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1 third-party administrator has filed a certification with the director certifying that
2 [, WHEN] the third-party administrator is operating only for a foreign insurer other
3 than a self-funded multiple employer welfare arrangement or self-funded
4 governmental plan regulated under AS 21.85, and [.] is registered as a third-party
5 administrator by the third-party administrator's resident insurance regulator in a state
6 that the director has determined has enacted provisions substantially similar to those
7 contained in AS 21.27.630 - 21.27.650 and that is accredited by the National
8 Association of Insurance Commissioners;

9 (3) the third-party administrator provides the director on January 1,
10 April 1, July 1, and October 1 of each year

11 (A) a list of current employees, identifying those transacting
12 business in this state or upon a subject resident, located or to be performed in
13 this state;

14 (B) a list of current insurers under contract; and

15 (C) other information the director may require;

16 (4) a written contract is in effect between the parties that establishes
17 the responsibilities of each party, indicates both parties' share of responsibility for a
18 particular function, and specifies the division of responsibilities;

19 (5) there is in effect a written contract between the insurer and third-
20 party administrator that contains the following provisions:

21 (A) the insurer may terminate the contract for cause upon
22 written notice sent by certified mail to the third-party administrator and may
23 suspend the underwriting authority of the third-party administrator during a
24 dispute regarding the cause for termination; but the insurer must fulfill all
25 lawful obligations with respect to policies affected by the written agreement,
26 regardless of any dispute between the insurer and the third-party administrator;

27 (B) the third-party administrator shall render accounts to the
28 insurer detailing all transactions and remit all money due under the contract to
29 the insurer at least monthly;

30 (C) all money collected for the account of an insurer shall be
31 held by the third-party administrator as a fiduciary;

1 (D) all payments on behalf of the insurer shall be held by the
2 third-party administrator as a fiduciary;

3 (E) the third-party administrator may not retain more than three
4 months estimated claims payments and allocated loss adjustment expenses;

5 (F) the third-party administrator shall maintain separate records
6 for each insurer in a form usable by the insurer; the insurer or its authorized
7 representative shall have the right to audit and the right to copy all accounts
8 and records related to the insurer's business; the director, in addition to other
9 authority granted in this title, shall have access to all books, bank accounts, and
10 records of the third-party administrator in a form usable to the director; any
11 trade secrets contained in books and records reviewed by the director,
12 including the identity and addresses of policyholders and certificate holders,
13 shall be kept confidential, except that the director may use the information in a
14 proceeding instituted against the third-party administrator or the insurer;

15 (G) the contract may not be assigned in whole or in part by the
16 third-party administrator;

17 (H) if the contract permits the third-party administrator to do
18 underwriting, the contract must include the following:

19 (i) the third-party administrator's maximum annual
20 premium volume;

21 (ii) the rating system and basis of the rates to be
22 charged;

23 (iii) the types of risks that may be written;

24 (iv) maximum limits of liability;

25 (v) applicable exclusion;

26 (vi) territorial limitations;

27 (vii) policy cancellation provisions;

28 (viii) the maximum policy term; and

29 (ix) that the insurer shall have the right to cancel or not
30 renew a policy of insurance subject to applicable state law;

31 (I) if the contract permits the third-party administrator to

1 administer claims on behalf of the insurer, the contract must include the
2 following:

3 (i) written settlement authority must be provided by the
4 insurer and may be terminated for cause upon the insurer's written
5 notice sent by certified mail to the third-party administrator or upon the
6 termination of the contract, but the insurer may suspend the settlement
7 authority during a dispute regarding the cause of termination;

8 (ii) claims shall be reported to the insurer within 30
9 days;

10 (iii) a copy of the claim file shall be sent to the insurer
11 upon request or as soon as it becomes known that the claim has the
12 potential to exceed an amount determined by the director or exceeds the
13 limit set by the insurer, whichever is less, involves a coverage dispute,
14 may exceed the third-party administrator's claims settlement authority,
15 is open for more than six months, involves extra contractual
16 allegations, or is closed by payment in excess of an amount set by the
17 director or an amount set by the insurer, whichever is less;

18 (iv) each party to the contract shall comply with unfair
19 claims settlement statutes and regulations;

20 (v) transmission of electronic data must occur at least
21 monthly if electronic claim files are in existence; and

22 (vi) claim files shall be the sole property of the insurer;
23 upon an order of liquidation of the insurer, the third-party administrator
24 shall have reasonable access to and the right to copy the files on a
25 timely basis; and

26 (J) the contract may not provide for commissions, fees, or
27 charges contingent upon savings obtained in the adjustment, settlement, and
28 payment of losses covered by the insurer's obligations; but a third-party
29 administrator may receive performance-based compensation for providing
30 hospital or other auditing services or may receive compensation based on
31 premiums or charges collected or the number of claims paid or processed.

1 * **Sec. 14.** AS 21.27.650 is amended by adding a new subsection to read:

2 (q) The director may, without advance notice or hearing, immediately suspend
3 by order the registration of a third-party administrator if the director finds that one or
4 more of the following circumstances exist:

5 (1) the third-party administrator is insolvent or impaired;

6 (2) a proceeding for bankruptcy, receivership, conservatorship, or
7 rehabilitation, or another delinquency proceeding regarding the third-party
8 administrator has been commenced in any state or by a governmental agency of
9 another jurisdiction;

10 (3) the third-party administrator is in an unsound condition, or is in a
11 condition or using methods or practices that render its further transaction of insurance
12 injurious to policy holders or the public.

13 * **Sec. 15.** AS 21.27 is amended by adding a new section to article 4 to read:

14 **Sec. 21.27.660. Definitions.** In AS 21.27.630 - 21.27.660,

15 (1) "insurer" includes the Comprehensive Health Insurance
16 Association created under AS 21.55.010 and a self-funded multiple employer welfare
17 arrangement or self-funded governmental plan regulated under AS 21.85;

18 (2) "transact" has the meaning given in AS 21.90.900.

19 * **Sec. 16.** AS 21.27.900 is amended by adding a new paragraph to read:

20 (33) "appointment" means an act by a person evidencing a grant of
21 authority to another to act on the grantor's behalf.

22 * **Sec. 17.** AS 21.34.040(d) is amended to read:

23 (d) A nonadmitted insurer may be eligible to provide coverage in this state if it
24 furnishes to the director a copy of its current annual statement that has been certified
25 by the insurer. Except in the case of an alien insurer, the [THE] statement shall be
26 provided **not** [NO] more than six months after the close of the period reported upon
27 and that is either filed with and approved by the regulatory authority in the domicile of
28 the nonadmitted insurer, or certified by an accounting or auditing firm licensed in the
29 jurisdiction of the insurer's domicile. An alien insurer shall provide the statement
30 not later than nine months after the close of the reporting period. In the case of
31 an insurance exchange, the statement may be an aggregate combined statement of all

1 underwriting syndicates operating during the period reported upon.

2 * Sec. 18. AS 21.34.100(a) is amended to read:

3 (a) When surplus lines insurance is placed, the surplus lines broker shall
4 promptly deliver to the named insured or the producing broker the policy or, if the
5 policy is not then available, [A CERTIFICATE,] cover note, binder, or other evidence
6 of insurance. The [CERTIFICATE,] cover note, binder, or other evidence of insurance
7 for the named insured shall be executed by the surplus lines broker and must contain a
8 summary of all material facts that would regularly be included in the policy, the
9 description and location of the subject of insurance, a general description of the
10 coverages of the insurance, the premium and rate charged and taxes to be collected
11 from the insured, the name and address of the insured, the name of each surplus lines
12 insurer and the percentage of the entire risk assumed by each, the name of the surplus
13 lines broker, and the license number of the surplus lines broker.

14 * Sec. 19. AS 21.34.100(f) is amended to read:

15 (f) A producing broker or other licensee may issue to a person, other than
16 the named insured, a certificate [EVERY CERTIFICATE ISSUED BY THE
17 PRODUCING BROKER OR OTHER LICENSEE] as evidence of insurance
18 negotiated, placed, or procured under this chapter. The certificate must bear the
19 name of the surplus lines broker, which may not be covered, concealed, or obscured
20 by the producing broker, and the following legend in at least 10-point type: "This is
21 evidence of insurance procured and developed under the Alaska Surplus Lines Law,
22 AS 21.34. It is not covered by the Alaska Insurance Guaranty Association Act,
23 AS 21.80."

24 * Sec. 20. AS 21.36.030(a) is amended to read:

25 (a) A person may not make, issue, circulate, broadcast, or have made, issued,
26 circulated, or broadcast an estimate, circular, statement, illustration, comparison, assertion, or
27 other written, electronic, or oral presentation that

28 (1) misrepresents the benefits, advantages, conditions, sponsorship,
29 source, or terms of an insurance policy;

30 (2) misrepresents the dividends or share of the surplus to be received
31 on an insurance policy;

1 (3) misrepresents an insurance policy as being a share or shares of
2 stock;

3 (4) makes a false or misleading statement as to the dividends or shares
4 of the surplus previously paid on an insurance policy;

5 (5) misrepresents or makes a misleading statement as to the financial
6 condition of an insurer or as to the legal reserve system upon which a life insurer
7 operates;

8 (6) uses a name or title of an insurance policy or class of insurance
9 policies misrepresenting its true nature;

10 (7) is a misrepresentation for the purpose of inducing, or that tends to
11 induce the lapse, forfeiture, exchange, conversion, or surrender of an insurance policy;

12 (8) is a misrepresentation for the purpose of effecting or tending to
13 effect a pledge or assignment of or loan against an insurance policy;

14 (9) appears to be an actual policy for a named individual when it is
15 merely an advertisement;

16 (10) does not clearly designate the name of the insurer providing the
17 coverage or about which the statements are made; or

18 (11) is in any other way misleading, false, or deceptive.

19 * **Sec. 21.** AS 21.36.030(a) is amended to read:

20 (a) A person may not make, issue, circulate, broadcast, or have made, issued,
21 circulated, or broadcast an estimate, circular, statement, illustration, comparison,
22 assertion, or other written, electronic, or oral presentation that

23 (1) misrepresents the benefits, advantages, conditions, sponsorship,
24 source, or terms of an insurance policy or a health discount plan;

25 (2) misrepresents the dividends or share of the surplus to be received
26 on an insurance policy;

27 (3) misrepresents an insurance policy as being a share or shares of
28 stock;

29 (4) makes a false or misleading statement as to the dividends or shares
30 of the surplus previously paid on an insurance policy;

31 (5) misrepresents or makes a misleading statement as to the financial

1 condition of an insurer or as to the legal reserve system upon which a life insurer
2 operates;

3 (6) uses a name or title of an insurance policy or class of insurance
4 policies misrepresenting its true nature;

5 (7) is a misrepresentation for the purpose of inducing, or that tends to
6 induce the lapse, forfeiture, exchange, conversion, or surrender of an insurance policy;

7 (8) is a misrepresentation for the purpose of effecting or tending to
8 effect a pledge or assignment of or loan against an insurance policy;

9 (9) appears to be an actual policy for a named individual when it is
10 merely an advertisement;

11 (10) does not clearly designate the name of the insurer providing the
12 coverage or about which the statements are made; [OR]

13 (11) is in any other way misleading, false, or deceptive;

14 (12) misrepresents a health discount plan as a form or type of
15 insurance;

16 (13) describes a health discount plan using common insurance
17 terminology; or

18 (14) states or implies that a health discount plan is underwritten
19 by or associated with an insurer.

20 * Sec. 22. AS 21.36 is amended by adding a new section to read:

21 **Sec. 21.36.065. Limitation on owner controlled and contractor controlled**
22 **insurance programs.** (a) An owner controlled insurance program or a contractor
23 controlled insurance program must be approved by the director and shall be allowed
24 only for a major construction project. Owner controlled and contractor controlled
25 insurance programs are limited to property insurance as defined in AS 21.12.060 and
26 casualty insurance as defined in AS 21.12.070.

27 (b) In this section, an owner controlled or contractor controlled insured
28 program does not include

29 (1) builder's risk or course of construction insurance;

30 (2) insurance relating to the transportation of cargo or other property;

31 (3) insurance covering one or more affiliates, subsidiaries, partners, or

1 joint venture partners of a person; or

2 (4) insurance policies endorsed to name one or more persons as
3 additional insureds.

4 (c) In this section,

5 (1) "contractor" means a person who meets the definition of
6 "contractor" in AS 08.18.171 and who undertakes the performance of a construction
7 project for a project owner, its agent, or its representative;

8 (2) "contractor controlled insurance program" means an insurance
9 program where one or more insurance policies are procured on behalf of a contractor,
10 its agent, or its representative, by its insurance producer, as defined in AS 21.27.900,
11 for the purpose of insuring the contractor and one or more of the following:

12 (A) the project owner;

13 (B) a subcontractor;

14 (C) an architect;

15 (D) an engineer; or

16 (E) a person performing professional services;

17 (3) "major construction project" means the process of constructing a
18 structure, building, facility, or roadway or major renovation of more than 50 percent of
19 an existing structure, building, facility, or roadway having a contract cost of more than
20 \$50,000,000 of a definite term at a geographically defined project site;

21 (4) "owner controlled insurance program" means an insurance program
22 where one or more insurance policies are procured on behalf of a project owner, its
23 agent, or its representative, by its insurance producer, as defined in AS 21.27.900, for
24 the purpose of insuring the project owner and one or more of the following:

25 (A) the contractor;

26 (B) a subcontractor;

27 (C) an architect;

28 (D) an engineer; or

29 (E) a person performing professional services;

30 (5) "project owner" means a person who, in the course of the person's
31 business, engages the service of a contractor for the purpose of working on a

1 construction project;

2 (6) "subcontractor" means a person to whom a contractor sublets all or
3 part of a contractor's initial undertaking.

4 * **Sec. 23.** AS 21.36 is amended by adding a new section to read:

5 **Sec. 21.36.155. Health discount plans.** (a) A person may not sell, market,
6 promote, advertise, or otherwise distribute a health discount plan unless

7 (1) each advertisement, policy, document, information, statement, or
8 other communication regarding the health discount plan and the plan itself contain a
9 statement, in bold and prominent type, that the health discount plan is not insurance;

10 (2) the discounts offered under the health discount plan are specifically
11 authorized by a contract with each provider of the services or supplies listed in
12 conjunction with the plan;

13 (3) the health discount plan states the name, address, and telephone
14 number of the administrator of the plan;

15 (4) the person makes readily available to the consumer a complete,
16 accurate, and up-to-date list of providers participating in the plan that offer discounted
17 health care services or supplies in the consumer's local area and the discounts offered
18 by the providers;

19 (5) the person provides the consumer the right to cancel the health
20 discount plan within 30 days after purchase of the plan; and

21 (6) the person provides the consumer with a full refund of all payments
22 made within 30 days after notification of cancellation of the plan under (5) of this
23 subsection.

24 (b) The director may adopt regulations to implement this section and to
25 establish additional requirements intended to prohibit unfair or deceptive practices
26 relating to health discount plans.

27 * **Sec. 24.** AS 21.36.190 is amended by adding a new subsection to read:

28 (f) Except as provided in AS 21.36.065, an insurer, whether an authorized or
29 unauthorized insurer, may not underwrite an owner-controlled insurance program or
30 contractor-controlled insurance program. In this subsection, "owner-controlled
31 insurance program" and "contractor-controlled insurance program" have the meanings

1 given in AS 21.36.065.

2 * **Sec. 25.** AS 21.36.195 is amended to read:

3 **Sec. 21.36.195. Surplus lines brokers and insurance producers; prohibited**
4 **acts.** A surplus lines broker or an insurance producer may not fail to provide evidence
5 of insurance, [AFFIDAVITS,] filings, or reports, or fail to maintain the records, or fail
6 to pay the taxes and fees, required under AS 21.34.

