one member who represents small employers;
- 25 (3) one member who represents employees of small employers;
- 26 (4) one member who represents health care providers; and
- 27 (5) one member who represents agents or brokers.

28 (b) The committee shall recommend benefit levels, cost sharing levels,
29 exclusions and limitations for the basic and standard health care insurance
30 [BENEFIT] plan offered under AS 21.56.140. The committee shall also design a basic
31 health care insurance [BENEFIT] plan and a standard health care insurance

1 [BENEFIT] plan that contain benefit and cost sharing levels that are consistent with
2 the basic method of operation and the benefit plans of health maintenance
3 organizations, including restrictions imposed by federal law. The plans recommended
4 by the committee may include the following cost containment features:

5 (1) utilization review of health care services, including review of the
6 medical necessity of hospital and physician services;

7 (2) case management;

8 (3) selective contracting with hospitals, physicians, and other health
9 care providers;

10 (4) reasonable benefit differentials applicable to providers that
11 participate or do not participate in arrangements using restricted network provisions;
12 and

13 (5) other managed care provisions.

14 * Sec. 76. AS 21.56.070 is amended to read:

15 **Sec. 21.56.070. Required report.** The board shall study and report at least
16 once every two years to the director on the effectiveness of this chapter. The report
17 must analyze the effectiveness of the chapter in promoting rate stability, product
18 availability, and coverage affordability. The report may contain recommendations for
19 actions to improve the overall effectiveness, efficiency, and fairness of the small group
20 health care insurance marketplace. The report must address whether insurers, agents,
21 brokers, managing general agents, and third-party administrators are fairly and actively
22 marketing or issuing health care insurance [BENEFIT] plans to small employers in
23 fulfillment of the purposes of the chapter. The report may contain recommendations
24 for market conduct or other regulatory standards or action. The board shall notify the
25 legislature that the report is available.

26 * Sec. 77. AS 21.56 is amended by adding a new section to read:

27 **Sec. 21.56.075. Premium report.** A member shall file not later than
28 March 15 of each year in a form prescribed by the director a report of total premiums
29 earned in the preceding calendar year and other information required by the director
30 for health care insurance plans delivered or issued for delivery to small employers in
31 this state.

1 * Sec. 78. AS 21.56.080 is amended to read:

2 Sec. 21.56.080. **Administrative Procedure Act.** The reinsurance association
3 is exempt from AS 44.62 (Administrative Procedure Act).

4 * Sec. 79. AS 21.56.090 is amended to read:

5 Sec. 21.56.090. **Tax exemption.** The reinsurance association is exempt from
6 the payment of fees and taxes levied by the state or any of its political subdivisions
7 except taxes levied on real or personal property.

8 * Sec. 80. AS 21.56.100 is amended to read:

9 Sec. 21.56.100. **Limitation of liability.** A member of the reinsurance
10 association is not liable for civil damages resulting from an act or omission of the
11 member on behalf of the reinsurance association unless the member acts with gross
12 negligence or intentional misconduct.

13 * Sec. 81. AS 21.56.110(a) is repealed and reenacted to read:

14 (a) A health care insurance plan offered, issued for delivery, delivered, or
15 renewed to small employers in this state is subject to the provisions of this chapter.

16 * Sec. 82. AS 21.56.110(c) is amended to read:

17 (c) Except as provided in this subsection, for purposes of this chapter, insurers
18 that are affiliated companies or that are eligible to file a consolidated tax return shall
19 be treated as one insurer and a restriction or limitation imposed under this chapter shall
20 apply as if all health care insurance [BENEFIT] plans delivered or issued for delivery
21 to a small employer in this state by an affiliated insurer were issued by one insurer.
22 An affiliated insurer that is a health maintenance organization having a certificate of
23 authority under AS 21.86 may be considered to be a separate insurer for the purposes
24 of this chapter.

25 * Sec. 83. AS 21.56.120(a) is amended to read:

26 (a) A premium rate for a health care insurance [BENEFIT] plan subject to
27 this chapter is subject to the following provisions:

28 (1) the premium rate charged or offered during a rating period to small
29 employers with similar case characteristics as determined by the insurer for the same
30 or similar coverage may not vary from the applicable index rate by more than 35
31 percent of the applicable index rate;

1 (2) regarding a health care insurance [BENEFIT] plan issued before
2 July 1, 1993, if premium rates charged or offered for the same or similar coverage
3 under a health care insurance [BENEFIT] plan covering a small employer with
4 similar case characteristics as determined by the insurer exceeds the applicable index
5 rate by more than 35 percent, an increase in premium rates for a new rating period
6 may not exceed the sum of

7 (A) a percentage change in the base premium rate measured
8 from the first day of the prior rating period to the first day of the new rating
9 period; plus

10 (B) adjustments due to changes in case characteristics or plan
11 design of the small employer, as determined by the insurer;

12 (3) the percentage increase in the premium rate charged to a small
13 employer for a new rating period may not exceed the sum of the following:

14 (A) the percentage change in the new business premium rate
15 measured from the first day of the prior rating period to the first day of the
16 new rating period; in the case of a health benefit plan into which the small
17 employer insurer is no longer enrolling new small employers, the small
18 employer insurer shall use the percentage change in the base premium rate,
19 provided that the change does not exceed, on a percentage basis, the change in
20 the new business premium rate for the most similar health care insurance
21 [BENEFIT] plan into which the small employer insurer is actively enrolling
22 new small employers;

23 (B) any adjustment, not to exceed 15 percent annually and
24 adjusted pro rata for rating periods of less than one year, due to the claim
25 experience, health status, or duration of coverage of the employees or
26 dependents of the small employer as determined from the small employer
27 insurer's rate manual; and

28 (C) any adjustment due to change in coverage or change in the
29 case characteristics of the small employer, as determined from the small
30 employer insurer's rate manual;

31 (4) adjustments in rates for claim experience, health status, and duration

1 of coverage may not be charged to individual employees or dependents; any
2 adjustment must be applied uniformly to the rates charged for all employees and
3 dependents of the small employer;

4 (5) a premium rate for a health care insurance [BENEFIT] plan shall
5 comply with the requirements of this section notwithstanding an assessment paid or
6 payable by small employer insurers under AS 21.56.050(d);

