Title 3. Commerce, Community, and Economic Development.

Part 2. Division of Insurance.

Chapter 21. Insurer - Financial.

Article 3. Record and Financial Reporting.

3 AAC 21.480 is amended to read:

3 AAC 21.480. Corporate minutes book. As used in AS 21.69.390(d)(8), a "corporate minutes book" must include the minutes of all meetings of the board of directors and **of** the **subcommittees appointed by the board of directors** [INVESTMENT COMMITTEE REQUIRED UNDER AS 21.21.040]. The minutes of the board of directors must include all

(1) resolutions adopted and acts taken by the board of directors; and

(2) resolutions adopted by a subcommittee of the board that must be adopted or approved by the board [OR A SUBCOMMITTEE OF THE BOARD] under AS 21.

Chapter 23. Producers, Managing General Agents, Surplus Lines Brokers, Reinsurance Intermediary Managers, Reinsurance Intermediary Brokers, Third Party Administrators, and Independent Adjusters.

3 AAC 23.860(a) is amended to read:

(a) The biennial renewal date for an individual licensee is based upon the individual's **birth month** [BIRTHDAY], as follows:

(1) if the individual licensee's birth year is an odd number, the renewal date is the **last day of the month in the** individual's **birth month** [BIRTHDAY] every odd-numbered year;

(2) if the individual licensee's birth year is an even number, the renewal date is **the last day of the month in the** individual's **birth month** [BIRHTDAY] every even-numbered year. (Eff. 7/1/92, Register 123; am 12/26/93, Register 128; am 3/11/98, Register 145; am 3/30/2003, Register 165; am 10/13/2011, Register 200; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.27.380

Chapter 25. Surplus Lines – Unauthorized Insurers.

Article 1. Unfair Claims Settlement Acts or Practices.

3 AAC 25.060 is amended to read:

3 AAC 25.060. Evidence of insurance. The prompt delivery of the evidence of insurance required by AS 21.34.100 means no later than 30 days after [THE EFFECTIVE DATE OF THE COVERAGE OR] the date the coverage is bound [, WHICHEVER OCCURS FIRST]. Evidence of insurance includes subsequent endorsements and company audits related to a policy. (Eff. 8/28/91, Register 119; am 9/4/2014, Register 211; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.34.100 AS 21.34.250

Chapter 26. Trade Practices.

3 AAC 26.040(d) is amended to read:

(d) This section does not apply to **an** [A GROUP] insurance claim subject to **AS 21.36.495** [AS 21.54.020] or other health insurance claim for which the insurer complies with **AS 21.36.495** [AS 21.54.020]. (Eff. 5/6/89, Register 110; am 9/15/2004, Register 171; am ____/____/____, Register ____)

Authority: AS 21.06.090 **AS 21.36.495** [AS 21.54.020]
AS 21.36.125

3 AAC 26.050(c) is amended to read:

(c) This section does not apply to **an** [A GROUP] insurance claim subject to **AS 21.36.495** [AS 21.54.020] or other health insurance claim for which the insurer complies with **AS 21.36.495** [AS 21.54.020]. (Eff. 5/6/89, Register 110; am 9/15/2004, Register 171; am ____/____/____, Register ____)

Authority: AS 21.06.090 **AS 21.36.495** [AS 21.54.020]
AS 21.36.125

3 AAC 26.070(d) is repealed and readopted to read:

(d) A person transacting a business of insurance who participates in the investigation, adjustment, negotiation, or settlement of a claim shall pay a judgment or settlement of the claim including advances, partial settlements, or similar payments:

(1) with a negotiable check payable in cash to the payee upon presentation to a bank located in this state; if the check is not drawn upon a bank having a physical location in this

state, it must be payable in cash upon presentation to at least one bank having a physical location in this state;

(2) by electronic funds transfer; or

(3) by prepaid card product, if approved by the director.