7 * **Sec. 26.** AS 21.51 is amended by adding a new section to read:

8 **Sec. 21.51.405. Rate requirements.** Rates charged for a health insurance
9 policy may not be excessive, inadequate, or unfairly discriminatory.

10 * **Sec. 27.** AS 21.55.500(16) is amended to read:

11 (16) "plan administrator" means an [THE] eligible entity that is
12 licensed as a third-party administrator under AS 21.27 and is selected by the
13 board and approved by the director to administer a state plan.

14 * **Sec. 28.** AS 21.66.080(a) is amended to read:

15 (a) Every company, on or before March 1 of each year, shall furnish the
16 director or the director's designee a sworn statement of assets and liabilities, and of
17 all title premiums received by it during the preceding calendar year, setting out, among
18 other things, the amounts that have been set aside and held by it in an account required
19 under AS 21.18.073. The reporting format for a given year is the most recently
20 approved National Association of Insurance Commissioners Annual Financial
21 Statement blank form and instructions, supplemented for additional information as
22 required by the director. The director may require the statement to be filed on
23 electronic media. The statement must also show all unpaid losses and claims upon title
24 insurance policies of which the title insurance company has received due notice in
25 writing from or on behalf of the insured. With the filing of the statement, the title
26 insurance company shall pay a filing fee set under AS 21.06.250.

27 * **Sec. 29.** AS 21.66.085(b) is amended to read:

28 (b) A quarterly financial statement, if required, is due 45 [60] days after the
29 end of the quarter to which it applies.

30 * **Sec. 30.** AS 21.85 is amended by adding new sections to read:

31 **Article 2. Self-Funded Governmental Plans.**

1 **Sec. 21.85.205. Applicability.** A self-funded governmental plan that is
2 exempt from coverage under a group policy covering state employees and their
3 dependents under AS 39.30.090 and regulations adopted under that section must
4 comply with the provisions of AS 21.85.210 - 21.85.230.

5 **Sec. 21.85.210. Filing requirements.** (a) A self-funded governmental pla
6 shall annually file

7 (1) at ' 60 days before the end of the plan year

8 (A) the contribution rates and an actuarial opinion of the
9 adequacy of the contribution rates for the next plan year;

10 (B) the summary plan description for the next plan year,
11 highlighting any changes to plan benefits from the preceding year; and

12 (C) the name of and contact information for each person
13 providing administrative services to the plan;

14 (2) within 120 days after the end of the plan's fiscal year

15 (A) a certification signed by a trustee of the plan that the plan
16 complies with the requirements of AS 21.85.205 - 21.85.230;

17 (B) an audited statement of financial condition and a statement
18 of change in financial condition for the plan's fiscal year, affirmed by a trustee
19 of the plan;

20 (C) an actuarial memorandum that

21 (i) certifies to the adequacy of reserves and stop-loss
22 insurance coverage;

23 (ii) describes the financial condition of the plan,
24 including any recommended actions the plan should take to improve
25 the financial condition of the plan; and

26 (D) a report showing the number of employees and number of
27 dependents covered under the plan.

28 (b) Within 60 days after the end of each quarter, a self-funded governmental
29 plan shall file a statement of financial condition and a statement of change in financial
30 condition for the preceding quarter.

31 (c) A self-funded governmental plan shall file additional information as

1 requested by the director relating to the financial condition, transactions, and affairs of
2 the plan.

3 **Sec. 21.85.215. Minimum standards.** A self-funded governmental plan shall

4 (1) operate in accordance with a trust agreement under the governance
5 of a board of trustees that is responsible for all operations of the plan; a trustee may
6 not be an owner, officer, or employee of the administrator of the plan;

7 (2) maintain a fidelity bond covering each trustee of the plan

8 (A) in an amount not less than 10 percent of the benefits paid
9 during the preceding plan year;

10 (B) and issued by an authorized insurance company;

11 (3) establish and maintain a plan of operation that ensures that the plan
12 will remain financially solvent as certified to by a qualified actuary;

13 (4) maintain stop-loss insurance coverage as recommended by a
14 qualified actuary;

15 (5) establish and maintain reserves in an amount at least as great as the
16 amount recommended and certified by a qualified actuary and in compliance with
17 AS 21.18.080 - 21.18.086;

18 (6) establish and maintain contribution rates at a level recommended
19 and certified to by a qualified actuary for the plan to remain financially solvent;

20 (7) maintain adequate facilities and competent personnel, as
21 determined by the director, to service the plan or contract with a third-party
22 administrator registered under AS 21.27 to service the plan;

23 (8) provide each participant a summary plan description that is
24 consistent with the disclosure requirements in 29 U.S.C. 1022 (Employment
25 Retirement Income Security Act of 1974) and 29 C.F.R. 2520.102-2, 29 C.F.R.
26 2520.102-3, and 29 C.F.R. 2520.102-4 to the extent applicable and not in conflict with
27 requirements of this title.

28 **Sec. 21.85.225. Additional standards.** In addition to the provisions
29 contained or referred to in AS 21.85.205 - 21.85.230, the following chapters and
30 provisions of this title also apply with respect to a self-funded governmental plan to
31 the extent applicable and not in conflict with the express provisions of AS 21.85.205 -

1 21.85.230 and the reasonable implications of the following chapters and provisions,
2 and, for the purposes of the application, the plan shall be considered to be a mutual
3 insurer:

4 (1) AS 21.03;

5 (2) AS 21.06;

6 (3) AS 21.07;

7 (4) AS 21.09.100, 21.09.300, and 21.09.320;

8 (5) AS 21.18.080 - 21.18.086 and 21.18.100;

9 (6) AS 21.36;

10 (7) AS 21.48;

11 (8) AS 21.42.345 - 21.42.365 and 21.42.375 - 21.42.500;

12 (9) AS 21.54;

13 (10) AS 21.78;

14 (11) AS 21.90.

15 **Sec. 21.85.230. Regulations.** The director may adopt regulations to
16 implement AS 21.85.205 - 21.85.225, including a requirement that a self-funded
17 governmental plan include coverages and standards that are required under this title
18 for insurance policies of the same type of risk or risks that the self-funded
19 governmental plan is intended to cover.

20 * **Sec. 31.** AS 21.85.500 is amended by adding a new paragraph to read:

21 (9) "self-funded governmental plan" means a governmental plan, as
22 defined under 29 U.S.C. 1002 (Employee Retirement Income Security Act of 1974),
23 that

24 (A) is not a federal governmental plan, as defined in
25 AS 21.54.500; and

26 (B) does not provide for payment of benefits under the plan
27 solely through a policy of insurance issued by one or more authorized
28 insurance companies.

29 * **Sec. 32.** AS 21.90.900(42) is amended to read:

30 (42) "third-party administrator" means a person who, for residents of
31 this state, or for residents of another jurisdiction from a place of business in this state,

1 performs administrative functions including claims administration and payment,
 2 marketing administrative functions, premium accounting, premium billing, coverage
 3 verification, underwriting authority, or certificate issuance in connection with life
 4 insurance, annuities, or health insurance offered or provided by an insurer, or in
 5 connection with coverage offered or provided by a multiple employer welfare
 6 arrangement or self-funded governmental plan regulated under AS 21.85 or the
 7 Comprehensive Health Insurance Association created under AS 21.55 [REGARD
 8 TO LIFE INSURANCE, HEALTH INSURANCE, OR ANNUITIES];

9 * Sec. 33. AS 21.90.900(43) is amended to read:

10 (43) "transact₁" with respect to insurance or the provision of coverage
 11 for medical care, includes

12 (A) solicitation and inducement;

13 (B) preliminary negotiations;

14 (C) effectuation of a contract of insurance or the provision of
 15 coverage for medical care;

16 (D) transaction of matters subsequent to effectuation of the
 17 contract of insurance or the provision of coverage for medical care and
 18 arising out of it;

19 * Sec. 34. AS 21.90.900 is amended by adding a new paragraph to read:

20 (45) "health discount plan" means a card, program, device,
 21 arrangement, contract, or mechanism that purports to offer discounts or access to
 22 discounts on health care services or supplies and that is not insurance or that does not
 23 provide coverage for services or benefits regulated under AS 21.86 or AS 21.87.

24 * Sec. 35. AS 21.24.040(b); AS 21.27.330(b), and 21.27.650(p) are repealed.

25 * Sec. 36. The uncodified law of the State of Alaska is amended by adding a new section to
 26 read:

27 TRANSITION: REGULATIONS. The director of insurance may proceed to adopt
 28 regulations to implement the changes made by secs. 21, 23, and 34 of this Act. The
 29 regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the
 30 effective date of secs. 21, 23, and 34 of this Act.

31 * Sec. 37. The uncodified law of the State of Alaska is amended by adding a new section to

1 read:

2 REVISOR'S INSTRUCTIONS. (a) The revisor of statutes is instructed to change the
3 heading of AS 21.85 from "Regulation of Multiple Employer Welfare Arrangements" to
4 "Regulation of Self-Funded Employer Plans."

5 (b) The revisor of statutes is instructed to designate AS 21.85.010 - 21.85.100 as
6 "Article 1. Self-funded Multiple Employer Welfare Arrangements" and to designate
7 AS 21.85.500 as "Article 3. General Provisions."

8 * Sec. 38. Sections 21, 23, and 34 of this Act take effect July 1, 2005.

9 * Sec. 39. Except as provided in sec. 38 of this Act, this Act takes effect immediately under
10 AS 01.10.070(c).

April 8, 2005

Dear Senator Bunde and Representative Lynn:

I am your constituent and live at 3230 Legacy Drive in Anchorage. I am writing to ask you to support SB 108 in its present form so that the State Division of Insurance can respond to complaints and regulate the ASEA Health Benefits Trust.

I think it is only a matter of time before there is a tragedy as a direct result of the irresponsible actions of six trustees who are not adequately trained and who appear to be puppets of the lawyers and consultants who are operating the Trust with the bottom line as their highest priority. The trustees are otherwise regular state workers with full-time jobs, who I understand have a total of four days of training in the field of health benefits management. After a four-day course that ends with a take-home test, they receive an impressive-sounding "Certificate of Achievement in Public Plan Policy."

In my personal experience during an appeal, the trustees were alternately intimidating and condescending to me as an ASEA member who was there to exercise my right to appeal a benefits determination. I brought a friend with me to my appeal. Weeks later when I requested records, among the records was an email from the Trust's attorney, Mary Stoll that says "I want to know who that woman with her was!" The Trust literally turned on me and treated me like an enemy when I questioned the basis for their decision to abruptly terminate my daughter's benefits.

My daughter has severe bipolar disorder, among other diagnoses. This is a serious and incurable disorder. In late June 2004 the trustees of the ASEA Health Benefits Trust threatened my daughter's well-being and possibly her life by abruptly terminating her benefits. My daughter was undergoing a successful drug therapy program that had kept her fairly stable for a period of months.

On June 18, 2004, the Trust notified me that she would no longer be covered effective July 1, 2004. Her benefits were cut off with only 8 business days' notice to me, during which my life was turned upside down while I desperately sought alternative insurance. The ASEA Health Benefits Trust has no emergency appeals process. The supervisory union plan, administered by the state, and **every other plan** I have looked at does have provisions for emergency appeals. If I had not been able to find insurance to help cover the costs of ongoing medications and therapy for

my daughter, her treatment would have been interrupted, with possible tragic results.

Over the long term, in most cases bipolar disorder can be controlled. Still, it is terrifying for me as a parent to see my daughter suffer with bipolar, and it is an enormous challenge for my daughter to cope. It is painful for me to put this in writing, but perhaps you will understand the seriousness of the Trust's actions if I explain to you that my daughter has hurt herself and has been hospitalized for psychiatric breakdowns and suicidal ideation on 7 different occasions since 1995. I am supporting her financially as she makes her way through college to pursue the dream of living an independent and productive life. She requires heavy-duty maintenance medications just to remain stable. As of this writing, however, her bipolar symptoms have resurfaced with a vengeance, despite her medications and other therapies, and her mental condition has destabilized. I am monitoring her condition very closely.

I believe the Trust not only erred in finding my daughter to be ineligible, but I believe that the abrupt termination of her benefits endangered her health and life. The Trust's use of "independent third party medical experts" is a farce. I learned that the first doctor who determined that my daughter was suddenly ineligible for benefits had been provided a total of five pages of information -- none were medical records! -- with which to evaluate my daughter's condition. This doctor proceeded to determine that she was able to work and support herself, and conceded that while her ongoing treatment was medically necessary, she was ineligible for benefits because she is able to work(!) A second opinion was supposedly written by a qualified doctor, but the medical review business used by the Trust has several levels of service. The level of service contracted by the Health Trust specifically keeps the name of the reviewing doctor confidential. The force-fed message is clear: "Just trust us!"

My daughter has never held a job that could support her financially. I wholeheartedly wish for her success in college so that she may be self-sufficient. During the process that led to the termination of my daughter's benefits, the Trust sent me a letter informing me that my daughter was no longer financially dependent on me. This was certainly news to me and is typical of "facts" the Trust pulls out of thin air which are never acknowledged to be in error and baseless. In my extensive communications with the Trust, I came to the realization that the Trust fabricates facts to support its decisions. Unfortunately and some day, tragically, it is completely free to do so. The Trust is the proverbial "big fish in a small pond" -- it is unregulated and there is absolutely no accountability.

Please feel free to forward this email to others, but I would greatly appreciate it if you do not forward my name, or provide this email to the ASEA Health Benefits Trust. I am available at the email address from which this was sent to provide details and documentation if necessary. My telephone number at work is 269-4902 and at home is 345-5904.

My daughter is not the first victim of the "Trust," nor will she be the last. How it managed to devolve into the autocratic, secretive, inbred, self-serving institution it is today is beyond me. I just know that it cries out for change - for the doors and windows to be thrown open, permitting sunshine in to expose and cleanse the dark corners. Only then will the "Trust" live up to its name and the purpose for which it was created - to deal with its members in a fair, honest and open manner and to render timely equitable decisions which can be documented and discussed, and therefore respected.

Should any one of you care to contact me, please do so. I am more than happy to speak with you at any time.

Sincerely,

Charlotte Hughes
Wage & Hour Investigator
Wage & Hour Administration
Alaska Dept. of Labor and Workforce Development

SB 108

	TRUST	MEWA	INSURER
Certificate of Authority		X	X
Deposit		200,000	300,000
Capital & Surplus		30% Claim Liability	Up to 5.2 Million
Risk Based Capital Analysis			X
Reserves	Statute 21.18	Statute 21.18	Statute 21.18
Audited Annual Statement	Traditional	Yes - 21 pages	Yes - 120 pages
Non-Audited Quarterly	X	X	X
Biographical Affidavits		X	X
Premium Tax		X	X
Fees		\$2,000	\$2,250
Fidelity Bond	10% of Claim Liability	ERISA \$500,000 Max	X Domestic Only

SENATE BILL 108

A. FILING REQUIREMENTS

1. Contribution Rates : Adequate to pay claims
2. Plan Description : To participants so know what is covered
3. Administrative Services : Qualified handling of claims
4. Financial Audit : Solvency Analysis
5. Actuarial Opinion : Reserves for claims, Stop Loss Coverage for plan protection, recommendations for financial condition
6. Number of employees & dependents covered

B. ADDITIONAL REQUIREMENTS

1. Scope of Insurance Code
2. Director Authority for Hearings and Orders
3. Managed Care – Internal and External Review/Judgement such as utilization or pre-authorization
4. Records
5. Reserve requirements
6. Trade Practices
7. Group Life
8. Mandates
9. Group Health – Federal Requirements such as HIPPA
10. Rehabilitation & Liquidation
11. Definitions

Mister Chair, For the record my name is Jeffrey A. Hart. I am a 24 year employee of the State of Alaska, currently with the Department of Transportation. I began paying dues as a member of Public Employees Local 71, 30 years ago. I have been serving as a shop steward for the past 14 years.