7 (6) a small employer insurer may use [UTILIZE] industry as a case
8 characteristic in establishing premium rates, provided that the rate factor associated
9 with an industry classification may not vary by more than 15 percent from the
10 arithmetic average of the highest and lowest rate factors associated with all industry
11 classifications;

12 (7) a small employer insurer shall

13 (A) apply rating factors, including case characteristics,
14 consistently with respect to all small employers; rating factors must produce
15 premiums for identical groups that differ only by amounts attributable to plan
16 design and do not reflect differences due to the nature of the groups assumed
17 to select particular health care insurance [BENEFIT] plans; and

18 (B) treat all health care insurance [BENEFIT] plans issued or
19 renewed in the same calendar month as having the same rating period;

20 (8) for the purposes of this subsection, a health care insurance
21 [BENEFIT] plan that contains a restricted provider network may not be considered
22 similar coverage to a health care insurance [BENEFIT] plan that does not use
23 [UTILIZE] a restricted provider network if the restriction of benefits to network
24 providers results in substantial differences in claim costs;

25 (9) a small employer insurer may not use case characteristics, other
26 than age, sex, industry, geographic area, family composition, and group size without
27 prior approval of the director.

28 * Sec. 84. AS 21.56.120(b) is amended to read:

29 (b) In connection with the offering for sale of a health care insurance
30 [BENEFIT] plan to a small employer, a small employer insurer shall [MAKE A
31 REASONABLE DISCLOSURE], as part of its solicitation and sales materials, disclose

1 in a manner understandable by the average small employer and sufficient to
2 reasonably inform small employers of their rights and obligations under the
3 health care insurance plan [OF THE FOLLOWING:]

4 (1) the extent that premium rates for a specified small employer are
5 established or adjusted based upon the actual or expected variation in claims costs or
6 actual or expected variation in health status of the employees of the small employer
7 and their dependents; and

8 (2) the provisions of the health care insurance [BENEFIT] plan

9 (A) concerning the small employer insurer's right to change
10 premium rates and factors [, OTHER THAN CLAIM EXPERIENCE] that
11 affect changes in premium rates;

12 (B) relating to renewability of policies and contracts; [AND]

13 (C) relating to any preexisting condition provision; and

14 (D) concerning the benefits and premiums available under
15 all health care insurance plans for which the small employer qualifies.

16 * Sec. 85. AS 21.56.120(d) is amended to read:

17 (d) The director may adopt regulations to implement the provisions of this
18 section and to ensure that rating practices used by small employer insurers are
19 consistent with the purposes of this chapter, including ensuring that differences in rates
20 charged for health care insurance [BENEFIT] plans by small employer insurers are
21 reasonable and reflect objective differences in plan design, not including differences
22 due to the nature of the groups assumed to select particular health care insurance
23 [BENEFIT] plans.

24 * Sec. 86. AS 21.56.140 is repealed and reenacted to read:

25 Sec. 21.56.140. Required offer of coverage. (a) Except as provided under
26 AS 21.56.160, a small employer insurer shall, as a condition of transacting business
27 in this state with small employers, offer to small employers all health care insurance
28 plans the small employer actively markets to small employers in this state, including
29 a basic health care insurance plan and a standard health care insurance plan.

30 (b) A small employer insurer shall issue a health care insurance plan to a small
31 employer that applies for a plan and shall accept for enrollment under the health care

1 insurer coverage all eligible employees and their dependents who apply for enrollment
2 during the period in which the employee first becomes eligible to enroll under the
3 terms of the plan. A small employer insurer may not place a restriction on an eligible
4 employee or dependent with respect to being a participant or beneficiary that is
5 inconsistent with AS 21.54.100.

6 (c) A small employer insurer may not increase a requirement for minimum
7 employee participation or for minimum employer contribution applicable to a small
8 employer at any time after the small employer has been accepted for coverage, except
9 that a small employer insurer may vary application of minimum participation and
10 employer contribution requirements by the size of the small employer group.

11 (d) If a small employer insurer offers coverage to a small employer, the small
12 employer insurer shall offer coverage to all of the eligible employees of the small
13 employer and their dependents. A small employer insurer may not offer coverage to
14 only certain individuals in a small employer group or to only part of the group, except
15 in the case of late enrollees as provided in AS 21.54.110(d).

16 (e) The small employer insurer shall apply this section uniformly to all small
17 employers without regard to the claims experience of the small employers and their
18 employees and dependents or a health status factor of an employee or dependent.

19 (f) A small employer insurer may not, directly or indirectly, encourage or
20 direct small employers to refrain from filing an application for coverage with a small
21 employer insurer or to seek coverage from another insurer because of a health status
22 factor, the claims experience, the industry, the occupation, or the geographic location
23 of the small employer.

24 (g) Except as provided in AS 21.54.110, a small employer insurer may not, by
25 a rider or amendment applicable to a specific individual, restrict or exclude coverage
26 or benefits by type of illness, treatment, medical condition, or service otherwise
27 covered by the plan.

28 (h) This section does not apply to health care insurance plans offered by a
29 small employer insurer if the insurer makes the health care insurance plans available
30 in the small employer market only through a bona fide association.

31 * Sec. 87. AS 21.56.160 is repealed and reenacted to read:

1 **Sec. 21.56.160. Exemption from required offer of coverage.** (a) A small
2 employer insurer offering health care insurance through a network plan is not required
3 to offer or renew coverage or accept applications under AS 21.56.140(a) if

4 (1) the small employer does not have eligible employees or dependents
5 who live, work, or reside in the service area for the network plan; or

6 (2) the small employer insurer demonstrates to the director that the
7 small employer insurer

8 (A) will not have the capacity to deliver services adequately to
9 eligible employees or dependents of additional groups because of the small
10 employer insurer's obligation to existing group contract holders and covered
11 employees or dependents; and

12 (B) applies this subsection uniformly without regard to the
13 claims experience of the employers and their employees and dependents or to
14 a health status factor relating to the employees and dependents.

15 (b) A small employer insurer offering health care insurance is not required to
16 offer or accept applications under AS 21.56.140(a) if

17 (1) the small employer insurer is only maintaining in-force business and
18 has ceased enrolling new employer groups on or before January 1, 1993; or

19 (2) the certificate of authority or bylaws of an insurer does not permit
20 the insurer to issue coverage on a marketwide basis; however, an insurer described in
21 this paragraph shall comply with AS 21.56.140 regarding small employers that meet
22 the requirements of the insurer's certificate of authority or bylaws.