3 AAC 26.070(e) is amended to read:

(e) The provisions of (a), (b), and (c) of this section do not apply to **an** [A GROUP] insurance claim subject to **AS 21.36.495** [AS 21.54.020] or other health insurance claim for which the insurer complies with **AS 21.36.495** [AS 21.54.020]. (Eff. 5/6/89, Register 110; am 9/15/2004, Register 171; am ____/____/____, Register ____)

Authority: AS 21.06.090 **AS 21.36.495** AS 21.96.030
AS 21.36.125 [AS 21.54.020]

3 AAC 26 is amended by adding a new section to read:

3 AAC 26.075. Arbitration. An insurer may allow for settlement of disputes through arbitration subject to the following:

(1) the arbitration process and rules must be agreed upon by all parties and the insurer may not prevent an insured from using an alternative process to settle a dispute;

(2) the venue of arbitration must be

(A) available in the community

(i) where the insured maintains its principal place of business in the state;

(ii) in the case of an individual, where the insured's principal residence is located; or

(B) at a location agreed to by the insured;

(3) the policy must

(A) contain or provide access to the rules under which arbitration will be conducted; and

(B) include an explanation of how the insured can initiate the arbitration process. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.125 AS 21.42.120

3 AAC 26.110(a)(2)(A) is amended to read:

(2) determine the final payment for a covered service or supply based on an amount that

(A) reflects the general cost differences between the geographical area where the service was performed and the other geographical areas used in establishing the statistically credible profile under (1) of this subsection; [THE ADJUSTMENT MAY BE BASED ON THE CONSUMER PRICE INDEX, THE MEDICAL CARE COMPONENT OF THE CONSUMER PRICE INDEX, OR ANOTHER REASONABLE BASIS STATED IN WRITING;] and

3 AAC 26.110(d) is amended to read:

(d) A health care insurer shall give written notice to a health care provider, [OR] health care facility, **or consumer** at least 30 calendar days before the insurer seeks recovery of an overpayment. The notice must include adequate information for the health care provider, [OR] health care facility, **or consumer** to identify the specific claim and the specific reason for the recovery. A health care insurer may not initiate recovery of an overpayment more than 365 days after the date the original payment was made to a health care provider, [OR] health care facility, **or consumer,** or its agents, unless the health care insurer has clear and documented reason to believe that the health care provider, [OR] the health care facility, **or consumer,** or its agents has committed fraud or other intentional misconduct.

3 AAC 26.110(e) is amended to read:

(e) A health care insurer shall provide a health care provider, [OR] health care facility, **or consumer** with an opportunity to challenge the recovery of an overpayment, including sharing of claims information, and shall establish written policies and procedures for a health care provider, [OR] health care facility, **or consumer** to follow in order to challenge the recovery of an overpayment.

3 AAC 26.110 is amended by adding new subsections to read:

(f) If a health insurance policy provides in-network and out-of-network benefits, the policy must provide at a minimum the in-network benefit level for the following:

(1) emergency services;

(2) services or supplies provided by an out-of-network health care provider or health care facility, if an in-network health care provider or health care facility is not reasonably accessible as defined in the policy;

(3) services provided by an out-of-network health care provider as part of a covered stay at an in-network health care facility when a covered individual does not have or is not given a choice of health care provider.

(g) An insurer may require a covered individual to purchase specialty drugs from a specific in-network health care provider in order to receive benefits under a health insurance policy, unless the specialty drug is not available from the health care provider when needed.

(h) An insurer may require a covered individual to receive transplant services from an in-network health care provider in order to receive benefits under a health insurance policy, unless transplant services are not available from a network health care provider when needed.

(i) An insurer may not process claims based on a procedure code that differs from the procedure code specified in the claim unless agreed upon by the health care provider that provided the service or supply.

(j) If an insurer provides benefits to a domestic partner, then the insurer may not unfairly discriminate on the basis of gender and must provide benefits to both same and opposite gender domestic partners.

(k) If an insurer, for purposes of negotiating discounts with a health care provider, delays payment of an otherwise clean claim beyond the timeframes in AS 21.36.495, the insurer is subject to the 15 percent interest penalty in AS 21.36.495(c) or AS 21.36.495(d).