I would like to take this opportunity to voice my concerns, and share my views of Senate Bill 108...specifically section 28 & 29. These sections speak of additional oversight of self-funded governmental plans.

When I first heard of SB108 3 days ago, and before even knowing it's specifics, my initial bent was to favor the possibility of some form of regulation over Local 71's self-funded Trust Fund. I have recently been following the discussions relating to the underfunding of the State PERS and TERS systems. I have also listened to debates as to why our nations Social Security System is in disaray. It would seem, additional oversite of our Trust Fund would give comfort to those who don't deal with the fund on a daily basis. However, my initial bent changed quickly. I know that even though the troubled PERS and TERS systems have been managed, and regulated vigerously, their unfunded liability is causing much discomfort.

Additional regulation is not always the cure-all. I have taken a stance of opposition to Section 28 & 29, as they would add extra tasks and costs to our State Government, particularly to some employee who is probably already burdened with a heavy workload. Section 28 & 29 proposes additional administrative tasks to the management of our Trust Fund which will decrease attention given to membership, and increase costs.

My union representatives have furnished me with many reasons why the regulations proposed in section 28 and 29 are unnecessary. They estimate 40 to 50 thousand dollars of additional costs anually. These costs will most likely have to be billed to the membership. I personally budget my income carefully and would not want to incur this unnessarry cost. They have informed me of several regulations, already being adhered to, and designed to keep our Trust healthy and solvent. Local 71 members are informed through mail-outs, and membership meetings, as to the condition of the Trust and it's Health Plan. We believe our Health Plan is adequate and positioned to meet our participants needs. We also believe we have gained the experience to improve it as needed.

I have, and will continue to trust my union leadership to be honest and forth-right with me as they look out for my families best interest. I believe Local 71 has, and will continue to work towards the best for all of its members. I ask that you see Sections 28 & 29 of Senate Bill 108 as unnecessary, and have them removed from this bill.

Thank you for this opportunity to testify.



Methodology



Processing the Data

Dittman Research employees completed coding, editing, data entry and verification, while data processing was completed through the in-house Dittman Research Corporation computer system featuring the Statistical Package for the Social Sciences (SPSS) program. The SPSS program is one of the most sophisticated research-oriented data processing and analytical systems available, and is designed specifically for the processing and analysis of survey research data.

Most of the state departments did not have enough responses to be independently analyzed. In order for the crosstabulations to have statistically valid groupings, state departments were combined as follows:

- **Health and Social Services** **n=140**

- **Transportation and Public Facilities** **n= 64**

- **Misc. Environmental** **n= 84**

- Environmental Conservation (n=21)*
 - Fish and Game (n=35)*
 - Natural Resources (n=28)*

- **Misc. Law** **n= 65**

- Corrections (n=29)*
 - Law (n=15)*
 - Public Safety (n=21)*

- **Misc.** **n=107**

- Administration (n=27)*
 - Commerce, Community & Economic Development (n=11)*
 - Congressional Delegation (n=1)*
 - Education and Early Development (n=13)*
 - Labor and Workforce Development (n=29)*
 - Military and Veterans Affairs (n=5)*
 - Revenue (n=18)*
 - Refused (n=3)*




CORRECTION

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



Central Microfilm Services
Department of Education & Early Development
State of Alaska



Methodology

D

Overview

During the period January 10, 2005 through January 16, 2005, four hundred nine (n=409) members of the Alaska State Employee Association (ASEA) Local 52 Health Benefits Trust were personally contacted via telephone by professional interviewing employees of the Dittman Research Corporation of Alaska. An additional fifty-one (n=51) interviews were conducted among members from the Southeast region of Alaska January 26, 2005 through January 27, 2005. Thus, a total of four hundred sixty (n=460) interviews were completed. The views and opinions of the Trust members were recorded on a strictly confidential basis.

Research Design

A random sample design was featured which provided that all ASEA Local 52 Health Benefits Trust members had essentially an equal chance of being interviewed.

Sample Selection

Individual respondents were randomly selected from a list of current Local 52 Health Benefits Trust members provided by ASEA. The regions were chosen and the final results were weighted to accurately reflect the distribution of Trust members. The number of interviews completed by region, as well as the geographic distribution of the weighted results, are as follows:

	<u>Number of Interviews</u>	<u>Sample Error</u>	<u>Geographic Distribution</u>
Anchorage/Mat-Su Valley	n=205	+/- 7%	48%
Southeast	n=103	+/- 9%	28%
Fairbanks	n=101	+/- 9%	12%
Other Alaska	n= 51	+/- 13%	11%

The sample error for n=460 surveys out of a population of 7480 members is +/- 4%.



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Environmental Conservation (n=21)
Fish and Game (n=35)
Natural Resources (n=28)

- **Misc. Law** **n= 65**

Corrections (n=29)
Law (n=15)
Public Safety (n=21)

- **Misc.** **n=107**

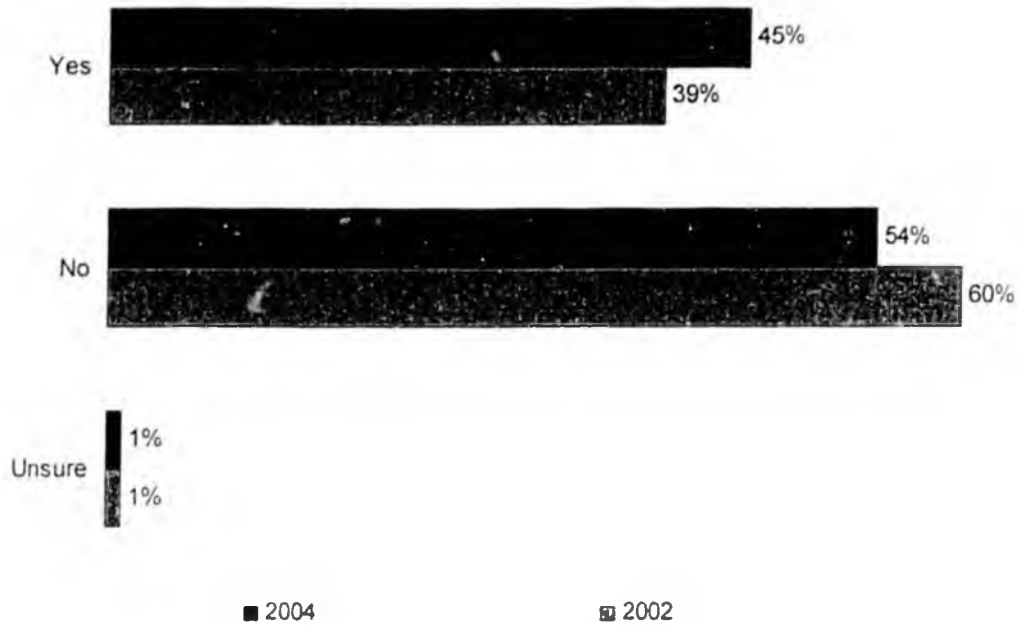
Administration (n=27)
Commerce, Community & Economic Development (n=11)
Congressional Delegation (n=1)
Education and Early Development (n=13)
Labor and Workforce Development (n=29)
Military and Veterans Affairs (n=5)
Revenue (n=18)
Refused (n=3)



II Findings

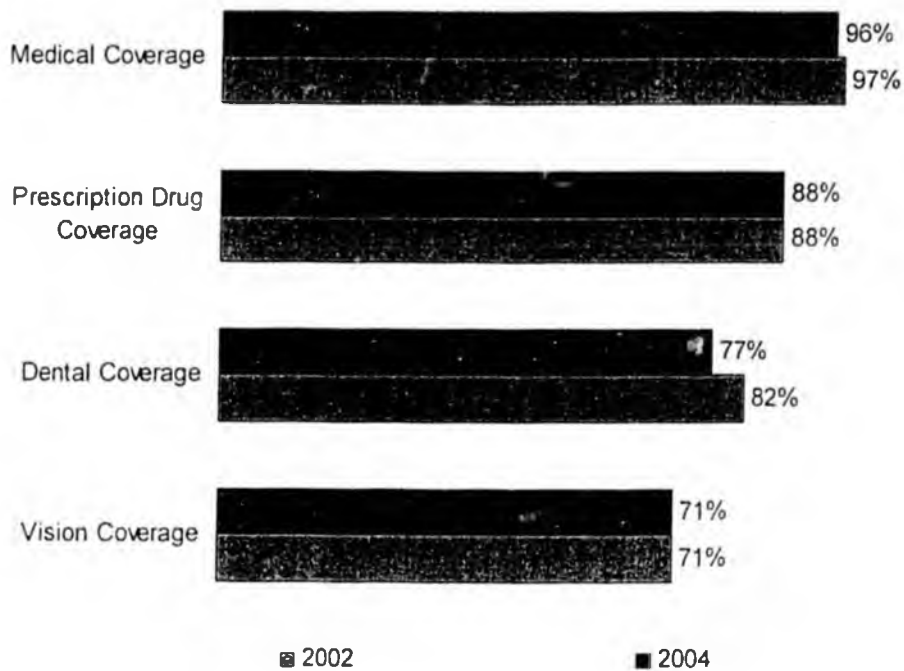
Nearly half (45%) of the ASEA Local 52 Health Benefits Trust members interviewed, or their families, are offered health plans in addition to the ASEA Local 52 health benefits. This has increased from the February 2002 research which indicated 39% were offered other health plans.

Question: Are you or any of your covered family members offered other health plans, in addition to the benefits provided by the Trust plan?



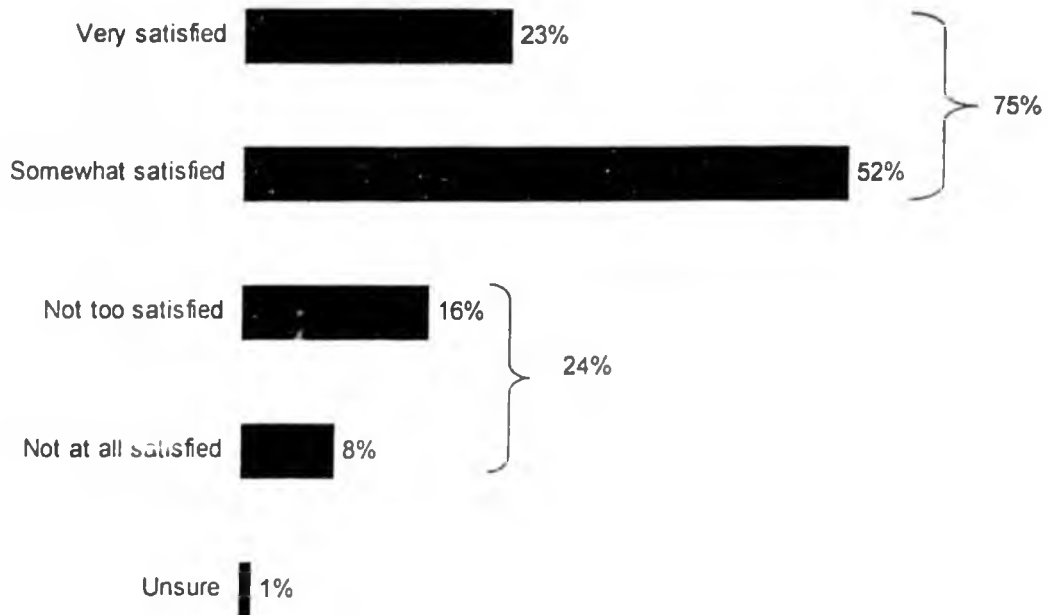
The other health plans nearly always (96%) offer medical coverage, and most (88%) offer prescription drug coverage. The only change from 2002 is that fewer respondents report other plans offering dental coverage (from 82% to 77%).

Question: What other coverages are offered by that other plan?



By far, the largest number of respondents (75%) are satisfied with Health Trust services.

Question: How satisfied are you with the services you have received from the Health Trust?



By a 2:1 ratio, Trust members reported they would prefer maintaining benefits (52%) to maintaining the employee contribution (26%).

Question: Which is more important to you... maintaining current level of benefits or employee contribution amounts?



Note: There may have been some respondent misunderstanding regarding the possible consequences of maintaining benefits. In 2002 a similar question was asked:

"As health care coverage becomes more expensive, which of the following options should the Trust consider using to help manage costs?"

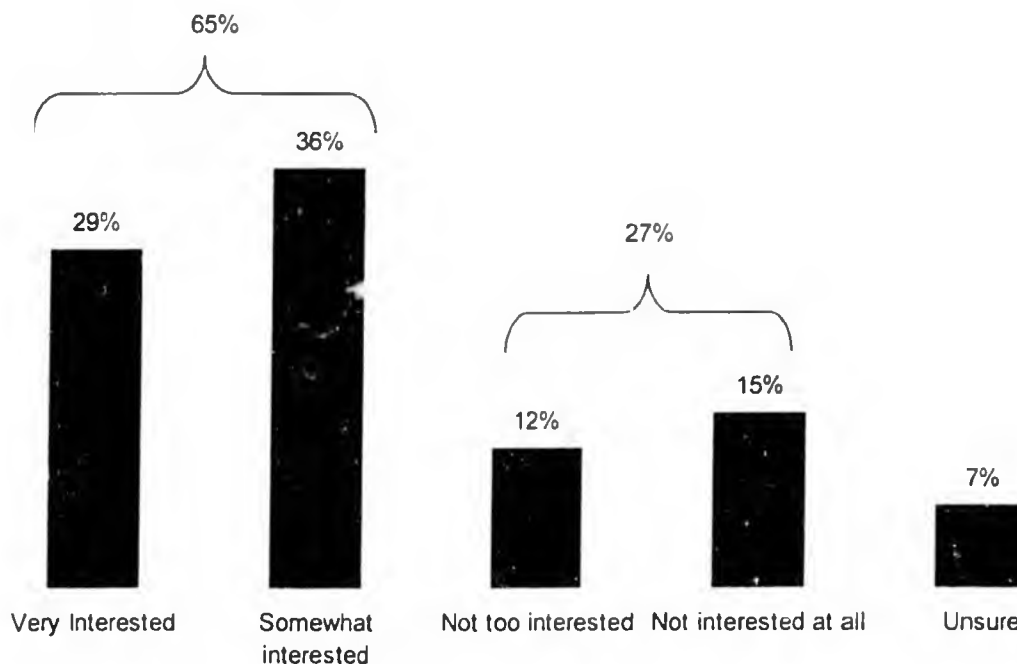
	<u>Yes</u>	<u>No</u>	<u>Unsure</u>
<i>Increase employee contribution to the plan?"</i>	23%	74%	3%

In that case, 74% opposed maintaining more expensive health care benefits by increasing employee contributions to the plan.



Nearly two-thirds (65%) of Local 52 respondents are interested in a voluntary program to help with chronic health problems. This benefit option is most popular among respondents from Fairbanks, and least popular among respondents from Other Alaska.

Question: How interested would you be in a voluntary program that would help with chronic health problems, such as diabetes, asthma, smoking, obesity, or other health conditions?