23 (c) A small employer insurer who denies health care insurance coverage in a
24 service area under (a) of this section may not offer coverage in the small employer
25 market within that service area for a period of 180 days after the date the coverage is
26 denied.

27 (d) If a small employer insurer demonstrates or the director determines under
28 AS 21.09.175 that a small employer insurer does not have the financial reserves
29 necessary to underwrite additional coverage, the small employer insurer may not offer
30 or renew health care insurance coverage in the small employer group market. The
31 small employer insurer may not reenter the small employer group market until the

1 director has determined that the insurer has sufficient financial reserves to underwrite
2 additional coverage.

3 * Sec. 88. AS 21.56.180 is repealed and reenacted to read:

4 **Sec. 21.56.180. Fair marketing standards.** (a) A small employer insurer
5 may not, directly or indirectly, enter into a contract, agreement, or arrangement with
6 an insurance producer, a managing general agent, or a third-party administrator that
7 provides for or results in the compensation paid to an insurance producer for the sale
8 of a health care insurance plan to vary based on the health status, claims experience,
9 industry, occupation, or geographic location of the small employer. This subsection
10 does not apply to a compensation arrangement that provides compensation to an
11 insurance producer, a managing general agent, or a third-party administrator on the
12 basis of a percentage of premium that does not vary based on the health status, claims
13 experience, industry, occupation, or geographic area of the small employer.

14 (b) A small employer insurer shall provide reasonable compensation, as
15 provided under the plan of operation of the program, to an insurance producer, a
16 managing general agent, or a third-party administrator, if any, for the sale of a basic
17 or standard health care insurance plan.

18 (c) A small employer insurer, an insurance producer, a managing general
19 agent, or a third-party administrator may not induce or otherwise encourage a small
20 employer to separate or otherwise exclude an employee from health coverage or
21 benefits provided in connection with the employee's employment.

22 (d) A small employer insurer may only deny an application for coverage from
23 a small employer in writing, and the writing must state the reasons for the denial.

24 (e) The director may establish by regulation additional standards to provide for
25 the fair marketing of health care insurance plans to small employers in this state.

26 (f) A person who enters into a contract, agreement, or other arrangement with
27 a small employer insurer to provide administrative, marketing, or other services related
28 to the offering of health care insurance plans to small employers in this state is subject
29 to this section as if it were a small employer insurer.

30 (g) A violation of this section by a person is an unfair trade practice for
31 purposes of AS 21.36.

1 * Sec. 89. AS 21.56.190 is amended to read:

2 **Sec. 21.56.190. Mandatory reissue of coverage.** The director may adopt
3 regulations to require small employer insurers, as a condition of transacting business
4 with small employers in this state after July 1, 1993, to reissue a health care
5 insurance [BENEFIT] plan to a small employer who has had its health care insurance
6 [BENEFIT] plan terminated or not renewed by the insurer after January 1, 1993. The
7 director may prescribe the terms for the reissue of coverage that the director
8 determines are reasonable and necessary to provide continuity of coverage to small
9 employers.

10 * Sec. 90. AS 21.56.250 is repealed and reenacted to read:

11 **Sec. 21.56.250. Definitions.** In this chapter,

12 (1) "actuarial certification" means a written statement by a member of
13 the American Academy of Actuaries or another individual acceptable to the director
14 indicating that, based on the person's examination, including a review of the
15 appropriate records, actuarial assumptions, and methods used by the insurer in
16 establishing premium rates for applicable health insurance plans, a small employer
17 insurer is in compliance with the provisions of AS 21.56.120;

18 (2) "affiliated" means a person who directly or indirectly, through one
19 or more intermediaries, controls or is controlled by or is under common control with
20 a specified person;

21 (3) "base premium rate" means the lowest premium rate charged or that
22 could have been charged under the rating system by the small employer insurer to
23 small employers with similar case characteristics for health care insurance plans with
24 the same or similar coverage;

25 (4) "basic health care insurance plan" means a lower cost plan offered
26 under AS 21.56.140;

27 (5) "beneficiary" has the meaning given in AS 21.54.500;

28 (6) "board" means the board of directors of the Small Employer Health
29 Reinsurance Association;

30 (7) "bona fide association" has the meaning given in AS 21.54.500;

31 (8) "case characteristics" means demographic or other objective

1 characteristics of a small employer that are considered by the small employer insurer
2 in the determination of premium rates for the small employer, except that claim
3 experience, health status, and duration of coverage may not be case characteristics for
4 the purposes of this chapter;

5 (9) "committee" means the health benefit plan committee established
6 in AS 21.56.060;

7 (10) "eligible employee" means an employee who works on a full-time
8 basis, with a normal work week of 30 or more hours; "eligible employee" includes a
9 sole proprietor, a partner of a partnership, or an independent contractor if the sole
10 proprietor, partner, or contractor is included as an employee under a health care
11 insurance plan of a small employer, but does not include an employee who works on
12 a part-time, temporary, or substitute basis;

13 (11) "employee" has the meaning given in AS 21.54.500;

14 (12) "group market" has the meaning given in AS 21.54.500;

15 (13) "health care insurance plan" has the meaning given in
16 AS 21.54.500;

17 (14) "health care insurer" has the meaning given in AS 21.54.500;

18 (15) "health status factor" has the meaning given in AS 21.54.500;

19 (16) "index rate" means, for small employers with similar case
20 characteristics and plan designs as determined by the insurer for a rating period, the
21 arithmetic average of the applicable base premium rate and the corresponding highest
22 premium rate,

23 (17) "large employer" has the meaning given in AS 21.54.500;

24 (18) "late enrollee" has the meaning given in AS 21.54.500;

25 (19) "member" means a health care insurer;

26 (20) "network plan" has the meaning given in AS 21.54.500;

27 (21) "new business premium rate" means the lowest premium rate
28 charged or offered, or that could have been charged or offered, by the small employer
29 insurer to small employers with similar case characteristics for newly issued health
30 care insurance plans with the same or similar coverage;

31 (22) "plan of operation" means the plan of operation of the reinsurance

i association adopted by the board under AS 21.56.040;

2 (23) "rating period" means the calendar period for which premium rates
3 established by a small employer insurer are assumed to be in effect;

4 (24) "reinsurance association" means the Small Employer Health
5 Reinsurance Association created in AS 21.56.010;

6 (25) "reinsuring insurer" means a small employer insurer participating
7 in the reinsurance association created in AS 21.56.010;

8 (26) "small employer" has the meaning given in AS 21.54.500;

9 (27) "small employer insurer" means a health care insurer offering,
10 issuing for delivery, delivering, or renewing health care insurance to small employers
11 in the state;

12 (28) "standard health care insurance plan" means a health care
13 insurance plan offered under AS 21.56.140 that includes more comprehensive benefits
14 than under a basic health care insurance plan.