(*l*) An insurer may not reduce the payment on a current claim for an overpayment on a previous claim unless the reduction

(1) is determined to be in compliance with (d) and (e) of this section; and

(2) does not result in a reduction on the amount allowed on any other claims of the covered individual. (Eff. 5/6/89, Register 110; am 4/20/97, Register 142; am 1/2/98, Register 145; am 9/15/2004, Register 171; am 10/16/2011, Register 200; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.495 AS 21.42.205
AS 21.36.125

3 AAC 26.300(3) is repealed:

(3) repealed ____/____/____.

3 AAC 26.300(9) is repealed:

(9) repealed ____/____/____.

3 AAC 26.300 is amended to add new paragraphs to read:

(13) "clean claim" has the meaning given in AS 21.36.495;

(14) "electronic funds transfer" means a paperless or cardless transfer of funds initiated by an insurer to authorize a financial institution to credit a claimant's account using the insurer's funds in order to pay a judgment or settlement of a claim;

(15) "emergency medical condition" means the sudden and, at the time, unexpected onset of a medical condition or illness that requires immediate medical attention and where the failure to provide medical attention would result in

(A) the placing of the person's health in serious jeopardy;

(B) a serious impairment to bodily functions; or

(C) a serious dysfunction of any bodily organ or part;

(16) "emergency services" means medical care services or items furnished or required to evaluate and treat an emergency medical condition;

(17) "health care insurance" has the meaning given in AS 21.12.050;

(18) "prepaid card product" means a reloadable card issued by a financial institution in the name of the claimant that is loaded with funds from an insurer to pay a judgment or settlement of a claim;

(19) "procedure code" means a universal code used by a health care provider to identify the services or supplies provided to an insured under a health care insurance policy. (Eff. 5/6/89, Register 110; am 4/20/97, Register 142; am 9/15/2004, Register 171; 6/6/2015, Register 214; am ____/____/_____, Register ____)

Authority: AS 21.06.090 AS 21.36.125

Article 6. Annuity Contract Disclosures.

3 AAC 26.755(a) is amended to read:

(a) If an application for an annuity contract is taken in a face-to-face meeting, the insurer or licensee shall at or before the time of application give the applicant a copy of

(1) the disclosure document described in (g) of this section; and

(2) the buyer's guide [OR THE EIA BUYER'S GUIDE, WHICHEVER IS APPLICABLE].

3 AAC 26.755(e) is amended to read:

(e) A solicitation other than a face-to-face solicitation for an annuity contract must include a statement that an applicant may contact the division or the insurer or licensee for a free buyer's guide [OR THE EIA BUYER'S GUIDE, WHICHEVER IS APPLICABLE].

(Eff. 7/25/2008, Register 187; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.030 AS 21.36.050
AS 21.36.020 AS 21.36.040 AS 21.36.900

3 AAC 26.769(1) is amended to read:

(1) "buyer's guide" means the National Association of Insurance Commissioners' ***Buyer's Guide for Deferred Annuities Fixed,* dated 2013** [*BUYER'S GUIDE TO FIXED DEFERRED ANNUITIES WITH APPENDIX FOR EQUITY-INDEXED ANNUITIES, DATED* 1999] and adopted by reference;

3 AAC 26.769(4) is repealed:

(4) repealed ____/____/____;

(Eff. 7/25/2008, Register 187; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.030 AS 21.36.050
AS 21.36.020 AS 21.36.040 AS 21.36.900

The editor's note following 3 AAC 26.769 is changed to read:

Editor's note: The National Association of Insurance Commissioners' ***Buyer's Guide for Deferred Annuities Fixed*, dated 2013** [*BUYER'S GUIDE TO FIXED DEFERRED ANNUITIES WITH APPENDIX FOR EQUITY-INDEXED ANNUITIES, DATED* 1999] **adopted by reference in 3 AAC 26.769,** may be obtained from Division of Insurance, P.O. Box 110805, Juneau, Alaska 99811-0805 or **viewed** on the division's website at **www.insurance.alaska.gov** [HTTP://WWW.DCED.STATE.AK.US/INSURANCE/CONSUMERINFO.HTML, UNDER INSURANCE PRODUCTS INFORMATION – ANNUITIES].