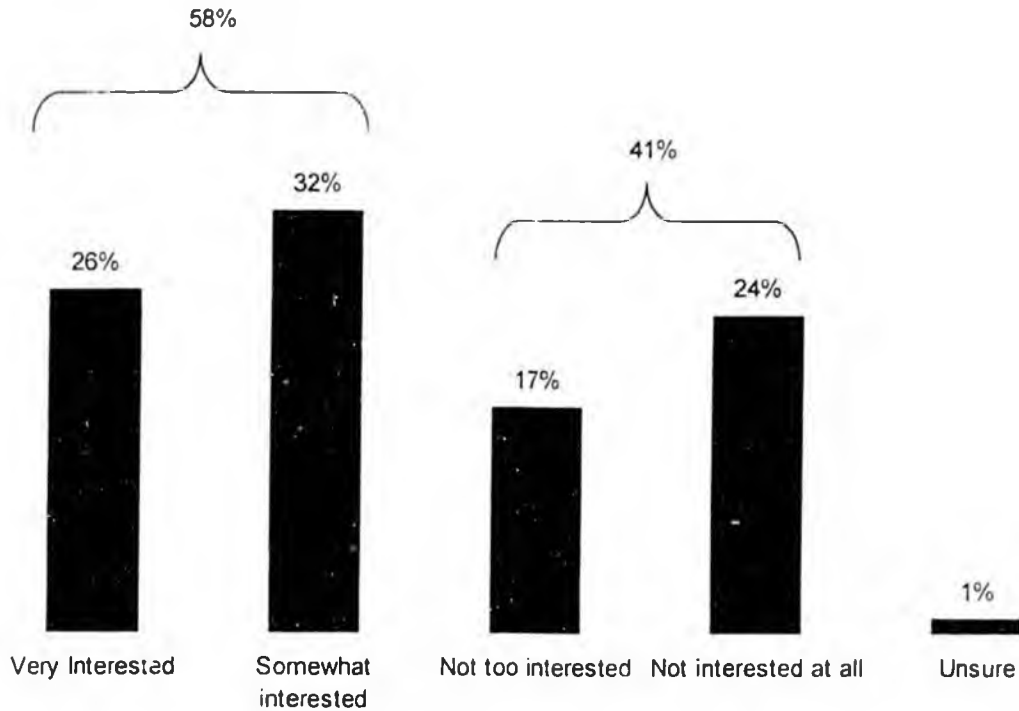


	<u>interested</u>	<u>Not interested</u>
Anchorage/Mat-Su	68%	28%
Fairbanks	73%	25%
Southeast	64%	24%
Other Alaska	54%	38%



Although not quite as popular as the "voluntary program" benefit, more than half (58%) of the respondents indicate they would be interested in adding coverage for travel expenses for diagnostic services. Residents of Anchorage and the Mat-Su Valley are less interested in this benefit than residents of the rest of Alaska.

Question: How interested would you be in seeing the Trust add coverage for travel expenses for diagnostic services, if it meant the plan's cost would increase by \$40 per employee per year?

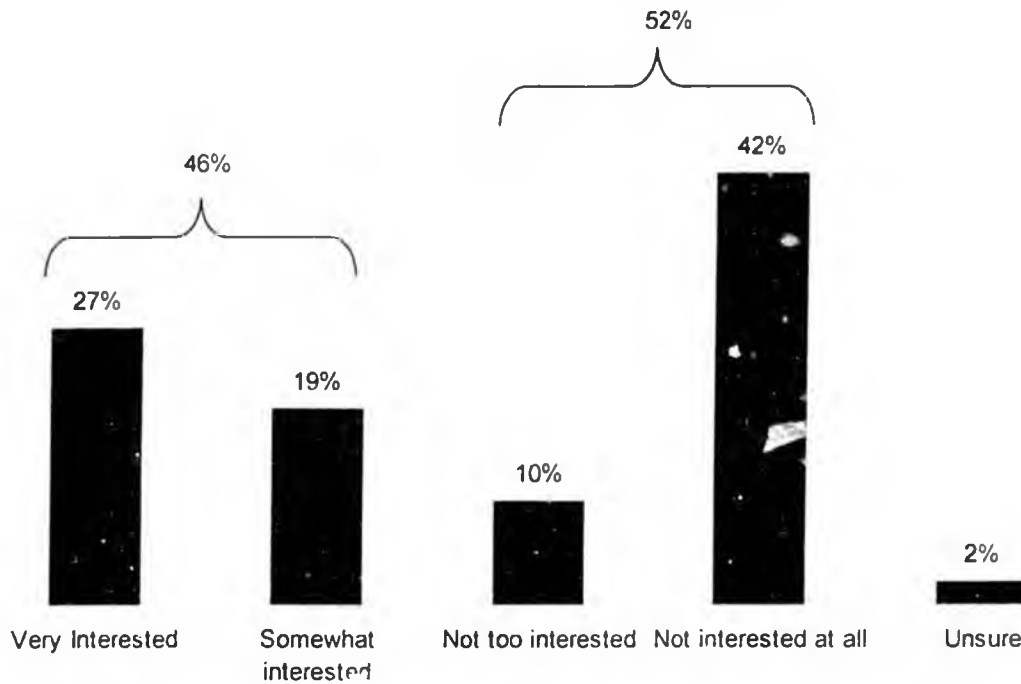


	<u>Interested</u>	<u>Not interested</u>
Anchorage/Mat-Su	48%	51%
Fairbanks	59%	41%
Southeast	69%	30%
Other Alaska	68%	32%



The Trust members are nearly evenly split in their interest regarding coverage for well baby care: 46% interested, 52% not interested. As could be expected, younger respondents are more likely to be interested, and older respondents are less likely to be interested, in well baby care.

Question: How interested would you be in seeing the Trust add coverage for well baby care, if it meant the plan's cost would increase by approximately \$12 per employee per year?

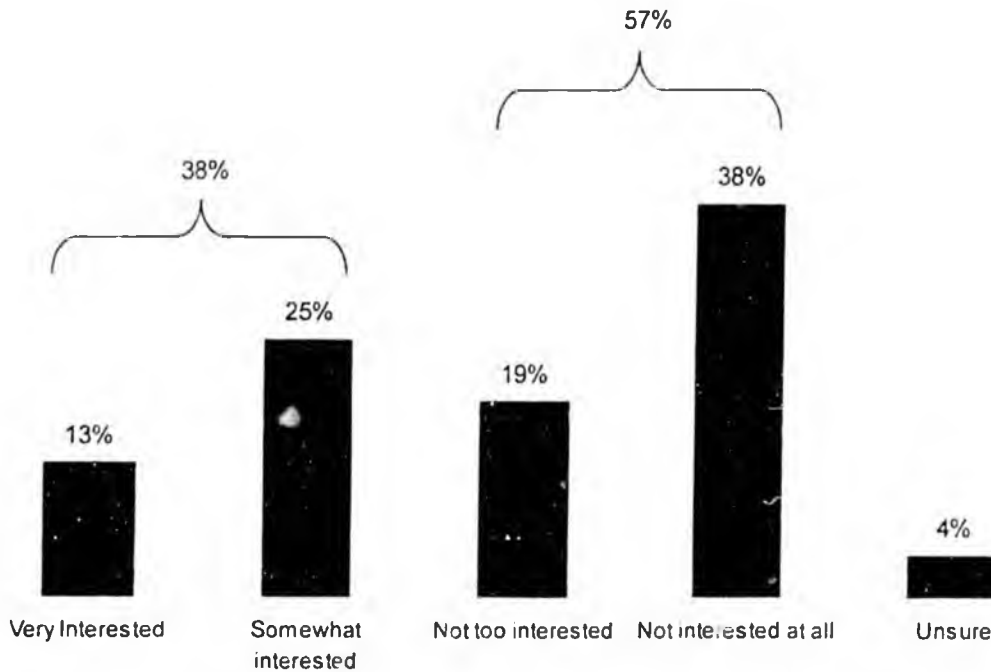


	<u>Interested</u>	<u>Not interested</u>
18-29	74%	22%
30-39	53%	46%
40-49	46%	54%
50-59	38%	60%



Respondents are least interested (38%) in adding coverages for annual preventive exams. Perhaps this can be attributed to "sticker shock" – this was the most expensive stated cost of the four options that were tested, at an estimated increase of \$200-\$240 per year. There were not significant differences based on region, marital status, number of children, income, age, or gender.

Question: How interested would you be in seeing the Trust add coverage for annual preventive exams, if it means the plan's cost would increase by \$200-\$240 per employee per year?



Suzanne Mullen

From: Frank P. schak [f1r2a3n4kp1@alaska.net]
Sent: Thursday, April 07, 2005 7:07 AM
To: Sen. Con Bunde; Sen. Ralph Seekins; Sen. Ben Stevens; Sen. Johnny Ellis; Sen. Bettye Davis
Subject: Testimony in Opposition to Sections 28 and 29 of SB 108

Attached is my testimony against Sections 28 and 29 of SB 108.

"An Act relating to the regulation of insurance, insurance licensing, surplus lines, insurer deposits, motor vehicle service contracts, guaranteed automobile protection products, health discount plans, third-party administrators, self-funded multiple employer welfare arrangements, and self-funded governmental plans; and providing for an effective date."

I encourage passage of SB 108 except for Sections 28 and 29.

Thank You for the opportunity to testify.

Testimony of Frank Puschak
Anchorage, AK

Members of the Committee,

I speak in opposition to Sections 28 and 29 of SB 108. I am a trustee of one of the affected health trusts, but speak to you today in my personal capacity.

Some claim the regulation is needed in order to ensure accountability and minimum standards. Our health trust is a legal entity and accountable to the Superior Court of Alaska. Moreover, it is accountable to the federal government to comply with a number of health care acts that include (but not limited to):

- Consolidated Omnibus Budget Reconciliation Act (**COBRA**)
- Uniformed Services Employment and Reemployment Rights Act (**USERRA**)
- Women's Health and Cancer Rights Act of 1998 (**WHCRA**)
- Health Insurance Portability and Accountability Act (**HIPAA**)
- Mental Health Parity Act of 1996 (**MHPA**)
- Consolidated Omnibus Budget Reconciliation Act (**COBRA**)
- Family and Medical Leave Act (**FMLA**)
- Public Health Service Act (**PHSA**)

The trustees are elected directly by the membership. There have been 138,084 medical/dental/vision claims submitted fiscal year-to-date. Of that number, there have been 47 claims appeals as of March 31, 2005. The appeal process is first to the Third Party Administrator, then the Board of Trustees, and then arbitration, which is binding. If that were not enough, there one more appeal to Superior Court.

Our trust has more accountability than the state's Select Benefit Plan wherein the Commissioner of Administration is the final decision on all appeals. A recent poll by our health trust done by Dittman Research (available on our website at www.aseahealth.org) showed that 75% of members were either Very Satisfied or Somewhat Satisfied with our plan.

With respect to minimum standards, our health trust must comply with the fiduciary standards of common law and the Superior Court. Under the terms of the trust agreement, which are enforceable by the Superior Court, the trustees are required to discharge their duties and administer the trust fund assets solely in the interest of the participating employees and their beneficiaries and for the exclusive purpose of providing benefits to participating employees and their beneficiaries, and defraying reasonable expenses of benefit plan administration.

Testimony of Frank Puschak
Anchorage, AK

In carrying out their duties, the trustees are required to act with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

Under common law the required level of skill is not that of the prudent man on the street, but that of a prudent fiduciary - which is a higher level of skill. This level of skill is enforceable under the Superior Court.

I am not aware of the fiduciary standards followed by the State of Alaska Select Benefits Plan and was unable to find any such subject on their web site. I would add that while it seems that the state is also exempt from this bill, the wording is vague. Reading and following the definitions cited in the statute seemed to me that the state as well as city and county governments would come under these sections.

I am enclosing a copy of a comparison of our health plan (an 80% coverage plan) with the state's Select Benefits 80% plan. You will see that our benefits are slightly better and cost less. This is directly attributable to the ability of the trust to operate independently.

Our health trust was formed because the state wanted to be rid of the effort and expense. Under Article 19.03 of our contract ASEA relieves the State of Alaska of any and all obligation under AS 39.30.090 to provide an insurance plan for eligible bargaining unit members and dependents. This bill would add to the state's work and incur additional expense as illustrated by the fiscal note.

Sections 28 and 29 are unnecessary and impose significant extra cost to hire outside consultants to comply with reporting requirements, and examinations done by the division of insurance. The trust has already retained qualified consultants and advisors to assist in operating the health plan. An independent CPA firm audits the financial records as well, and the annual report is available free to all members. Sections 28 and 29 are an unnecessary regulatory burden.

There's the saying, "If it ain't broke, don't fix it." However, I do agree with the corollary that "If it ain't broke, it can be improved" and that's what we deserve the opportunity to do.

ASEA/AFSCME Local 52 Health Benefits Trust
 Comparison to State of Alaska Select Benefits Plan
 2004-2005

	Trust Plan		State Select Benefits Plan
	Plan A or B		Standard Plan
Medical			
Deductible			
Individual	\$250		\$250
Family	\$500		\$500
Reimbursement Percentage	80%		80%
Annual Out-of-Pocket Maximum per Person (does not include deductible)	\$1,000		\$1,000
PPO Provision with Non-PPO penalties?	Yes, for hospital and PT services in Anchorage		Yes, for hospital services in Anchorage
Prescription Drug			
Retail			
Copay - 30 day supply	20%, max \$50		20%, min \$8, max \$50
Copay - 31-90 day supply	20%, max \$50		20%, min \$16, max \$100
Mail Order Copay	20%, max \$50		\$20 brand, \$8 generic
Annual Maximum Copay	\$500 per Person		\$1,000 Individual \$2,000 Family
Dental			
Deductible	\$25 per Person \$75 per Family (waived for Preventive)		\$25 (waived for Preventive)
Reimbursement Percentage			
Preventive	100%		100%
Restorative	85%		85%
Prosthetic	50%		50%
Annual Maximum Benefit	\$1,500		\$1,500
Vision			
Reimbursement Percentage	90%		90%
Exam Benefit	1 per year		1 per year
Maximum Frame Reimbursement	\$90; 1 every 2 years		\$90; 1 every 2 years
Maximum Contact Lens Benefit	\$170		\$170
Lens Benefit	1 pair per year		1 pair per year
Annual Maximum Benefit	\$350		\$350
	<u>Family</u>	<u>Employee Only</u>	
Total Monthly Plan Cost	\$923	\$861	\$945
Monthly Employer Contribution*	\$763	\$763	\$742
Monthly Employee Contribution	\$160	\$98	\$203

*Trust Contribution is based on the negotiated rates, once contributions are funded;
 State Contribution is based on the rate for most participants

Alaska Public Employees Association/AFT (AFL-CIO)

State Headquarters/Juneau Field Office

211 Fourth Street, Suite 306, Juneau, Alaska 99801

Phone: (907) 586-2334 / (800) 478-9991 (Within Alaska) / Fax: 463-4980 / Acct Fax: 586-5980

Website: www.apea-aft.org

APEA/AFT



March 30, 2005

The Honorable Con Bunde,
Alaska State Senator and
Chair, Senate Labor & Commerce Committee
State Capitol Room 506
Juneau, AK 99801

RE: Opposition to SB 108 - Insurance

Dear Senator Bunde:

APEA/AFT wishes to express strong concerns about several sections of SB 108, which is currently before your committee.

The legislation impacts just a small number of our members but is both significant and negative in its impact. We represent approximately 300 school district employees in the Juneau School District, who work in maintenance, nursing, para-educators, and administrative clerks. Like many Alaskans, they have seen their health benefits costs increase to prohibitive levels.

The Juneau Education Support Staff (JESS) worked long hours with the school administration to reduce and control the staggering costs of the employees' health insurance program. Between 2002 and 2004, our Blue Cross health insurance premiums increased \$268.00 per employee per month, from \$500 to \$768. Last spring, we signed a contract to form our own health insurance trust. We have worked during the past year to finally establish that trust, and succeeded in reducing the monthly contribution rate to \$685 per employee, more than \$75.00 below the existing plan cost, and saving substantial amounts of money to both the employees and the school district.

Unfortunately, provisions within SB 108 will pertain to our new trust and will result in the imposition of large fees and unanticipated costs to the trust. The new fees and costs do not improve or enhance our health insurance plans. Our members have taken the initiative to help bring their medical insurance costs down, thus helping both the state and the school districts, but if SB 108 passes as currently written, our members will be punished for their efforts and successful reduction of health insurance costs. We ask that you exempt our small group from excessive, costly and unnecessary requirement.