15 * Sec. 91. AS 21.66.110(a) is amended to read:

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

23 * Sec. 92. AS 21.66.390(a) is amended to read:

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

28 (1) the desirability for stability of rate structures;

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

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

3 (4) investment income.

4 * Sec. 93. AS 21.69.310(a) is amended to read:

5 (a) Meetings of stockholders or members of a domestic insurer shall be held
6 in the city or town of its principal office or place of business in this state. The
7 meetings may be held, for good cause, in another location within the state upon
8 approval of the director.

9 * Sec. 94. AS 21.69.520(a) is amended to read:

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

19 * Sec. 95. AS 21.75.045(a) is amended to read:

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

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

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

31 * Sec. 96. AS 21.76.020(b) is amended to read:

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

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

6 (2) include an analysis, certified by a member of the American
7 Academy of Actuaries, of the sufficiency of the loss reserves; and

8 (3) be certified by a certified public accountant.

9 * Sec. 97. AS 21.76.080(e) is amended to read:

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

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

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

18 (3) AVAILABLE FOR PUBLIC INSPECTION.]

19 * Sec. 98. AS 21.78.293(b) is amended to read:

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

26 * Sec. 99. AS 21.84.590 is amended to read:

27 **Sec. 21.84.590. Other provisions applicable.** In addition to the provisions
28 contained in this chapter, the following provisions of this title apply to fraternal benefit
29 societies to the extent applicable and not in conflict with the express provisions of this
30 chapter and the reasonable implications of this chapter:

31 (1) AS 21 03;

- 1 (2) AS 21.06;
 2 (3) AS 21.09.050 and 21.09.100;
 3 (4) AS 21.09.200 and 21.09.205;
 4 (5) AS 21.18;
 5 (6) AS 21.21;
 6 (7) AS 21.27;
 7 (8) AS 21.33;
 8 (9) AS 21.36;
 9 (10) AS 21.42.290, 21.42.347, and 21.42.355;
 10 (11) AS 21.53;
 11 (12) AS 21.54;
 12 (13) AS 21.56;
 13 (14) AS 21.69.370 and 21.69.640;
 14 (15) [(13)] AS 21.78;
 15 (16) [(14)] AS 21.89.060.

16 * Sec. 100. AS 21.86.150 is amended by adding new subsections to read:

17 (g) A health maintenance organization that offers, renews, issues for delivery,
 18 or delivers in this state a health care insurance plan in the group market that does not
 19 impose a preexisting condition exclusion with respect to a particular coverage option
 20 under the plan may impose an affiliation period for that coverage option only if the
 21 affiliation period

- 22 (1) is applied uniformly without regard to a health status factor;
 23 (2) does not exceed two months for new enrollees and three months for
 24 late enrollees;
 25 (3) begins on the enrollment date; and
 26 (4) runs concurrently with any waiting period under the plan.

27 (h) A health maintenance organization may use a method other than a
 28 preexisting condition exclusion or an affiliation period to lessen the risk of adverse
 29 selection only with prior written approval of the director.

30 * Sec. 101. AS 21.86.260(a) is amended to read:

- 31 (a) Except as provided in AS 21.36, AS 21.42, AS 21.54, AS 21.56 and in this

1 chapter, this title does not apply to a health maintenance organization that obtains a
2 certificate of authority under this chapter. This subsection does not apply to an insurer
3 licensed under AS 21.09 or a hospital or medical service corporation licensed under
4 AS 21.87 except with respect to its health maintenance organization activities
5 authorized by and regulated under this chapter.

6 * Sec. 102. AS 21.86.900 is amended by adding new paragraphs to read:

7 (10) "affiliation period" means a period of time under a contract with
8 a health maintenance organization

9 (A) that must expire before coverage becomes effective;

10 (B) during which the health maintenance organization is not
11 required to provide health care services or benefits; and

12 (C) for which no premium is charged to the participant or
13 beneficiary for coverage during the period;

14 (11) "beneficiary" has the meaning given in AS 21.54.500;

15 (12) "enrollment date" has the meaning given in AS 21.54.500;

16 (13) "group market" has the meaning given in AS 21.54.500;

17 (14) "health status factor" has the meaning given in AS 21.54.500;

18 (15) "participant" has the meaning given in AS 21.54.500;

19 (16) "preexisting condition exclusion" has the meaning given in
20 AS 21.54.500;

21 (17) "waiting period" has the meaning given in AS 21.54.500.

22 * Sec. 103. AS 21.87.140(c) is amended to read:

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

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

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

31 (3) if the participant provider withdraws from the agreement, the

1 withdrawal may not be effective as to a subscriber's contract in force on the date of
2 the withdrawal until the termination of the subscriber's contract or the next anniversary
3 of the subscriber's contract, whichever date is the earlier.

4 * Sec. 104. AS 21.87.150(c) is amended to read:

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

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

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

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

17 * Sec. 105. AS 21.87.180(a) is amended to read:

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

25 * Sec. 106. AS 21.87.190(b) is amended to read:

26 (b) The service corporation shall, before use, file with the director (1) a
27 schedule of subscription rates, fees, or payments of any kind to be charged subscribers;
28 (2) every rating manual, schedule, plan, rule, or formula; and (3) [SHALL FILE]
29 before use, any modification to the rating manual, schedule, plan, rule, or formula.
30 Each filing must state the effective date and must provide a comprehensive
31 description of the coverage. The director may withhold the rating formula from

1 public inspection for as long as the director determines that withholding the
 2 rating formula is necessary to protect the service corporation against unwarranted
 3 iniurv or is in the public interest [EVERY PROPOSED CHANGE OR
 4 MODIFICATION IN THE RATES, FEES, OR PAYMENTS].