In 2010 the revisor of statutes, acting under AS 01.05.031, renumbered former AS 21.36.150 as AS 21.36.900. As of Register 196 (January 2011), the regulations attorney made a conforming technical revision under AS 44.62.125(b)(6), to the authority citation that follows 3 AAC 26.769, so that the citation to former AS 21.36.150 now refers to the renumbered statute, AS 21.36.900.

Chapter 28. Life, Health, Variable, and Related Insurance.

Article 4. Consumer Credit Insurance.

3 AAC 28.370 is repealed:

3 AAC 28.370. Experience reports and adjustment of prima facie rates. Repealed.

(Eff. 3/29/81, Register 77; am 6/6/93, Register 126; am 7/2/2001, Register 158; am 4/4/2002, Register 162; repealed ____/____/____, Register ____)

Chapter 29. Property, Casualty, and Related Insurance.

Article 2. Rate and Rating Plan Filings.

3 AAC 29.220(c) is repealed:

(c) repealed ____/____/____. (Eff. 8/7/92, Register 123; am 12/24/93, Register 128; am 1/17/98, Register 145; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.39.070 AS 21.39.130
AS 21.39.040

3 AAC 29.280(b) is repealed:

(b) repealed ____/____/____. (Eff. 8/7/92, Register 123; am 1/17/98, Register 145; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.39.070 AS 21.39.130
AS 21.39.040

Article 5. Information Filings for Commercial Insurance.

3 AAC 29.500 is amended to read:

3 AAC 29.500. Applicability. The provisions of 3 AAC 29.500 – 3 AAC 29.550 apply to rate and form filings providing **commercial insurance** coverage **as defined in AS 21.12.130** for exempt commercial policyholders as defined in 3 AAC 29.545. (Eff. 6/11/2005, Register 174; am ____/____/_____, Register _____)

Authority: AS 21.06.090 AS 21.39.040 **AS 21.42.120**

AS 21.12.130

3 AAC 29.550(2) is amended by adding a new subparagraph to read:

(F) a designation as a Chartered Enterprise Risk Analyst, Chartered Enterprise Risk Actuary, Certified Enterprise Risk Analyst, or Certified Enterprise Risk Actuary, (CERA) issued by an entity recognized as an Award Signatory under the Global Enterprise Risk Management Designation Recognition Treaty. (Eff. 6/11/2005, Register 174; am ____/____/_____, Register _____)

Authority: AS 21.06.090 AS 21.39.040 AS 21.42.120

Chapter 30. Workers' Compensation.

Article 3. Workers' Compensation Review and Advisory Committee.

The citation of authority for 3 AAC 30.200 is changed to read:

Authority: AS 21.06.090 AS 21.39.090 AS 21.39.120

AS 21.39.060 [AS 21.39.100] AS 21.39.155

Chapter 31. Miscellaneous.

Article 1. Fees.

The citation of authority for 3 AAC 31.050 is changed to read:

Authority:	AS 21.06.090	AS 21.12.020	AS 21.85.030
	AS 21.06.250	**AS 21.66.080**	AS 21.85.040
	AS 21.09.130	AS 21.85.010	AS 21.85.100
	AS 21.09.200		

3 AAC 31.060(a)(33) is amended to read:

(33) air ambulance service provider renewal biennial registration application fee, $200; [.]

3 AAC 31.060(a) is amended by adding new paragraphs to read:

(34) health discount plan initial biennial registration application fee, $1,000;

(35) health discount plan renewal biennial registration application fee, $200;

(36) returned check fee, $25.

(Eff. 6/2/88, Register 106; am 7/1/89, Register 110; am 7/1/92, Register 123; am 3/30/94, Register 129; am 3/15/97, Register 141; am 8/23/2001, Register 159; am 12/30/2006, Register

Register _____, _____ 2016 COMMERCE, COMMUNITY, AND EC. DEV.