Thank you for giving us this opportunity to bring the issue to your attention. Please feel free to contact me should you need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read 'Pete Ford', written over the word 'Sincerely'.

Pete Ford
Southeast Regional Manager

cc: Members of the Senate Labor and Commerce Committee

Anchorage Field Office

3310 Arctic Blvd., Suite 200, Anchorage, Alaska 99503

Phone: (907) 274-1688 / (800) 478-9992 (Within AK) / Fax: 277-4588

Fairbanks Field Office

825 College Road, Fairbanks, Alaska 99701

Phone: (907) 456-5412 / (800) 478-9993 (Within AK) / Fax: 456-7478

Frank H. Murkowski, Governor

Alaska Department of Community and Economic Development

Division of Insurance

550 W. 7th Avenue, Suite 1580, Anchorage, AK 99501-3567

Telephone: (907) 269-7900 • Fax: (907) 269-7910 • Text Telephone: (800) 485-5437

Email: insurance@dced.state.ak.us • Website: www.dced.state.ak.us/insurance/

March 19, 2004

RECEIVED
MAR 29 2004

Labor Trades & Crafts - LL
Local 71 Trust Fund
Trust Administrator - Sandie Hayes
2510 Arctic Blvd.
Anchorage, AK 99503

Public Employees Local 71
Trust Fund

Re: Compliance with the Insurance Code

Dear Ms. Hayes,

On July 1, 2002, new provisions in the insurance code (AS 21) became effective that directly affects the health benefits trust of Local 71 Trust Fund.

Under AS 21.03.021(b), "a person that provides coverage for the cost of medical care in this state is subject to this title unless the person shows that, while providing coverage for medical care, the person is subject to the jurisdiction of another agency of this state or of the federal government by providing the director with the appropriate certificate, license, or other document issued by the other governmental agency that permits or qualifies the person to provide coverage for medical care."

If a person is unable to show that the person is subject to the jurisdiction of another governmental agency, then the person is subject to all appropriate provisions of AS 21. AS 21.03.021(c). The person also must submit to an examination by the director for the division of insurance to determine the organization and solvency of the person and to determine whether the person complies with AS 21. And, the person must advise every purchaser, prospective purchaser, or covered person that the person's coverage may not be regulated under Alaska insurance law and may not be covered by the Alaska Life and Health Insurance Guaranty Association under AS 21.79. AS 21.03.021(d).

The division understands that Local 71's union health trust is a governmental health plan and as such it is not subject to ERISA. As a non-ERISA plan, the trust would not be subject to regulation by the federal Department of Labor or other federal agency. The division also is not aware of any other state agency that regulates the plan. Accordingly, the trust cannot make the necessary showing that, while providing coverage for medical care, it is subject to jurisdiction of the federal government or another state agency. As a result, the trust is subject to all applicable provisions of AS 21.

"Promoting a healthy economy and strong communities"

RECEIVED
MAR 22 2004

Public Employees Local 71
Trust Fund

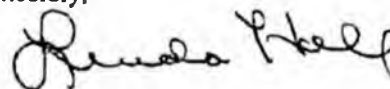
Page -2-
March 19, 2004
Compliance with the Insurance Code

The director also has authority to conduct an examination of the trust to determine its organization and solvency and to determine its compliance with the code. With this letter, the division gives you notice of the director's intent to initiate such an examination. An examination call letter will be forwarded under separate cover. Further, the director has authority under AS 21.06.080(c) to conduct an investigation to determine if the trust or persona acting on behalf of the trust have violated the insurance code, which may be conducted in conjunction with or separately of examination.

I also ask that you provide me with confirmation that the trust has made the required disclosures in AS 21.03.021(d). Failure to make such disclosures is a violation of the insurance code and subject to civil penalties, in addition to other violations that may be revealed in the examination. Please provide me confirmation of disclosures within 14 days of the date of this letter.

If you have any questions or comments, please let me know.

Sincerely,



Linda S. Hall
Director



DON VALESKO
Business Manager/
Secretary-Treasurer

JIM ASHTON
Assistant Business Manager

HEADQUARTERS
2510 Arctic Blvd.
Anchorage, Alaska 99503
FAX (907) 279-7171
(907) 276-7211

2122 Airport Way
Fairbanks, Alaska 99701
FAX (907) 456-1771
(907) 452-5024

710 West 9th Street
Juneau, Alaska 99801
FAX (907) 586-5757
(907) 586-6993

April 12, 2004

Ms. Linda S. Hall, Director
Alaska Dept. of Community and Economic Development
Division of Insurance
550 West 7th Avenue, Suite 1560
Anchorage, AK 99501-3587

Re: AS 21.03.021 Examination

Dear Ms. Hall:

I am Chairman of the Board of Trustees for the Public Employees Local 71 Trust Fund (Trust). The Trust Administrator forwarded your letter to her of March 19, 2004, to me for response.

The Letter of Agreement (LOA) executed in 1994 between the State of Alaska and Public Employees Local 71 was a result of bargaining between the State and Local 71. During bargaining, the substance and structure of the Trust was reviewed and approved by the State. The 1994 LOA (and the subsequent 1998 LOA) authorized the Plans offered through the Trust, provided such Plans would comply with all applicable law. It is the Trust's position that, as a self-insured entity, it is not subject to the disclosure and reporting provisions of AS Title 21 that regulate policies and contracts of insurance issued within the State of Alaska. Moreover, the Trust was authorized and created by the State and the Union



Ms. Linda S. Hall, Director
Dept. of Community and Economic Development
April 12, 2004
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through collective bargaining, and the State in effect licensed the Trust through execution of the LOA, creating the Trust.

It is the Trust's intent to assist in your investigation of the Trust to determine its organization and solvency. Therefore, I offer you this response and relevant attached documents to aid you in your independent review of the Trust's status.

The Trust offers a self-insured flexible health benefit plan that complies with IRC Section 125 (cafeteria plan rules) and allows eligible members of Local 71 to elect coverage from four coverage choices, depending upon their family status and other health coverage. The flexible benefit plan complies with the mandates of AS 39.30.090 (coverage for spouse and dependents). The Trust also offers a self-insured health care spending account plan to reimburse participant out-of-pocket health expenses on a pre-tax basis, consistent with IRC Section 105(h). The Trust does not provide, purchase, or contract for policies or contracts of insurance, with the exception of stop-loss coverage. The Trust and Plans are authorized by the Public Health Service Act (PHSA) 42 USC 300gg, and they comply with the amendments to the PHSA relating to COBRA, HIPAA, WHCRA, USERRA, and FMLA, and are subject to civil penalties for violations of the mandates of these acts. The Department of Health and Human Services, the Office of Civil Rights, and IRS are charged with enforcement of the provisions of the PHSA and the various other federal acts and Internal Revenue Code requirements.

The Trust has been determined to be a tax-exempt, voluntary employee benefit association by the IRS. It has been determined to be exempt from ERISA pursuant to Department of Labor (DOL) Opinion Letter 2000-01A, under ERISA Section 3(32). While the Trust is exempt from Title I of ERISA, the Trust is operated in compliance with all fiduciary standards codified in ERISA and provides participants access to all plan documentation and financial records required by the DOL Regulations. The Trust also provides participants with a three-tier appeal procedure in the event of a challenge of a denied benefit claim. The Trust is covered by a fidelity bond and the Trustees are covered by fiduciary liability insurance. The Board of Trustees is charged with the duty of Plan Administrator and acts as the Plans' fiduciary. The Trust uses an in-house professional administrator and trained staff, contracts with a professional third-party claims administrator (Welfare & Pension Administration Services, Inc.), a prescription drug benefit manager (AdvancePCS), a pre-certification and case management organization (Qualis), a trust attorney (Law Offices of Mary L. Stoll), and a benefit plan consultant (Marsh USA).

Ms. Linda S. Hall, Director
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At the time that AS 21.03.021 was amended, the Trust's advisors reviewed the application of the new provisions in subsections (b), (c) and (d) to the Trust. Given the facts that the Trust is regulated by numerous federal acts and agencies, and that, through the LOAs executed in 1994 and 1998, the Trust was authorized and created by the State through bargaining to provide self-insured benefit plans, and complies with AS 30.30.090, the Trust determined that it was in compliance with subsection (b). Considerable attention was given at that time to the relevant House Labor & Commerce Minutes relating to HB 246, which focused exclusively on confidentiality of insurance records provided to the Division of Insurance during an examination, and to the regulation of Multiple Employee Welfare Arrangements (MEWAs) and health maintenance associations (HMOs). The Plans offered through the Trust were collectively bargained into existence with the State; the participating Local 71 members are employees of the State, a State municipality, borough, or State school district; and, the Trust is substantially funded by contributions from the State. As such, the Trust and Plans do not fall under the definition of MEWA or HMO. In addition, in evaluating the other provisions of AS 21, they deal with the provision of health care insurance, policies and contracts of insurance, and health care insurance plans. The Trust does not contract for policies of health insurance, nor does the Trust issue contracts or policies of insurance. It would be impractical if not impossible for the Trust to comply with the requirements of the insurance code for insurance companies or insured plans.

The group health Plans offered through the collectively bargained Trust bear the risk for the cost of the benefits provided from the contributions made by the State employers, employee contributions, and from Trust reserves. There is no risk shifting in exchange for payment of a premium for a policy of insurance in this self-insured arrangement. The Trust maintains a fully funded IBNR reserve in addition to significant general reserves to cushion the Trust in the event of negative claims experience. The financial status of the Trust is represented in the Trust's most recent Annual Audit Report prepared by an independent certified public accounting firm nationally recognized for its expertise in employee benefit plan accounting and reporting.

In order to assist you with your review of the Trust's solvency and organization I have attached the following Trust documents for your review:

- Trust Agreement and Amendments;

Ms. Linda S. Hall, Director
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- Plan Documents for the Benefits Plus Plan and Health Care Spending Account Plan;
- Current Plan Booklet;
- Most recent Open Enrollment Package; and
- Letters of Agreement with the State of Alaska executed in 1994 and 1998.

The Trust is not willing to release the Annual Audit report and IRS Form 990 or provide this information for your review at the Administrative Office while the Union and State are in the process of bargaining over the collective bargaining agreement. However, the Trust will provide you, upon request, a statement from the auditing firm which performed the audit, as an independent expert, that the Trust is solvent and the reserves are reasonable in consideration of the total annual benefit paid by the Plans offered through the Trust.

I believe that once you have reviewed these documents, you will be satisfied that the Trust is properly organized and funded, and is exempt from AS 21.

Sincerely,



Don Valesko, Chairman
Public Employees Local 71 Trust Fund

Enclosures

cc: Board of Trustees
Colleen Savoie, Trust Consultant
Mary Stoll, Trust Attorney
Sandie Hayes, Trust Administrator



SB 108

Additional Talking Points – Public Employees Local 71

JIM ASHTON
Business Manager/
Secretary-Treasurer

ROBERT JOHNSON
President

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(907) 586-6993

History

- Trust has been providing benefits since 1994, and has been self-funded since 2000.
- Trustees have worked hard to create a plan that benefits members. Worked to keep employee contributions and out-of-pocket expenses as low as possible. Benefit payments make up 92% of total self-funded Trust expenditures. Only 8% are administrative costs. **This bill would increase administrative costs – which leaves less \$ to provide benefits for our participants.**

Trust Structure

- The Board of Trustees is made up of working people. All of the Trustees are covered by the plan. The PE71 Board includes union representatives who work with members on a day to day basis. **The Board also includes members themselves. Who knows the needs of the PE71 participants better than PE71 members?**
- The Trust hires plan professionals to run the Plan. This includes administrators to pay the claims, medical review firms to consult on medical issues, investment managers to manage plan assets, attorneys for legal issues, health care consultants to help the plan run smoothly, etc.
- The Trustees are fiduciaries – they must act in the best interests of plan participants. They receive training on fiduciary issues as well as topics of concern to health plans.
- Participants can provide feedback to the Trustees and plan administrators. The Trustees take this feedback seriously, and after due consideration, may act if it is in the best interests of the membership. A good example is that the Trust switched from a single plan of benefits to a flexible plan design with participant choice, based in part on participant feedback.
- Participants have the right to appeal denied benefit claims. The appeal is heard by the Board of Trustees – a Board which includes their peers – and if dissatisfied with the decision of the Board, the participant may appeal to a neutral arbitrator.

Why Oppose this Bill?

- Increased administrative costs - the actuarial filings alone create a significant administrative burden
- Impossible administrative burden – it is unlikely an actuary will be willing to “ensure” plan solvency. The fidelity bond requirements could also create difficulties.

actuary who "ensures" the plan solvency or by the Director who could dictate the terms of the Plan. Trustees could no longer respond to participant needs or design the plan with participants in mind.

- **No health plan is perfect, and not all participants like their health plan all of the time, but the PE71 plan is operated for the sole and exclusive benefit of its participants. Prior to 1994, participants received benefits as part of the State plan. The Trust was formed in 1994 in order to give participants a voice, and focus on the needs of the plan participants. Prior to July 2000, the Trust was insured, but became self-funded so that plan decisions can be made by the Trustees – not by an insurance company. HB 147 would make it difficult, if not impossible, for the Trust to continue operating efficiently and effectively, as a self-funded governmental plan, focused on its participants.**

GAP

- 1) The bill states that GAP is "insurance". This automatically subjects auto dealers to regulation by the State regardless of what regs are issued. For what it's worth, the definition of "guaranteed automobile protection product" in Sec. 33 of the proposed statute does not work in any event. The definition uses the word "insurance" to describe the product, which is a conclusion, rather than a definition. From a legal perspective, the proposed definition does not resolve the question of whether debt cancellation contracts are insurance, it just raises new ambiguities.
- 2) "GAP Waivers" or similar types of "debt cancellation agreements" are not an insurance product, and should not be regulated as such. Treating GAP Waivers as "insurance" demonstrates a misunderstanding of the nature of the relationship between the dealer and its customer. Debt cancellation programs are structured very differently from other types of credit insurance programs. With GAP Waivers, the dealer, which is the originating lender, enters into a contract with its customer regarding how the debt may be cancelled, suspended, or otherwise modified under limited circumstances. It is nothing more than a contract between the dealer and its customer. The dealer, in turn, may then choose to purchase an insurance policy to cover this potential liability. The insurance contract, which is between the dealer and the insurance company, is already subject to regulation by the Division of Insurance.
- 3) Thirty nine other States have ruled that GAP is not insurance but is actually debt cancellation, not subject to regulation by the insurance division.
- 4) The vast majority of GAP contracts are issued by banks and credit unions. However, due to their federal charter, they are exempt from State regulation. The contracts are typically sold by highly trained and compensated finance and insurance managers in auto dealerships versus part time, low paid tellers in the banks and credit unions. I am certain that my employees are more qualified than a part time bank teller yet we would be subject to regulation and the banks would not. This is not a level playing field.
- 5) GAP contracts are a minimal cost to the customer and profit to the dealer but provide enormous benefits to both parties in the event the customer's vehicle is totaled. The typical contract sells for \$300 with a profit to the dealer of \$150 at the time of sale. However, let's assume that customer totals their vehicle a year after purchase. For discussions sake, we'll assume that the loan balance is \$7,000 higher than the fair market value of the vehicle as determined by their insurance company (\$6,000 to \$7,000 negative equity on vehicles is very common on financed vehicles). GAP will pay the deficiency, period. If the customer does not have GAP coverage, they will be liable for the \$7,000 deficiency and will have to pay off the loan balance. Most customers do not have this much cash on hand and, in such cases, the loan would go into default. The result of such a default would mean ruin of the customer's credit rating and would likely leave them without reliable transportation as banks will not finance someone who has defaulted on a loan. In this scenario, which occurs quite often, the customer loses, the dealership loses and the economy of the State loses.
- 6) The Director of Insurance currently requires dealer personnel who sell GAP contracts to have a limited lines insurance license. First, this license provides no benefits to dealership personnel or the customer as it is irrelevant to the product sold. Secondly, there is no clear cut guidance from the Director's office regarding testing, study materials or acceptable continuing education requirements. I am a CPA and my testing and acceptable continuing education credits are very clear cut. Furthermore, the benefits of licensing and continuing education to myself and my clients were very clear when I practiced as a CPA.
- 7) Since the debt cancellation agreement between the customer and the dealer is straightforward and uncomplicated, there is no good policy reason for requiring that dealers be licensed to offer GAP waivers, nor is there any pressing need to regulate the terms of the debt

ALASKA AUTO DEALERS ASSN.
FROM JON COOK

cancellation contract itself. The cost of the GAP waiver is already adequately addressed as part of the truth in lending disclosures.