5 * **Sec. 107.** AS 21.87.200 is repealed and reenacted to read:

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

9 * **Sec. 108.** AS 21.87.340 is amended to read:

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

- 16 (1) AS 21.03;
- 17 (2) AS 21.06;
- 18 (3) AS 21.09, except AS 21.09.090;
- 19 (4) AS 21.18.010;
- 20 (5) AS 21.18.030;
- 21 (6) AS 21.18.040;
- 22 (7) AS 21.18.120;
- 23 (8) AS 21.21.321;
- 24 (9) AS 21.36;
- 25 (10) AS 21.42.345 - 21.42.365 and 21.42.375 - 21.42.395 [, 21.42.375,
- 26 21.42.380, AND 21.42.385];
- 27 (11) AS 21.51.120;
- 28 (12) AS 21.53;
- 29 (13) AS 21.54 [AS 21.54.020];
- 30 (14) AS 21.56;
- 31 (15) AS 21.69.400;

- 1 (16) AS 21.69.520;
2 (17) AS 21.69.600, 21.69.620, and 21.69.630;
3 (18) AS 21.78;
4 (19) AS 21.89.040;
5 (20) AS 21.89.060;
6 (21) AS 21.90.

7 * Sec. 109. AS 21.89.020(g) is amended to read:

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

13 * Sec. 110. AS 21.90.900(29) is amended to read:

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

20 * Sec. 111. AS 21.90.900 is amended by adding new paragraphs to read:

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

25 (42) "medical care" means amounts paid for

26 (A) diagnosis, care, mitigation, treatment, or prevention of
27 disease, or amounts paid for the purpose of affecting any structure or function
28 of the body;

29 (B) transportation primarily for and essential to medical care
30 described in (A) of this paragraph; and

31 (C) insurance covering medical care described in (A) and (B)

1 of this paragraph.

2 * **Sec. 112.** AS 21.42.375(d), 21.42.395(d); AS 21.56.110(b), 21.56.110(d), 21.56.130,
3 21.56.150, 21.56.170; and AS 21.81 are repealed.

4 * **Sec. 113.** AS 21.54.150, enacted by sec. 59 of this Act, is repealed.

5 * **Sec. 114.** Sections 3, 4, and 5, ch. 101, SLA 1992, are repealed.

6 * **Sec. 115.** Sections 4, 7, 9, 12, and 13, ch. 39, SLA 1993, are repealed.

7 * **Sec. 116.** AS 21.54.150, enacted by sec. 59 of this Act, takes effect January 1, 1998.

8 * **Sec. 117.** Sections 6, 7, 27 - 30, and 91 of this Act take effect January 1, 1998.

9 * **Sec. 118.** Except as provided in secs. 116, 117, and 119 of this Act, this Act takes effect
10 July 1, 1997.

11 * **Sec. 119.** Section 113 of this Act takes effect September 20, 2001.



Official Business

Alaska State Legislature

Senate

Rules Committee

State Capitol
Juneau, AK. 99801-1182

MEMORANDUM

DATE: April 16, 1997

TO: Rep. Norm Rokeberg, Chairman
House Labor & Commerce Committee

FROM: Senator Tim Kelly, Chairman *TDK*
Senate Rules Committee

SUBJ: Request For Committee Substitute - HB 218

I would appreciate your consideration of making a committee substitute for your HB 218, the Omnibus Insurance bill. The inclusion I propose would be the material which composes the Kennedy / Kassebaum portable health plan provisions passed at the national level, and to which Alaska must soon conform.

I have attached a copy of the draft which would merge our CSSB 104 (L&C) and the K/K language. I urge your consideration of this C.S. because it appears absolutely necessary to pass this session, and I understand that your committee members have been exposed to a hearing on the K/K issues already.

It is the intention of Senator Pearce to merge the same material into CSSB 104 (L&C) in the Senate Finance Committee hearing next week. I feel it is imperative to have both versions be the same to facilitate passage of one or the other this session.

Support material is attached for your review. If there are any questions, please contact Tim Benintendi at 3770. Thank you.

TDK/tb/m13

Key Dates for Group and Individual Health Insurance Reform

Actions by States

April 1, 1997: **Deadline** for a state to notify the HHS Secretary that the state has enacted or intends to enact any necessary legislation to provide for the implementation of an acceptable alternative mechanism for the individual market; and to provide the HHS Secretary with any information required by the Secretary to review the mechanism and its implementation or proposed implementation.

Note: The Act also requires states to file information about their alternative mechanisms every 3 years. The Act does not specify whether the due date is the same date as the state filed its initial notice and information, or the date on which or by which the HHS Secretary determined that the state's mechanism was acceptable.

Note: The Act also provides that if a state submits its notice and information about an alternative mechanism **after Jan. 1, 1997**, the mechanism shall be considered an acceptable alternative **unless** the Secretary makes a determination that the mechanism is not acceptable within 90 days of the date of submission. A mechanism not found unacceptable becomes effective 90 days after the end of the 90 day submission period. The Act does not contain any similar provision for automatic approval for notices submitted on or before Jan. 1, 1997.

July 1, 1997: Federal portability and renewability provisions become effective for individual health insurance unless state has implemented, or has filed notice of intent to implement, an alternative mechanism.

July 1, 1997: Portability, availability, and renewability provisions become effective for group health plans and health insurance coverage offered in connection with such plans with no respect to years beginning on or after this date.

Jan. 1, 1998: Deadline for state enactment of legislation providing for implementation of alternative mechanism in individual market, except for states where legislature does not meet within 12 months after date of enactment of this Act. (Aug. 21, 1996, is the enactment date.)

July 1, 1998: Deadline for state enactment of legislation providing for implementation of alternative mechanism for individual market in states where legislature does not meet within 12 months after date of enactment of this Act. (Aug. 21, 1996, is the enactment date.)

December 31, 2000: Deadline for the CEO of each state to submit to the HHS Secretary a report on the access of large employers to health insurance coverage in the state and the

circumstance - for lack of access to coverage, if any, of large employers or classes of large employers.

Note: The Act also requires the CEO of each state to file a similar report every three years addressing the access to coverage of large employers.

Federal Regulations

April 1, 1997: Secretary of HHS required to issue interim final regulations for individual market.

April 1, 1997: Secretaries of Treasury, Labor, and HHS required to issue interim final regulations for group market

Other Key Dates

July 1, 1996: Covered people generally begin accumulating creditable coverage.

June 1, 1997: Health plans and issuers required to begin issuing certifications of prior creditable coverage for both group and individual markets.