180; am 10/13/2011, Register 200; am 1/1/2014, Register 208; am 9/4/2014, Register 211; am

_____/_____/_____, Register _____)

Authority:	AS 21.06.090	AS 21.36.355	AS 21.61.109
	AS 21.06.250	**AS 21.36.505**	AS 21.66.210
	AS 21.27.025	AS 21.61.105	AS 21.75.045
	AS 21.34.040		

Article 2. Filing Procedure for Forms, Rates, Manuals, Rating Plans, and Rules.

3 AAC 31.205(a) is repealed and readopted to read:

(a) A person shall submit a filing electronically by

(1) using an electronic filing system approved by the director under AS 21.96.080; or

(2) electronic mail, if approved by the director.

(Eff. 11/12/2006, Register 180; am ____/____/____, Register ____)

Authority:	AS 21.06.090	AS 21.42.123	AS 21.84.255
	AS 21.39.040	AS 21.42.125	AS 21.86.070
	AS 21.39.041	AS 21.57.080	AS 21.87.180
	AS 21.39.210	AS 21.66.370	AS 21.87.190
	AS 21.39.220	AS 21.66.450	AS 21.96.080
	AS 21.42.120		

Editor's note: [THE ADDRESS FOR MAILING A FILING TO THE DIRECTOR IS DIRECTOR OF INSURANCE, RATE AND FORM FILINGS, DIVISION OF INSURANCE, P.O. BOX 110805, JUNEAU, ALASKA 99811-0805. THE ADDRESS FOR PERSONAL DELIVERY OF A FILING IS 333 WILLOUGHBY AVENUE, STATE OFFICE BUILDING, NINTH FLOOR, JUNEAU, ALASKA.]

In 2010 the revisor of statutes, acting under AS 01.05.031, renumbered former AS 21.89.080 as AS 21.96.080. As of Register 196 (January 2011), the regulations attorney made a conforming technical revision under AS 44.62.125(b)(6), to 3 AAC 31.205(a), so that the cross-reference to former AS 21.89.080 now refers to the renumbered statute, AS 21.96.080. In addition, the regulations attorney made a conforming technical revision to the authority citation that follows 3 AAC 31.205, so that the citation to former AS 21.89.080 now refers to the renumbered statute, AS 21.96.080.

3 AAC 31.210 is repealed and readopted to read:

3 AAC 31.210. Filing. (a) Each filing submitted to the director by electronic mail must include the appropriate transmittal document as described in 3 AAC 31.221 or 3 AAC 31.225. The transmittal document is considered part of the filing. Each filing submitted using an electronic filing system approved under AS 21.96.080 by the director must include the information specified in the transmittal document as described in 3 AAC 31.221 or 3 AAC 31.225 in the appropriate fields.

(b) Except as provided in (d)(1) – (3) and (e) of this section, a separate filing must be made for each type of insurance.

(c) Forms must be submitted separately from rates and rules.

(d) For property and casualty types of insurance,

(1) private passenger auto liability and private passenger auto physical damage types of insurance may be submitted in a single filing;

(2) commercial auto liability and commercial auto physical damage types of insurance may be submitted in a single filing;

(3) new rates, rules, or forms that apply to different or multiple types of insurance but have the same purpose and effect, or revisions or replacements to existing rates, rules, or forms that apply to different or multiple types of insurance where the proposed revisions have the same purpose and effect, may be submitted in a single filing;

(4) rates and rules may be submitted in a single filing when filed under AS 21.39.041 or AS 21.39.220;

(5) rates filed under AS 21.39.210 may only contain rules that are revised to update the corresponding rate changes; and

(6) if rate, rule, and form filings for a single program are submitted at the same time, the transmittal document for each filing must cross-reference the other filings submitted for the program.

(e) For life, annuity and health types of insurance offered to employer groups, a single filing with multiple life, annuity and health types of insurance may be filed.

(f) Except for health care insurance rates or forms and subject to the requirements in (b) and (d) of this section, insurers with the same National Association of Insurance Commissioners' group number may submit substantially similar rates, rules, or forms

(1) in a single filing for all insurers if the filing

(A) contains the name of each insurer;

(B) clearly describes the differences between the rates, rules, or forms if they differ by insurer; and

(C) clearly identifies which insurer will use each rate, rule, or form; or

(2) in separate filings for each insurer if the filing

(A) cross-references any substantially similar filings for other insurers in the group that are submitted simultaneously or have already been submitted; and

(B) describes any differences in the rates, rules, or forms submitted in each filing.