8) Since GAP Waivers are not insurance, grouping them with other insurance products is like trying to put a square peg in a round hole. This becomes self evident when you look at other title 21 provisions governing insurance.

Since the dealer is not an insurance company (there should be no real dispute over this), and since the product being sold is not a policy of insurance, much of the existing legislation simply makes no sense when applied to GAP Waivers. The courts will be kept very busy sorting out the mess that will be created if the Division is successful in applying all of Title 21 to GAP Waivers.

9) Proposed Sec. 30 allows the division to regulate those who "administer" GAP Waivers. This could include anyone at the dealership who is involved, even tangentially, with GAP. For example, it could include administrative staff who assist a customer with making a GAP claim years after the sale. The statute should track the licensing statutes, which address those who "negotiate," "sell" or "solicit" insurance products.

10) For most common types of insurance, Alaska law specifies what may or may not be included in the insurance contract. There is no corresponding law regarding GAP Waivers, yet the proposed legislation would allow the Division the authority to regulate the contents of GAP waiver agreements.

11) The proposed legislation specifically and only targets the automobile industry. GAP contracts can also be sold on recreational vehicles, heavy and medium duty trucks, snowmachines, personal watercraft and motorcycles to name a few. However, the legislation as proposed does not apply to GAP contracts sold on any of these products. Why is only one industry being targeted as the contract provides the same coverage for all of the products listed? This paradox again details the lack of a level playing field in the treatment of automobile dealers.

Service Contracts

1) It is my understanding that the Division of Insurance once had oversight of service contracts but that this oversight authority was taken away as they can not require dealership personnel to obtain a license to sell service contracts. Why does the Division want or need this oversight authority back?

2) The proposed legislation (Section 30 (c)) states that "this section does not apply to a motor vehicle service contract issued by the manufacturer of the motor vehicle covered by the service contract." I'm assuming that the reason this provision was inserted is that the Division felt that they did not need to police the Manufacturers which would in turn benefit new car dealers. Unfortunately, the wording above is seriously flawed and had several unintended consequences. Technically, the manufacturers do not issue service contracts directly, they do so through a subsidiary. I'm sure an attorney would have no problem making this distinction were any litigation to result. Secondly, the language does not exempt GM service contracts sold on non GM vehicles, Ford service contracts sold on non Ford vehicles, etc. Every new car dealer in the State sells their manufacturer service contracts on used vehicles for which they do are not the franchise which means that this exemption would not apply. If the intent of this wording was to exempt manufacturer service contracts entirely, the mission has failed.

3) While the Divisions proposed language attempts to exempt the manufacturers, it does not exempt the many other reputable companies who sell service contracts in Alaska. If the Division does not feel the need to regulate GM, Ford, etc, why would they need to regulate companies such as GE, EZ Care, which is owned by Ford, Universal, etc? These companies are utilized by

Used Car Dealers in the State of Alaska who will bear the unfair brunt of this proposed legislation, if passed.

4) I am guessing that the consumer protection motivation behind this legislation largely relates to the national failure of Smart Choice, of which a minimal number were sold in the state of Alaska in terms of the overall numbers of service contracts sold per annum. As far as I am aware, Smart Choice is the only service contract company failure in the State of Alaska in the last ten years. Next, Smart Choice's national failure was largely due to fraud and Alaska already has statutes on the books to deal with fraud. It is not at all clear that the ability to regulate the sale of ESC's by dealers would prevent another fiasco like occurred with Smart Choice. The problem with Smart Choice originated because the provider was a risk retention group, not backed by sufficient insurance or re-insurance. Under federal law, states have very limited authority to regulate risk retention groups. Nevertheless, regulating dealers will not solve future problems with contracts offered by RRG's. Also, federal law already allows states to require notice to consumers that the product is not being offered by an insurance company. The fact that states have limited power to regulate RRG's should not be used as an excuse to shift responsibility and/or liability to dealers.

5) As I noted in item (11) above, these provisions only apply to and target automobile dealers. Why are these other entities and industries exempted and automobile dealers targeted?

6) The amounts charged by the providers for service contracts in general, and those sold by the manufacturers specifically, do not come close to covering the claims they pay out on the contracts. For example, GMPP send monthly reports to our dealership telling us how much money they lose selling service contracts in Alaska as the claims far outstrip the amount charged for the service contract. Currently, the majority of service contracts do not have an Alaska surcharge, despite the higher loss rate. Service contracts losses in Alaska are essentially subsidized by areas that experience lower loss rates. A similar subsidy on destination charges, which are equal across the United States, exists to the benefit of all Alaskans. Overly burdensome regulation or taxation may cause the manufacturers to impose a surcharge on Alaska service contracts, to the detriment of all.

7) See my previous comment regarding the language of GAP Waivers. The statute would also give the Division the authority to regulate the contents of extended service contracts.

8) Under existing law, a person need not be licensed to sell extended service contracts. Yet the statute would give the Division the authority to adopt regulations for "licensing or registration of persons not exempt from licensing under AS 21.27." Since everyone is exempt from licensing with respect to ESC's, I'm not sure what the statute is intended to accomplish. This language should be clarified, to make it clear that no one involved with the sale or administration of ESC's on behalf of a dealer needs to be licensed or registered.

9) The proposed legislation would allow the Division to adopt regulations governing the content of ESC's. It is conceivable the Division could rely on this authority to require that ESC's provide for dealer liability, i.e. make Alaska a "dealer obligor" state. If so, sellers of used cars could not disclaim implied warranties, since this would be prohibited by the federal Magnuson Moss Warranty Act.

Another point concerning both GAP and Service Contracts is that dealers are already subject to a high degree of scrutiny and oversight from Ed Sniffen at the Attorney General's office. Ed is very familiar with the automobile industry and dealers in the State of Alaska and would not hesitate to address any problems with GAP or Service contracts, in the form of litigation if need be. Ed has the ability to enforce the Unfair Trade Practices Act and other laws that are already on the books that would address any consumer complaints with regard to GAP or Service Contracts. Do we really need two state agencies policing automobile dealers and does the Division of Insurance have the resources necessary to regulate the automobile industry?

Were this enabling legislation to be passed, our belief is that the Division would adopt regs that are onerous and ill thought out, as is the case with the proposed legislation. The Division of Insurance did not obtain any input with regard to the language in the proposed legislation from affected parties such as the AADA or any of its members so it is difficult to imagine that our concerns will be heard and addressed during any public hearings for any proposed regulations. It is our belief that this enabling legislation is only the tip of the iceberg with regard to regulation and oversight of automobile dealers. We are also wondering if the proposed legislation may allow the Division to impose a "premium" or like tax on service contracts as a stealth form of taxation.

Comments on SB 108 (HB 147)

March 31, 2005

My name is James Wilson, a member and participant in the ASEA Health Benefits Trust. For the record, I am writing as an individual. I am by employment an Economist. I also am an IFEBP trained trustee (master), but I do not serve on the Health Trust Board.

Thank you for receiving these comments.

I am concerned only with sections 28 and 29 of SB 108, to which I am strongly opposed. These proposals to create additional regulation for benefit trusts will not achieve a useful purpose. They will not improve or provide any guarantees for the solvency of trust funds. They will not give us any more security for the trusts financial affairs. They will not give me, or any other member, any further rights or power with issues or disputes that we do not already have. We already have an administrative system, and an appeals process. Ultimately the trust is under the authority of the Alaska Superior Court.

What sections 28 and 29 will do is create an expensive burden, raising our administrative costs many fold, diminishing our effectiveness in paying benefits. For smaller organizations this additional cost could be a serious problem.

Trusts are managed by a board of elected trustees, who have legally binding fiduciary duties. They have a powerful incentive to make prudent and careful decisions. I do not want a technician or administrator in the Division of insurance, who has no financial accountability, making decisions that affect the finances or solvency of a trust.

Ronald Reagan synthesized a philosophy for a productive economy. Do not impede private sector organizations with burdensome regulations. Let them do what they do best, and what they certainly do better than government can. This is a good philosophy to apply here.

Mr. Chairman, I ask this committee to allow employee benefit trusts to do what they have proven they can do best. Do not try to fix something that is not broke. I urge you to send sections 28 and 29 of this bill into the waste bin, so you can move the good parts forward. The House L&C committee has removed language from its version of this bill (HB 147), that were the source of my concerns and objections, and I hope you will do the same.

That concludes my comments. Thank you.

Members of the Senate Labor & Commerce Committee: I am a current GGU employee and receive health benefits through the ASEA Local 52 Health Benefits Trust (Trust). I am also a member of the ASEA Executive Board. I ask the committee members to consider my statements during your deliberations of SB108.

12/2003 - The ASEA Executive Board sent a letter to the Division of Insurance expressing their concerns with the Trust.

02/2004 - The ASEA Biennial convention passed Resolution 14: "the union formally request the State of Alaska regulate the ASEA health benefits trust under state insurance laws."

05/2004 - The ASEA members elected representatives to the ASEA Contract Negotiating Committee (CNC) who negotiated the Tentative Agreement (TA) for FY2005 through 2007, with no changes impacting the Trust.

08/2004 - The ASEA membership ratified the 3 year TA which included the Trust in its present form.

01/05 - The Trust conducted a Dittman survey containing the following question: "How satisfied are you with the services you have received from the Health Trust?" 75% of ASEA members voted they were satisfied.

The ASEA Local 52 membership has exhibited its support of the Trust through membership election of the Trustees, election of the CNC, in voting to ratify the TA, and in response to the Health Trust Dittman survey.

SB108 will negatively impact the Trust with expensive administrative costs that will NOT provide for an improved health plan and will result in additional payroll deductions to the ASEA membership.

The proposed regulations appear to have no safeguards for the confidentiality of sensitive Trust information this may have a negative impact on the collective bargaining process.

The Trustees are ASEA members elected by ASEA members, and have exhibited their high fiduciary duty to the membership. The Trustees continue to improve the health plan for its members and beneficiaries, as well as promote member understanding of the health plan, and have been very responsive to the membership.

No matter what health plan is in place there will always be complaints. The Trust has worked very diligently to educate the ASEA members on their health coverage, to maximize the benefits of the plan, and the Dittman survey is a positive indicator of those efforts.

I urge the Committee to remove the language in Sections 28 & 29 that will adversely affect union sponsored health trusts.

Thank you for the opportunity to comment. I do appreciate the challenging and often contentious work of the legislators and their staff.

Sue Layton
ASEA Local 52
267 S. Klevin #B
Anchorage, AK 99501
907-563-5736



Submitted by Colleen Sovie at the request of Public Employees Local 71

**Opposition to Alaska State Legislature House Bill 147 / Senate Bill 108
Sections 28 and 29**

Summary: Sections 28 and 29 of HB 147/SB 108 impose unnecessary regulation and costly administrative burden on Trust health plans which were established through the collective bargaining process to provide benefits to state employees.

JIM ASHTON
Business Manager/
Secretary-Treasurer

ROBERT JOHNSON
President

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Imposes a Costly Administrative Burden

- The bill would require the Trusts to file actuarial reports and other documents. Two annual reports would be required, as well as a report each quarter. The estimated cost to the Trust in actuarial fees to produce the required filings is a minimum of \$40,000-\$50,000, assuming the actuary was already familiar with the plan. The fees could increase significantly if the actuary were not already familiar with the plan. In addition, we anticipate administrative costs and legal fees related to these filings.
- The bill requires the Trust maintain a fidelity bond covering each trustee in an amount not less than 10% of the benefits paid during the preceding plan year. For a large Trust, such as the ASEA/AFSCME Local 52, a bond of at least \$6.4 million would be required. This is substantially larger than the bonding requirements of ERISA and it is unusual for a health trust to carry a bond of this size. Consequently, coverage may be difficult or impossible to obtain. A bond of this size may no longer be considered an ERISA bond and may carry higher rates. A substantial deductible may also be required.
- The Division of Insurance will bear additional administrative expenses in order to review and process these filings.
- The State and State employees will also bear this administrative burden. The funds held by the Trusts' health plans are to be used to provide health benefits to plan participants. Every dollar that is diverted to administrative expenses is a dollar that is not available to provide health benefit coverage.

Interferes With Collective Bargaining

- This bill would allow the State to unilaterally determine the benefits to be provided to covered participants, because the Trust would be required to comply with all State-mandated benefits, the State-mandated requirements for the plan administered by the Department of Administration, and regulations adopted by the director. Although the Trust plans currently provide coverage at a level that is as high as or higher than what is mandated by the State, the Trust benefits are tailored to the participant group. The Trusts were originally created through the collective bargaining process in order to allow the health benefit contributions to be used in such a way to better benefit participants.
- Under this regulation, the Trust would be required to provide any additional information requested by the director, "relating to the financial condition, transactions, and affairs of the plan." This requirement could be used, to the State's advantage, during the collective bargaining process.

Imposes Requirements which may be Impossible to Meet

- The bill requires that the Trust "establish and maintain a plan of operation that ensures that the plan will remain solvent as certified to by a qualified actuary." It is unlikely that an actuary would assume the liability to "ensure" solvency of any health plan.
- The bill requires filing of contribution rates at least 60 days before the end of the plan year (June 30 for both the PE71 and ASEA plans). The employer contribution is funded by the legislature, and historically the funding has not been passed by the legislature early enough to enable this filing.

Is Unnecessary

- Each of the Trusts was approved by the Division of Retirement and Benefits and has an existing Letter of agreement in place allowing the provision of coverage to the members of the sponsoring union.
- Each Trust plan is subject to PHSa, HIPAA, COBRA, WHCRA, FMLA, USERRA, MHPA and other federally mandated requirements.
- The Trusts are also regulated by the IRS and have received tax-exempt determination letters as qualified voluntary employee beneficiary associations and must comply with all of the Treasury Regulations associated with VEBA qualification.
- The Trusts already report to the State under the terms of the LOAs.
- Both the PE71 and ASEA plans voluntarily comply with the fiduciary standards set forth in ERISA. The Trustees are fiduciaries, receive fiduciary training, are insured as fiduciaries, and purchase fidelity bonds to protect against dishonesty.
- The Trust plans already provide Summary Plan Descriptions to covered participants.
- The Trust plans undergo an annual audit by a qualified independent certified public accounting firm qualified in employee benefit plan audits. The participants are entitled to a copy of the audit results.
- Participants have an opportunity to appeal denied benefit claims; if they are dissatisfied with the appeal determination, the participant may arbitrate, and if dissatisfied with the decision of the arbitrator may file suit in State Superior Court.
- The Trusts are subject to the jurisdiction of the State of Alaska Superior Courts.

Subject: Re: Supporting HB 108

From: Gordon Glaser and Mary Jo Robinson <mensch@ptialaska.net>

Date: Mon, 21 Mar 2005 20:08:27 -0900

To: "Glaser, Gordon" <gordon_glaser@health.state.ak.us>, Linda Hall
<linda_hall@commerce.state.ak.us>

CC: Michael R Williams <michael_williams@revenue.state.ak.us>, Barbara Brandt
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<wyatt_wheeler@commerce.state.ak.us>, Barbara Brandt - Home <brandt@gei.net>, "Wyatt W.
Wheeler (Anchorage)-H" <w3@gci.net>

Linda S. Hall, CPCU, CIC
Director
Division of Insurance
Department of Commerce, Community, and Economic Development
Alaska State Government

Dear Director Linda Hall,

We follow with interest that the Governor's Senate Bill 108, "An Act relating to the regulation of insurance."