Jan. 1, 1998: Earliest date that the Act would permit an enforcement action against a group health plan or health insurance issuer, as long as the plan or issuer was trying to comply in good faith with the law's requirements. If regulations are not issued by April 1, 1997, no enforcement action can be taken until the regulations are issued, even if they are issued after Jan. 1, 1998.

~~K.K. PLUS~~

~~CSSB 104 (LTC)~~

CS FOR SENATE BILL NO. 104(FIN)
IN THE LEGISLATURE OF THE STATE OF ALASKA
TWENTIETH LEGISLATURE - FIRST SESSION

BY THE SENATE FINANCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE

A BILL

FOR AN ACT ENTITLED

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

1 an effective date."

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

3 * Section 1. PURPOSE. The purpose of secs. 3, 11, 12, 31 - 34, 43 - 57, 59 - 90, 99 -
4 102, 108, and 110 - 116 of this Act is to implement the minimum federal standards for health
5 care insurance enacted under P.L. 104-191 (Health Insurance Portability and Accountability
6 Act of 1996).

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

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

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

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

19 (b) In this section,

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

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

23 (3)] "health care insurer" has the meaning given in AS 21.54.500
24 [MEANS AN INSURER TRANSACTING THE BUSINESS OF HEALTH
25 INSURANCE, A HEALTH MAINTENANCE ORGANIZATION UNDER AS 21.86,
26 A HOSPITAL SERVICE CORPORATION UNDER AS 21.87, A MEDICAL
27 SERVICE CORPORATION UNDER AS 21.87, OR A COMBINED MEDICAL
28 SERVICE AND HOSPITAL SERVICE CORPORATION UNDER AS 21.87].

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 (b) Each insurer, and each formerly authorized insurer with respect to
8 premiums received while an authorized insurer in this state, shall pay a tax on the total
9 direct premium income received during the year ending on the preceding December
10 31 and paid for the insurance of property or risks resident or located in the state, other
11 than wet marine and transportation insurance, after deducting from the total direct
12 premium income the applicable cancellations, returned premiums, the unabsorbed
13 portion of any deposit premium, all policy dividends, unabsorbed premiums refunded
14 to policyholders, refunds, savings, savings coupons, and other similar returns paid or
15 credited to policyholders with respect to their policies. No deductions may be made
16 of cash surrender value of policies. Considerations received on annuity contracts are
17 not included in the direct premium income and are not subject to tax. The tax shall be
18 paid to the director at least annually but not more often than once each quarter on
19 the dates specified by the director. The method of payment must be by the
20 electronic or other payment method specified by the director. The tax [OR
21 BEFORE MARCH 1, AND] is computed at the rate of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 (1) the National Association of Insurance Commissioners; and
4 (2) the insurance regulatory agency in each state in which the insurer
5 is authorized to transact business [,] if the insurance regulatory agency has requested
6 the report in writing from the insurer; a report requested under this paragraph shall be
7 delivered

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

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

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

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

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

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

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

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

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

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

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

1 (C) reserves for accidental death benefits;

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

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

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

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

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

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

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

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

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

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

1 insurance policies or groups of policies

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

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

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

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

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

18 (1) 80 percent of the total termination rate used in the calculation of
19 gross premiums; or

20 (2) eight percent.

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

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

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

29 (1) a maximum interest rate equal to the maximum interest rate allowed
30 under AS 21.18.10 for the valuation of whole life insurance issued on the same date
31 as the health insurance policy;

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

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

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

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

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

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

16 (5) a morbidity assumption for

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

23 (B) group disability income insurance issued

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

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

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

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

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.

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

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

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

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

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

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

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

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

26 (d) Claim reserves must be determined as follows:

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

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

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

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

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

9 (B) group disability income insurance for policies issued

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

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

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

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

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

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

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

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

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

1 included;

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

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

5 (F) all other information requested by the director;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (1) either

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

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

5 (2) the person

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

7 (B) wholly owns the admitted insurer; or

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

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

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

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

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

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

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

1 placing.

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

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

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

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

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

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

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

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

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

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

24 (5) provide in or with its application

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2 (1) was born out of wedlock;

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

5 (3) does not reside with the parent; or

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

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

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

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

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

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

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

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

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

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

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

1 insurance coverage;

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

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

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

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

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

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

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

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

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

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

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

5 (3) if the insured fails to pay the premium as required by the insurer

6 for renewal.

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

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

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

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

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

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

1 require.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 (1) 48 hours after a vaginal birth; and

13 (2) 96 hours after a caesarean birth.

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

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

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

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

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

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

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

29 **Sec. 21.42.355. Coverage for cost of services provided by nurse midwives.**

30 (a) If a health care insurance plan or an excepted benefits policy or contract [AN
31 INDIVIDUAL OR GROUP HEALTH INSURANCE POLICY, SUBSCRIBER'S

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

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

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

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

- 26 (1) benefits of at least \$9,600 over two consecutive benefit years; and
27 (2) lifetime benefits of at least \$19,200.

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

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

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

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

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

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

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

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

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

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

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

30 (e) In this section,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 (c) The coverage required by this section

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

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

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

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

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

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

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

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

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

1 * Sec. 54. AS 21.42.385 is repealed and reenacted to read:

2 Sec. 21.42.385. Dental, vision, and hearing coverage. (a) Except for a
3 fraternal benefit society, a health care insurer that offers, issues for delivery, delivers,
4 or renews in this state a health care insurance plan, including a Medicare supplement
5 policy to the extent not prohibited by 42 U.S.C. 1395, shall offer to each plan sponsor
6 or individual minimum dental, vision, and hearing coverage described in (b) of this
7 section. Coverage required under this subsection may be offered as a rider or in a
8 separate policy.

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

10 (1) be provided under contract with another health care insurer; and

11 (2) not be less than the dental, vision, and hearing coverage provided
12 on January 1, 1992, to an individual entitled to medical benefits under AS 39.35.535
13 (public employees' retirement system of Alaska).

14 (c) This section does not apply to a health care insurer that has written less
15 than \$300,000 in premiums in the previous calendar year. A health care insurer
16 exempt under this subsection shall disclose the exemption when offering, issuing for
17 delivery, delivering, or renewing a health care insurance plan or an excepted benefits
18 contract, and shall advise the individual covered under the plan that health care
19 insurers that have written more than \$300,000 in premiums in the previous calendar
20 year are required to offer coverage under (a) and (b) of this section.