Our executive board voted to support this legislation in its present format.

ASEA has experienced great difficulty with our ASEA health insurance trust

The complaints by our members of the Health Trusts actions continue

The appeal process is not working for many of our members

Contracts involving large sums of our money remain hidden. The Health Trust Board refuses to disclose the contents of these contracts to the ASEA members or their State Executive Board

Services to our rural chapters are not acceptable

Well Baby and Maternal services are not acceptable

The ASEA health trust believes that they are not accountable to any union

entity besides the health trust board. They believe that the only recourse of the membership is an expensive court battle.

I trust this legislation will allow;

Independent oversight of the health trust;

The membership will have access to the contracts signed by the health trust;

The membership will learn the amount of money in referral fees paid by the preferred provider;

Will encourage a standardized and equitable appeal procedure of the health trust;

SB 108 appears to provide a positive solution to a serious problem for many of our members.

Thank you for your efforts to protect Alaskans who are struggling with illness and their insurance providers

Let me know what I can do to help. I look forward to your response by a method of your choosing. .

Sim shalom lech l'shalom
Gordon Glaser
ASEA President

1029 Potlatch Circle
Anchorage AK
99503
240-0177



DIVISION OF INSURANCE

Frank H. Murkowski, Governor

March 30, 2005

The Honorable Con Bunde
Senate Labor & Commerce
Alaska State Senate
State Capitol, Room 506
Juneau, AK 99801

RE: SB 108

Dear Senator Bunde:

The Division of Insurance strongly supports SB 108. The omnibus insurance bill proposes statutory changes that will make the regulation of insurance more efficient for the Division and more uniform for industry while at the same time providing increased protection for Alaskan consumers

There are proposed changes in several areas including streamlining the licensing process and continuing efforts to conform to National Association of Insurance Commissioners models and national standards. Other changes involve continuing efforts to clean up surplus lines statutes, clarify the registration of third party administrators, and make adjustments in the administration of insurer deposits. The bill would give the Division of Insurance the authority to regulate health discount plans, would clarify the state's regulation of guaranteed auto protection products and motor vehicle services contracts, and also set standards for certain self-funded governmental health coverage plans.

I would ask for your support for the measures contained in SB 108.

Thank you.

Sincerely,

Linda Hall
Director

LH/go4650
033005a

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 1
 Bill Version: SB 108
 (S) Publish Date: 2/14/05

Revision Date/Time (Note if correction): _____ Dept. Affected: Commerce
 Title: Omnibus Insurance RDU: Insurance (116)
 Component: Insurance Operations
 Sponsor: Rules Component No.: 354
 Requester: By Request of the Governor

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services	35.0	36.0	37.0	38.0	40.0	41.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	1.0	0.0	0.0	0.0	0.0	0.0
Supplies	2.5	0.0	0.0	0.0	0.0	0.0
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	38.5	36.0	37.0	38.0	40.0	41.0

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	38.5	36.0	37.0	38.0	40.0	41.0
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	38.5	36.0	37.0	38.0	40.0	41.0

Estimate of any current year (FY2005) cost: 0.0

Mark this box (X) if funding for this bill is included in the Governor's FY 2005 Budget proposal:

POSITIONS

Full-time	1	1	1	1	1	1
Part-time						
Temporary						

ANALYSIS: (Attach a separate page if necessary)

A Consumer Services Specialist will need to be added to respond to additional inquiries from the public on the union health trust fund provisions.

Prepared by: Linda S. Hall, Director Phone: 907.269.7900
 Division: Insurance Date/Time: 2/14/05 9:48 AM
 Approved by: Edgar Blatchford, Commissioner Date: 2/14/2005
 Agency: Commerce, Community & Economic Development

FRANK H. MURKOWSKI
GOVERNOR
GOVERNOR@GOV.STATE.AK.US



SB108
P.O. Box 110001
JUNEAU, ALASKA 99811-0001
(907) 465-3500
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WWW.GOV.STATE.AK.US

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

February 11, 2005

The Honorable Ben Stevens
President of the Senate
Alaska State Legislature
State Capitol, Room 111
Juneau, AK 99801-1182

Dear President Stevens:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting an omnibus insurance bill.

The bill would make changes to certain insurance licensing provisions to provide more efficient licensing processes and to bring Alaska's law into greater conformity with other states' laws. It would make minor changes to the surplus lines statutes to clean up language and to make reporting easier for alien insurers.

The bill also would make changes to the requirements for the administration of insurer deposits and would provide authorization for insurer deposits to be paid to the state insurance guaranty funds rather than becoming an asset of an insolvent insurer. Finally, the bill would give the Division of Insurance in the Department of Commerce, Community, and Economic Development the authority to regulate health discount plans, would clarify the state's regulation of guaranteed auto protection products and motor vehicle service contracts, and would provide for oversight of certain self-funded governmental plans.

A sectional analysis, describing the bill in more detail, is available from the division of insurance.

In sum, this omnibus insurance bill will make the regulation of insurance more efficient for the state, easier for industry, and at the same time give heightened protection to Alaska insurance consumers. I urge your prompt and favorable action on this measure.

Sincerely yours,

Frank H. Murkowski
Governor

Enclosure

Governor Transmittal Letter

Section Analysis of HB 147/SB 108

Sec.	Statute	Change	Purpose or Effect
1	21.09.160	Amended	Removes requirement that the director provide specific notice to agents appointed with an insurer of the suspension or revocation of the insurer's certificate of authority; clarifies automatic suspension or revocation of authority of a managing general agent of an insurer whose certificate of authority has been suspended or revoked.
2	21.09.160(c)	Added	Requires an insurer to notify its agents and managing general agents of the insurer's suspension or revocation.
3.	21.24.040(a)	Amended	Removes never used option for how deposits may be made by deleting references to a safe deposit box.
4.	21.24.040(c)	Amended	Removes never used option for how deposits may be made by deleting references to a safe deposit box.
5.	21.24.130(d)	Amended	Provides public protection by permitting the director to release an insurer's statutory deposits to a guaranty fund of which the insurer is a member, if a right to receive all or a portion of the deposit is assigned to the guaranty fund.
6	21.27.010(c)	Amended	Removes reference to the functions of a third party administrator since those are defined in AS 21.90.900; changes reference to the specific third party administrator statutes.
7	21.27.100	Amended	Eliminates requirement for insurer or managing general agents to file appointments with the division; requires the insurer and producer to maintain a listing of agents/managing general agents and to provide the list upon request of the director.
8	21.27.110	Amended	Eliminates requirement for an insurer or reinsurer to file termination of appointments with the division since appointments will no longer be filed with the division; however, an insurer or reinsurer will be required to file notice of termination when the termination is for cause.
9	21.27.380(a)	Amended	Allows the director to notify a licensee of renewal by means other than mail.
10	21.27.630(b)	Amended	Replaces the term "class of insurance" with the defined term "class of authority."
11	21.27.630(c)	Amended	Removes reference to the functions of a third party administrator since those are defined in AS 21.90.900.
12	21.27.630(k) and (l)	Added	Removes the requirement of an admitted insurer to file and obtain a separate third party administrator registration; adds a requirement for a third party administrator who qualifies for exemption to file a certification with the director.
13	21.27.650(a)	Amended	Includes a requirement for a person who meets an exemption provision under the chapter to file a certification with the division.
14	21.27.660	New	Clarifies that the Comprehensive Health Insurance Association is considered an insurer for the purposes of a person who acts as a third party administrator on behalf of that association.
15	21.27.650(q)	Added	Authorizes the director to immediately suspend a third party administrator's registration, without advance notice or hearing, if the

Sectional Analysis

administrator is insolvent, in bankruptcy, in receivership or other delinquency proceeding or is using methods or practices injurious to policy holders or the public.

16.	21.27.900(33)	New	Defines appointment
17.	21.34.040(d)	Amended	Specifies the timing for financial reporting for alien insurers to coincide with their filing dates for stockholder reports; eliminates duplication.
18.	21.34.100(a)	Amended	Makes minor changes to surplus lines filing insurance placement requirements; reflects industry practices.
19.	21.34.100(f)	Amended	Makes minor changes to surplus lines filing insurance placement requirements; reflects industry practices.
20.	21.36.030(a)	Amended	Expands provision prohibiting misrepresentation and false advertising to include electronic communications.
21.	21.36.030(a)	Amended	Adds reference to health discount plans to give the director authority to regulate trade practices of health discount plans that are not otherwise regulated under AS 21; specifies that misleading references to health discount plans are considered unfair trade practices.
22.	21.36.155	New	Adds provision to give the director authority to regulate trade practices of health discount plans that are not otherwise regulated under AS 21 and establishes guidelines for regulation of these products.
23.	21.36.195	Amended	Makes minor changes to surplus lines filing insurance placement requirements; reflects industry practices.
24.	21.51.405	New	Requires that rates for health insurance policies not be excessive, inadequate or unfairly discriminatory. The change makes the standards applicable to individual health insurance rates the same as those that apply to other types of insurance and brings Alaska law in line with other states.
25.	21.55.500(16)	Amended	Clarifies that the plan administrator for the Comprehensive Health Insurance Association must be registered as a third party administrator.
26.	21.66.080(a)	Amended	Allows the director to designate the location for filing of financial statements for title insurers to be consistent with other insurers.
27.	21.66.085(b)	Amended	Changes the due date for financial statements for title insurers to be consistent with other insurers.
28.	21.85.200 - .230	New	Provides for division oversight of certain self-funded governmental plans that are exempt from coverage under the state's group plan.
29.	21.85.500	New	Defines self-funded governmental plans.
30.	21.89.120	New	Clarifies the director's authority to adopt regulations regarding the regulation of motor vehicle service contracts and guaranteed automobile protection products.
31.	21.90.900(42)	Amended	Expands definition of third party administrators to include administrators for the Comprehensive Health Insurance Association or for self-funded employer plans subject to AS 21.85.
32.	21.90.900(43)	Amended	Expands definition of transact to apply in the context of providing coverage for medical care.
33.	21.90.900(45) - (47)	New	Adds definitions for guaranteed automobile protection, health discount plan and motor vehicle service contract.
34.	21.24.040(b); 21.27.330(b); 21.27.650(p)	Repealed	Removes reference to

use of safe deposit boxes; eliminates requirement for firms to file and pay a fee for branch offices; and removes provision that defines transact with respect to operating requirements for third party administrators as it has been moved to a definition section at the end of the article pertaining to third party administrators.

35.	Uncodified Law	Amended	Allows regulations for implementation for certain sections but not before those sections are effective.
36.	Uncodified Law	Amended	Provides revisors instructions regarding title of section 21.85 and restructuring of section into three articles.
37.	Effective Date		Makes certain sections effective July 1, 2005.
38.	Effective Date		Makes all other sections effective immediately.

Add a new Section, AS 21.12.140, as follows:

Section 21.12.140. LIMITATION ON OWNER CONTROLLED INSURANCE PROGRAMS AND CONTRACTOR CONTROLLED INSURANCE PROGRAMS.

- (a) Owner Controlled Insurance Programs and Contractor Controlled Insurance Programs must be approved by the Director, are limited to property insurance and casualty insurance as those terms are defined in AS 21.12.060 and AS 21.12.070, respectively, and shall be allowed only for construction projects.
- (b) As used herein, the following terms shall have the following meanings:
 - (1) "Owner Controlled Insurance Program" means an insurance program where one or more insurance policies are placed by a project owner, its agent, representative or broker, with such policy or policies insuring the project owner, and one or more of the following persons: The contractor, one or more subcontractors, or an architect, engineer or other person performing professional services.
 - (2) "Contractor Controlled Insurance Program" means an insurance program where one or more insurance policies are placed by a contractor, its agent, representative or broker, with such policy or policies insuring the contractor and one or more of the following persons: The project owner, one or more subcontractors, an architect, engineer or other person performing professional services.
 - (3) "Project owner" means a person who, in the course of the person's business, engages the service of a contractor for the purpose of performing a construction project.
 - (4) "Contractor" means a person who undertakes the performance of a construction project for a project owner, its agent or representative.

- (5) "Subcontractor" means a person to whom a contractor sublets all or a part of the contractor's initial undertaking.
 - (6) "Construction project" means the process of constructing a structure, building, facility or roadway pursuant to a contract cost in excess of \$50,000,000.00 of a definite term at a defined geographical project site, and includes major renovations involving the replacement of more than fifty percent (50%) of existing structures, buildings, facilities or roadways. Construction project shall not include the operation, maintenance or repair of structures, buildings, facilities, or roadways, even if such activities include minor construction activities.
- (c) Notwithstanding (a) or (b) of this section, the following shall not constitute an Owner Controlled Insurance Program or a Contractor Controlled Insurance Program:
- (1) Builder's Risk or Course of Construction Insurance;
 - (2) Insurance relating to the transportation of cargo or other property;
 - (3) Insurance covering one or more affiliates, subsidiaries, partners or joint venture partners of a person; or
 - (4) Insurance policies endorsed to name one or more persons as additional insureds.

Add a new subsection (f) to AS 21.36.190 ("Fictitious groups"), as follows:

- (f) An insurer, whether an authorized or unauthorized insurer, may not underwrite Owner Controlled Insurance Programs or Contractor Controlled Insurance Programs except as set forth in AS 21.12.140.



Alaska Independent
Insurance Agents & Brokers, Inc.

March 14, 2005

Senator Con Bunde, Chairman
Labor & Commerce Committee
24th Legislative, 1st Session
Alaska State Capitol
Juneau, AK 99801-1182

Senate Bill 108 - Alaska Statutes Section 21 Insurance

Dear Senator Bunde,

Enclosed is a proposed amendment to this legislation addressing limitations on the use of Owner Controlled Insurance Programs (OCIP) and Contractor Controlled Insurance Programs (CCIP) to the construction of large (\$50,000,000.00 +) projects of public or private nature over a defined period of time at a specific location or region

OCIP and CCIP's have been designed in the past to provide for uniformity of insurance coverage limits and forms for a specific large construction project involving an array of various industry trades. Examples that are often described as OCIP and CCIP projects include the Trans Alaska Pipeline, Hoover Dam, and the Sears Tower in Chicago.

There are large employers in Alaska that are proceeding with or contemplating the use of OCIP and CCIP's for the maintenance and repairs of their existing facilities.

There are several problems with using this insurance method for maintenance and repair programs:

(1). The removal of any insurance clients out of the already fragile Alaska insurance market may lead to further deterioration of that competitive arena. The total volume of insurance business in Alaska is so small that any reduction in the available insurance risks would lead to additional insurance markets exiting the state.

P.O. Box 112908, Anchorage, AK 99511-2908
Phone: (907) 349-2500 Fax: (907) 349-1500

(2). Any loss of the current insurance market will adversely affect the remaining clients overall bottom line cost. Fewer insurance markets leads to higher costs for the rest of the clients not involved with the OCIP and CCIP.

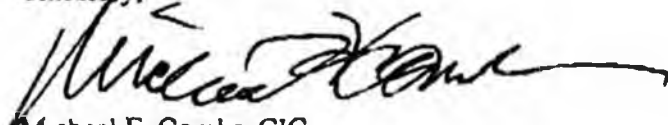
(3). OCIP and CCIP include all owners, contractors, and sub-contractors for all aspects of the construction project. All employers are defined and included on the insurance program. No dual employer situations exist, and the insurance provided is the sole source and remedy for the public and employee exposures. This is not so clear when the OCIP and CCIP form of insurance is used for maintenance or repairs of existing facilities.

Employees of XYZ sub-contractor may have several locations and jobs throughout the state for operations during the year, but only a small portion is performed on an OCIP facility. XYZ sub-contractor would provide workers compensation benefits to their employees during travel exposures around the state, but the OCIP or CCIP program might only provide benefits for the employee while actually present at the maintenance site. If the employee is being sent to the OCIP site by XYZ sub-contractor but not included for benefits until they actually arrive at the maintenance site, who is responsible for the travel exposure? This could lead to a lot of unnecessary litigation to determine the employer/employee status at the time and place of injury.

This proposed language amendment is designed to clarify when an OCIP or CCIP may be used, and would be subject to the Division of Insurance oversight and approval.

Please give this amendment your consideration. Thank you.

Sincerely,



Michael F. Combs, CIC
Legislative Committee
Alaska Independent Insurance Agents & Brokers, Inc

SB

124

SENATE COMMITTEE REPORT First Committee of Referral

DATE: 3/2/05

FURTHER: Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: _____

Labor and Commerce Committee considered SENATE BILL NO. 124

SB 124 FISHERIES BUSINESS LICENSE; BOND

"An Act relating to requirements to obtain and maintain a fisheries business license; relating to security required of fish processors and primary fish buyers; and providing for an effective date."

and recommends:

- be replaced with _____ CS _____ (_____)
- adopt previous _____ CS _____ (_____)
- attached amendment(s)
- adopt Letter of Intent by _____ Committee
- further referral to _____ Committee

Senate Bill:

- Same Title
- New Title

House Bill:

- Same Title
- Technical Title Change
- New Title w/ SCR # _____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	Do PASS	Do NOT PASS	No REC	AMEND
<i>Beth Davis</i>	X			
<i>R. Miller</i>			X	
<i>Ralph Seebin</i>	✓			
CHAIR: <i>C. Bluff</i>	✓			

TO CHUCK #1
2375

24-GS1013Y
Utterohle
3/16/05

CS FOR SENATE BILL NO. 124()

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY

**Offered:
Referred:**

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to requirements to obtain and maintain a fisheries business license;
2 relating to security required of fish processors and primary fish buyers; and providing
3 for an effective date."

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

5 * **Section 1.** AS 43.75.020 is amended to read:

6 **Sec. 43.75.020. Application for license** (a) Application for a license shall
7 be filed with the department and accompanied by an annual fee of \$25. A separate
8 annual fee is required for each plant specified in the application covered by the
9 license. The application must contain the name of the applicant, the line of business to
10 be licensed, place of business, and other facts that the department prescribes. The
11 applicant shall state that the applicant, as a condition of obtaining and maintaining
12 the license, agrees to pay

13 (1) the taxes levied under this title [TAX IMPOSED BY
14 AS 43.75.015 OR 43.75.100], and that the applicant will make a return and pay

1 the taxes [TAX] at the time provided by law;

2 (2) any seafood marketing assessment levied under AS 16.51;

3 (3) contributions imposed under AS 23.20 (Alaska Employment
4 Security Act);

5 (4) any administrative penalties assessed under AS 18.60.093 for a
6 violation of a provision of AS 18.60.010 - 18.60.105; and

7 (5) any applicable fishery sales, use, or severance taxes imposed by
8 a municipality in the state.

9 (b) Upon receipt of an [THE] application in proper form under (a) or (c) of
10 this section, accompanied by the annual fee, the department shall issue the license if
11 the

12 (1) applicant has paid in full, including interest and penalties, the
13 following:

14 (A) taxes levied under this title; and

15 (B) any assessments under AS 16.51;

16 (2) department has not received notification from the Department
17 of Labor and Workforce Development that the applicant has failed to pay in full

18 (A) an assessment of delinquent contributions that is final
19 under AS 23.20.205(c) or 23.20.220(c); or

20 (B) an administrative penalty that is final under
21 AS 18.60.093 or 18.60.097; and

22 (3) department has not received a copy of a final judgment
23 obtained against the applicant for unpaid fishery sales, use, or severance taxes
24 imposed by a municipality in the state.

25 (c) Instead of a license issued under (a) of this section, the department may
26 issue a direct marketing fisheries business license to a licensed commercial fisherman
27 who processes fishery resources caught using a vessel that does not exceed 65 feet in
28 overall length and is owned or leased by the commercial fisherman. The licensee may
29 place into commerce in the state and outside of the state processed or unprocessed
30 fishery resources caught using the vessel described in the license. Fishery resources
31 that are caught using the vessel and owned by the licensee from the time of harvest

1 through sale, as defined by the department by regulation, may be processed by the
2 licensee on the vessel, at a shore-based facility, or by means of custom processing
3 services obtained by the licensee. An application for a direct marketing fisheries
4 business license shall be filed with the department and accompanied by an annual fee
5 of \$25. A separate direct marketing fisheries business license and annual license fee
6 are required for each vessel on which processing is performed. The application must
7 state the name and address of the applicant, the fishery resources for which the
8 applicant holds a commercial fishing entry permit or interim-use permit or quota
9 share, a description of the vessel and each shore-based facility where the applicant will
10 process fishery resources, and other information that the department prescribes by
11 regulation. The application must state that the applicant, as a condition of obtaining
12 and maintaining the license, agrees to pay the taxes, assessment, employment
13 security contributions, and penalties as set out in (a)(1) - (5) of this section [TAX
14 IMPOSED BY AS 43.75.015(d) OR 43.75.100, AND THAT THE APPLICANT
15 WILL MAKE A RETURN AND PAY THE TAX AT THE TIME PROVIDED BY
16 LAW]. A person who holds a direct marketing fisheries business license may not
17 under that license (1) purchase fishery resources for resale or processing for sale; or
18 (2) process fishery resources for another licensed commercial fisherman or for a
19 fisheries business licensed under this chapter. In this subsection, "licensed
20 commercial fisherman" means a natural person who holds a commercial fishing entry
21 permit or interim-use permit issued under AS 16.43 or a quota share issued under
22 federal law.

23 * Sec. 2. AS 43.75.055 is amended by adding a new subsection to read:

24 (g) Real property, a surety bond, or other security being used to secure
25 payment of the tax for the year preceding the application year, may also be used to
26 secure payment of the estimated tax for the application year if the security is
27 acceptable to the department and the applicant has not failed to pay a tax under this
28 chapter in a timely manner during any of the three years preceding the application
29 year.

30 * Sec. 3. AS 44.25.040 is repealed and reenacted to read:

31 **Sec. 44.25.040. Security for certain obligations.** (a) A person applying for a

1 license as a fish processor or primary fish buyer shall file with the commissioner of
2 revenue a performance bond, conditioned upon the promise to pay the following:

3 (1) wages owing to all persons employed by the fish processor or
4 primary fish buyer, including contractual employee benefits;

5 (2) independent registered commercial fishermen for the price of the
6 raw fishery resource purchased from them;

7 (3) contributions imposed under AS 23.20 (Alaska Employment
8 Security Act).

9 (b) A fish processor that processes more than 30,000 pounds of fish a year and
10 a primary fish buyer shall file a performance bond with the commissioner in the
11 amount specified in this subsection. The amount of the bond is \$10,000 unless, during
12 the five years preceding the application, one of the following has occurred:

13 (1) a final judgment in excess of \$10,000 was awarded against the
14 bond required under this section; if the final judgment against the bond was in excess
15 of \$10,000 but less than \$50,000, the amount of the bond is increased to a total of
16 \$50,000; if the final judgment against the bond was \$50,000 or more, the amount of
17 the bond is increased to a total of \$100,000;

18 (2) the commissioner has determined that a fish processor or primary
19 fish buyer has engaged in the business of fish processor or primary fish buyer in the
20 state while not in compliance with this section and has not yet satisfied a final
21 judgment entered against the processor or fish buyer for payment for labor furnished
22 to, or raw fishery resources purchased by, the processor or fish buyer; if the fish
23 processor or primary fish buyer has engaged in the business of a fish processor or
24 primary fish buyer while not in compliance with this section and has not yet satisfied a
25 final judgment for payment for labor furnished to, or raw fishery resources purchased
26 by the processor or fish buyer, the amount of the bond is increased to a total of
27 \$100,000; or

28 (3) the commissioner has determined under (i) of this section that a
29 claim against the bond filed by the Department of Labor and Workforce Development
30 under (h) of this section met the requirements in (h) of this section; if the amount of
31 the claim was in excess of \$10,000 but was less than \$50,000, the amount of the bond

1 is increased to a total of \$50,000; if the amount of the claim was \$50,000 or more, the
2 amount of the bond is increased to a total of \$100,000; an increase in bond amount
3 under this paragraph may not be imposed until 45 days after the commissioner
4 determines under (i) of this section that the claim of the Department of Labor and
5 Workforce Development met the requirements in (h) of this section.

6 (c) A fish processor that processes 30,000 pounds or less of fish a year shall
7 file a performance bond with the commissioner in the amount specified in this
8 subsection. The amount of the bond is \$2,000 unless, during the preceding five years,
9 one of the following has occurred:

10 (1) a final judgment in excess of \$2,000 was awarded against the bond
11 required under this section; if the final judgment against the bond was in excess of
12 \$2,000 but less than \$10,000, the amount of the bond is increased to a total of
13 \$10,000; if the final judgment against the bond was \$10,000 or more, the amount of
14 the bond is increased to a total of \$20,000;

15 (2) the commissioner has determined that a fish processor has engaged
16 in the business of a fish processor in the state while not in compliance with this section
17 and has not yet satisfied a final judgment entered against the processor for payment for
18 labor furnished to, or raw fishery resources purchased by, the processor; if the fish
19 processor has engaged in the business of a fish processor while not in compliance with
20 this section and has not yet satisfied a final judgment for payment of labor furnished
21 to, or raw fishery resources purchased by the processor, the amount of the bond is
22 increased to a total of \$20,000; or

23 (3) the commissioner has determined under (i) of this section that a
24 claim against the bond filed by the Department of Labor and Workforce Development
25 under (h) of this section met the requirements in (h) of this section; if the amount of
26 the claim was in excess of \$2,000 but was less than \$10,000, the amount of the bond is
27 increased to a total of \$10,000; if the amount of the claim was \$10,000 or more, the
28 amount of the bond is increased to a total of \$20,000; an increase in bond amount
29 under this paragraph may not be imposed until 45 days after the commissioner
30 determines under (i) of this section that the claim of the Department of Labor and
31 Workforce Development met the requirements in (h) of this section.

1 (d) If a fish processor who has filed a performance bond under (c) of this
2 section processes more than 30,000 pounds of fish in a year, the processor shall,
3 within seven days after the day on which the 30,000 pound threshold is exceeded,
4 notify the commissioner and comply with (b) of this section. If a processor who has
5 filed a performance bond under (c) of this section processes more than 30,000 pounds
6 of fish in a year, and does not comply with (b) of this section within seven days after
7 the date on which the 30,000 pound threshold is exceeded, the processor shall suspend
8 processing fish until a bond has been filed under (b) of this section.

9 (e) A fish processor or primary fish buyer may use only a surety bond, cash
10 deposit, or other negotiable security as a performance bond under this section. The
11 surety must be satisfactory in the determination of the commissioner. The use of other
12 negotiable security as a performance bond must be in a form acceptable to the
13 commissioner. The commissioner shall waive the filing of a performance bond under
14 this section if the fish processor or primary fish buyer

15 (1) has more than \$10,000 in lienable real property located in the state
16 and provides proof of the property in a form satisfactory to the commissioner;

17 (2) is not required under (b) or (c) of this section to post a bond in
18 excess of \$10,000; and

19 (3) within the five years preceding the application under AS 43.75.020,
20 an employee or fisherman has not obtained a final judgment against the fish
21 processor's or fish buyer's bond under this section.

22 (f) If an applicant for a license as a fish processor or primary fish buyer has
23 complied with this section, the Department of Revenue may issue that applicant a
24 license to engage in the business of fish processor or primary fish buyer.

25 (g) A claim against a fish processor or primary fish buyer for failing to pay an
26 employee for wages or contractual benefits owed or for failing to pay an independent
27 registered fisherman for the price of raw fishery resource purchased from the
28 fisherman may be brought upon the bond filed under this section in the superior court
29 of the judicial district in which the work was done or in any judicial district in the state
30 in which jurisdiction may be obtained. If an action is brought upon the bond, a copy
31 of the complaint shall be served by registered or certified mail upon the commissioner

1 at the time the suit is filed. The commissioner shall transmit a copy of the complaint
2 and any judgment to the surety or holder of the negotiable security. If a judgment is
3 entered against cash deposited with the commissioner, the commissioner, upon receipt
4 of a certified copy of a final judgment, shall pay the judgment from the amount of the
5 deposit. The commissioner shall maintain a record, available for public inspection, of
6 all suits commenced under this subsection.

7 (h) A claim against a fish processor or primary fish buyer for failing to pay
8 contributions imposed under AS 23.20 may be brought by the Department of Labor
9 and Workforce Development against the bond filed under this section by filing a claim
10 against the bond with the commissioner, along with proof, satisfactory to the
11 commissioner, that the fish processor or primary fish buyer

12 (1) received a notice of assessment under AS 23.20.205;

13 (2) did not pay the amount specified in the notice of assessment within
14 30 days after receiving the notice of assessment or, if the assessment was contested
15 under AS 23.20.220, within 30 days after receiving the department's final decision
16 under AS 23.20.220(c); and

17 (3) did not file an appeal of the assessment under AS 23.20.220 or
18 filed an appeal but did not initiate a proceeding for judicial review under
19 AS 23.20.445 within 30 days after the department's final decision under
20 AS 23.20.220(c).

21 (i) If the commissioner determines that the Department of Labor and
22 Workforce Development has met the claim requirements in (h) of this section, the
23 commissioner shall forward the claim and supporting documents to the surety or
24 holder of the negotiable security. If the fish processor or primary fish buyer has
25 deposited cash with the commissioner, the commissioner shall pay the claim of the
26 Department of Labor and Workforce Development from the amount of the deposit. If
27 the commissioner determines that the Department of Labor and Workforce
28 Development has not met the claim requirements in (h) of this section, the
29 commissioner shall provide the Department of Labor and Workforce Development
30 with written notice of the deficiency of its claim.

31 (j) If a performance bond is insufficient to satisfy all claims filed against it

1 under this section, claims brought against the bond under (g) of this section have
2 priority over a claim filed against the bond under (h) of this section. The Department
3 of Labor and Workforce Development shall return to the commissioner money
4 received from a claim filed against a fish processor's or primary fish buyer's
5 performance bond under (h) of this section if an employee or fisherman obtains a final
6 judgment under (g) of this section against that processor's or fish buyer's bond and the

7 (1) processor or fish buyer has not replenished the bond after it was
8 used to cover the claim filed under (h) of this section; or

9 (2) final judgment obtained by the employee or fisherman is more than
10 the amount of the bond available under (b) or (c) of this section.

11 (k) The term of a performance bond expires two years after the fish processor
12 or fish buyer is no longer licensed in this state, except that if, during that two-year
13 period, a claim has been asserted against the bond, the term of the bond is five years.
14 If the surety on the bond wishes to cancel the bond, the surety may do so by giving the
15 commissioner written notice of intention to cancel. The cancellation is effective 30
16 days after the notice is delivered to the commissioner.

17 * **Sec. 4.** AS 44.25.042 is amended by adding a new subsection to read:

18 (h) If the commissioner determines under AS 44.25.040(i) that a claim filed
19 under AS 44.25.040(h) is sufficient to allow collection against the performance bond
20 filed under AS 44.25.040, the fish processor's or primary fish buyer's license shall be
21 suspended until the amount of the claim under AS 44.25.040(h) is paid in full and the
22 performance bond is replenished.

23 * **Sec. 5.** This Act takes effect immediately under AS 01.10.070(c).