21 (d) This section does not require an insurer who offers only group insurance
22 coverage under AS 21.54 to offer dental, vision, and hearing coverage to an individual.

23 * Sec. 55. AS 21.42.395(a) is repealed and reenacted to read:

24 (a) Except for a fraternal benefit society, a health care insurer that offers,
25 issues for delivery, delivers, or renews in this state a health care insurance plan shall
26 provide coverage for the costs of prostate cancer screening tests as required under the
27 schedule described in (b) of this section and shall provide coverage for the costs of
28 cervical cancer screening tests as required under (c) of this section. The coverage
29 required by this section is subject to standard policy provisions applicable to other
30 benefits, including deductible or copayment provisions. If a physician recommends
31 that a covered individual undergo prostate cancer screening by taking a prostate

1 antigen blood test, coverage may not be denied because the covered individual has
2 already had a digital rectal examination and the examination results were negative.

3 * Sec. 56. AS 21.42 is amended by adding a new section to read:

4 Sec. 21.42.500. Definitions. In AS 21.42.345 - 21.42.395,

5 (1) "copayment" means the portion of medical care expenses in excess
6 of the deductible to be paid by a covered individual;

7 (2) "deductible" means the portion of medical care expenses for which
8 a covered individual must pay before benefits become payable;

9 (3) "excepted benefits" has the meaning given in AS 21.54.160;

10 (4) "fraternal benefit society" has the meaning given in AS 21.84.900;

11 (5) "health care insurance plan" has the meaning given in
12 AS 21.54.500;

13 (6) "health care insurer" has the meaning given in AS 21.54.500;

14 (7) "placed for adoption" has the meaning given in AS 21.54.500.

15 * Sec. 57. AS 21.53.090 is amended to read:

16 Sec. 21.53.090. Required regulations. The director shall adopt regulations
17 regarding

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

20 (A) [(1)] terms of renewability;

21 (B) [(2)] initial and subsequent conditions of eligibility;

22 (C) [(3)] nonduplication of coverage provisions;

23 (D) [(4)] coverage of dependents;

24 (E) benefit triggers;

25 (F) [(5)] preexisting conditions and recurrent conditions;

26 (G) [(6)] termination of insurance;

27 (H) [(7)] continuation or conversion;

28 (I) [(8)] probationary periods, limitations, exceptions,
29 reductions, and elimination periods; [,] and

30 (J) requirements for replacement;

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31

(3) nonforfeiture or minimum value requirements; and
(4) consumer protection standards, including standards for full and
fair disclosure setting out the manner and content of required disclosures.

* Sec. 58. 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. 59. AS 21.54 is amended by adding new sections to read:

Article 2. Health Care Insurance Provisions.

Sec. 21.54.100. Unfair discrimination. (a) A health care insurer that offers, issues for delivery, delivers, or renews a health care insurance plan in the group market may not establish rules for eligibility, including continued eligibility and waiting periods under the plan, for an individual or dependent of an individual based on

- (1) health status;
- (2) medical condition, including physical and mental illnesses;
- (3) claims experience;
- (4) receipt of health care;
- (5) medical history;
- (6) genetic information;
- (7) evidence of insurability, including conditions arising from acts of domestic violence; or
- (8) disability.

(b) A health care insurer may not require an individual, as a condition of enrollment or continued enrollment under a health care insurance plan offered in the group market, to pay a premium, contribution, or policy fee greater than a premium, contribution, or policy fee for a similarly situated individual already enrolled in the plan on the basis of a health status factor for the individual or a dependent of the individual.

Sec. 21.54.110. Preexisting condition exclusion. (a) A health care insurance plan offered, issued for delivery, delivered, or renewed in the group market may not contain a preexisting condition exclusion that

- (1) relates to a condition, regardless of cause, for which medical advice,

1 diagnosis, care, or treatment was recommended or received more than six months
2 before the enrollment date;

3 (2) considers genetic information as a condition for which a preexisting
4 condition exclusion may be imposed in absence of a diagnosis of the condition related
5 to the information;

6 (3) extends for more than 12 months after the enrollment date of a
7 covered individual; or

8 (4) excludes a condition relating to pregnancy.

9 (b) A period of a preexisting condition exclusion permissible under (a) of this
10 section must be reduced by the aggregate of periods of creditable coverage, if any, as
11 determined in AS 21.54.120, applicable to the participant or beneficiary as of the
12 enrollment date. The aggregate of periods of creditable coverage is determined by
13 adding together all periods of creditable coverage before the enrollment date, excluding
14 periods of creditable coverage before a continuous break in coverage of more than 90
15 days. A waiting period or affiliation period may not be considered in determining the
16 90-day period. This subsection does not apply if an individual's most recent period
17 of creditable coverage ended on a date more than 90 days before the enrollment date.
18 This subsection does not preclude application of a waiting period to all new enrollees
19 under a health care insurance plan.

20 (c) A health care insurance plan offered, issued for delivery, delivered, or
21 renewed in this state in the group market may not apply a preexisting condition
22 exclusion to an individual who is (1) a newborn covered under creditable coverage as
23 of the last day of the 30-day period beginning with the date of birth; or (2) adopted
24 or placed for adoption before attaining 18 years of age and who is covered under
25 creditable coverage as of the last day of the 30-day period beginning with the date of
26 adoption or placement for adoption. This subsection does not apply to an individual
27 after the end of the first continuous 90-day period during all of which the individual
28 was not covered under creditable coverage.

29 (d) A health care insurance plan offered, issued for delivery, delivered, or
30 renewed in this state in the group market may exclude coverage for late enrollees for
31 the greater of 18 months or an 18-month preexisting condition exclusion. If both a

1 waiting period and a preexisting condition exclusion under (a) of this section are
2 applicable to a late enrollee, the combined period may not exceed 18 months from the
3 date the individual enrolls for coverage under a health care insurance plan.

4 **Sec. 21.54.120. Creditable coverage.** (a) A health care insurer that offers,
5 issues for delivery, delivers, or renews in this state a health care insurance plan in the
6 group market shall count a period of creditable coverage based on

7 (1) the standard method authorized by 42 U.S.C. 300gg (Health
8 Insurance Portability and Accountability Act of 1996) for determining creditable
9 coverage without regard to the specific benefits covered during the period; or

10 (2) an alternative method based on coverage of benefits within each of
11 several classes or categories of benefits specified in federal regulation if

12 (A) made on a uniform basis for all participants and
13 beneficiaries; and

14 (B) the insurer counts a period of creditable coverage with
15 respect to any class or category of benefits if any level of benefits is covered
16 within the class or category.

17 (b) A health care insurer that offers, issues for delivery, delivers, or renews in
18 this state a health care insurance plan in the group market shall provide a certification
19 of coverage

20 (1) at the time an individual ceases to be covered under a health care
21 insurance plan or becomes covered under a federal continuation provision;

22 (2) at the time an individual ceases to be covered under a federal
23 continuation provision; and

24 (3) upon request by an individual or on behalf of an individual with 24
25 months after the date coverage under the health care insurance plan or a federal
26 continuation provision ceases.

27 (c) A health care insurer that offers, issues for delivery, delivers, or renews in
28 this state a health care insurance plan in the group market shall establish periods of
29 creditable coverage with respect to an individual through certification under (b) of this
30 section or as specified in federal regulation.

31 (d) A health care insurer that offers, issues for delivery, delivers, or renews in

1 this state a health care insurance plan in the group market shall prominently state and
2 describe the effect of the health care insurer's election to count a period of creditable
3 coverage using a permissible alternative method

4 (1) in any disclosure statement concerning the health care insurance
5 plan or coverage;

6 (2) to each enrollee at the time of enrollment; and

7 (3) to each employer at the time of offer or sale of coverage.

8 (e) A health care insurer issuing a certification under (b) of this section shall
9 disclose information regarding coverage of classes and categories of health benefits
10 available under the health care insurer's plan at the request of an entity that

11 (1) enrolls an individual who has provided the certification of coverage;

12 (2) elects to count a period of creditable coverage according to a
13 permissible alternative method under (a)(2) of this section; and

14 (3) pays the health care insurer for the reasonable cost, if any, of
15 disclosing the information described in this subsection.

16 **Sec. 21.54.130. Renewability, termination, and modification of coverage.**

17 (a) Except for a multiple employer welfare arrangement, a health care insurer that
18 offers, issues for delivery, delivers, or renews in this state a health care insurance plan
19 in the group market shall renew or continue in force the coverage under the plan at the
20 option of the plan sponsor unless

21 (1) the plan sponsor has failed to pay premiums or contributions in
22 accordance with the terms of the health care insurance plan or the health care insurer
23 has not received timely premium payments;

24 (2) the plan sponsor has performed an act or practice that constitutes
25 fraud or made an intentional misrepresentation of material fact under the terms of the
26 coverage;

27 (3) the plan sponsor has failed to comply with a material plan provision
28 relating to minimum participation or employer contribution requirements;

29 (4) the health care insurer ceases to offer coverage in accordance with
30 (b) and (c) of this section;

31 (5) the health care insurer offers the plan only through a network plan

1 and there is no longer an enrollee in connection with the plan who lives, resides, or
2 works in the service area of the insurer or in the area for which the insurer is
3 authorized to transact business; or

4 (6) in the case of a plan that is made available only through a bona fide
5 association, the employer's membership in the association ceases and coverage is
6 terminated uniformly without regard to a health status factor of a covered individual.

7 (b) A health care insurer may discontinue offering a particular type of health
8 care insurance plan in the group market as permitted by this title if the insurer

9 (1) provides written notice of the decision to discontinue coverage to
10 all affected plan sponsors, participants, and beneficiaries and to the insurance
11 regulatory official in each state in which an affected covered employee or dependent
12 is known to reside; notice required under this paragraph must be given at least 180
13 days before the insurer fails to renew the health care insurance plan;

14 (2) provides written notice of the decision to discontinue coverage to
15 the director and to the insurance regulatory official in each state in which the insurer
16 is licensed at least 30 days before notice is given to the affected plan sponsors,
17 participants, and beneficiaries as described under (1) of this subsection;

18 (3) offers to each plan sponsor who is provided the particular type of
19 health care insurance plan the option to purchase another health care insurance plan
20 currently being offered by the insurer to plan sponsors in the same market in the state;
21 and

22 (4) acts uniformly without regard to the claims experience of those plan
23 sponsors or to any health status factor of a covered participant or beneficiary or a new
24 participant or beneficiary who may become eligible for coverage.

25 (c) A health care insurer may discontinue offering and renewing all health care
26 insurance plans in the group market as permitted by this title if the insurer

27 (1) provides written notice of the decision to discontinue coverage to
28 all affected plan sponsors, participants, and beneficiaries and to the insurance
29 regulatory official in each state in which an affected covered employee or dependent
30 is known to reside; notice required under this paragraph must be given at least 180
31 days before discontinuation of the plans;

1 (2) provides written notice of the decision to discontinue coverage to
2 the director and to the insurance regulatory official in each state in which the insurer
3 is licensed at least 30 days before the notice is given to the affected plan sponsors,
4 participants, and beneficiaries as described under (1) of this subsection; and

5 (3) does not issue a health care insurance plan in the group market in
6 this state for five years from the date the last group health care insurance plan was
7 discontinued.

8 (d) A health care insurer may modify a large employer's health care insurance
9 plan at the time of plan renewal.

10 (e) Except for coverage available only through a bona fide association, a health
11 care insurer may modify a small employer's health care insurance plan consistent with
12 this title at the time of plan renewal only if the modification is uniform for all small
13 employers with the same health care insurance plan.

14 (f) If a covered employee or dependent has committed a fraudulent act or
15 made an intentional misrepresentation of a material fact in regard to a health care
16 insurance plan, a health care insurer may terminate the coverage of the employee or
17 the dependent under the plan.

18 (g) For purposes of this section, a plan sponsor includes an employer member
19 of a bona fide association for a health care insurance plan made available by the health
20 care insurer only through a bona fide association.

21 **Sec. 21.54.140. Renewability of coverage for a multiple employer welfare**
22 **arrangement.** A health benefit plan that is a multiple employer welfare arrangement
23 subject to this title may not deny an employer whose employees are covered under the
24 plan continued access to the same or a different plan according to the terms of the
25 plan, except

- 26 (1) for nonpayment of contributions;
27 (2) for fraud or other intentional misrepresentation of material fact by
28 the employer;
29 (3) for noncompliance with material plan provisions;
30 (4) where the plan is ceasing to offer any coverage in a geographic
31 area;