(g) An insurer shall include in each applicable filing a cross-reference to other similar or related filings that are submitted simultaneously with the new filing or other similar or related filings that have already been submitted. The filing must describe any differences between the new rates, rules, or forms in the new filing and any similar or related filing.

(h) If a filing is a revision to or replacement of an existing rate, rule, or form, the filing must include each assigned identification number under which the material proposed for revision is currently approved or authorized. The filing must also include a marked copy of the form, rule, or rate page showing the new material underlined and the deleted material with a line stricken through it, or by a similar method of identifying changes that has been approved by the director.

A revised or replaced item that is not identified as required may not be approved or authorized for use.

(i) If a filing is a resubmission of a prior filing that was withdrawn or disapproved, the filing must include the identification number assigned to the withdrawn or disapproved filing and must specifically address any questions or comments raised by the director with respect to the withdrawn or disapproved filing. The filing must also include a marked copy of the form, rule or rate page showing the new material underlined and the deleted material with a line stricken through it, or by a similar method of identifying changes that has been approved by the director. A revised or replaced item that is not identified as required may not be approved or authorized for use.

(j) Upon receipt of a filing, the director will assign an identification number to the filing. All subsequent communications regarding the filing must include the assigned identification number.

(k) If the filing does not include the information required under 3 AAC 31.221 or 3 AAC 31.225 and all other information required under this section, the director may reject the filing and the rate, rule, or form may not be used.

(*l*) If an insurer's response to questions asked by the director does not provide all the information requested or is submitted to the director less than five days before the expiration of the waiting period and an extension under AS 21.42.125, the director will disapprove the filing or consider the failure of an adequate response to be a request to withdraw the filing.

(m) An insurer may not issue insurance to a resident of this state under a group including an out-of-state group that does not meet the requirements of AS 21.54.060 for health insurance,

AS 21.54.070 for blanket insurance and AS 21.48.010 for life insurance. Prior to issuing coverage to a resident of this state through a policy issued to an association or trust including a union trust an insurer must file and obtain approval of each association or trust through which a resident of this state will be issued coverage subject to the following:

(1) if the constitution or by-laws of the association or trust are modified, the insurer must refile and obtain approval of the association or trust;

(2) the filing for approval of the association or trust must be submitted separately from the forms that will be issued to the association or trust unless the form will be issued exclusively to the association or trust.

(n) Life and health insurers submitting a form filing consisting of endorsements, applications, declarations, or schedules that will be attached to a previously approved or authorized policy or coverage form must include the identification number of the filing in which the policy or coverage form was approved or authorized.

(o) A filing is not required if the only change to the form is a change to the insurer's logo. (Eff. 12/4/94, Register 132; am 11/12/2006, Register 180; am 1/1/2011, Register 196; am ____/____/____, Register ____)

Authority:

AS 21.06.090	AS 21.42.123	AS 21.84.255
AS 21.39.040	AS 21.42.125	AS 21.86.070
AS 21.39.041	AS 21.57.080	AS 21.87.180
AS 21.39.210	AS 21.66.370	AS 21.87.190
AS 21.39.220	AS 21.66.450	**AS 21.96.080**
AS 21.42.120		

[**EDITOR'S NOTE:** THE ADDRESS FOR MAILING A FILING TO THE DIRECTOR IS DIRECTOR OF INSURANCE, RATE AND FORM FILINGS, ALASKA DIVISION OF INSURANCE, P.O. BOX 110805, JUNEAU, ALASKA 99811-0805.]

The section heading of 3 AAC 31.215 is changed to read:

3 AAC 31.215. Filings submitted by electronic mail [PAPER FILINGS].

3 AAC 31.215(a) is amended to read:

(a) A [PAPER] filing **submitted by electronic mail** must include

(1) **a copy** [THREE COPIES] of the appropriate transmittal document described in 3 AAC 31.221 or 3 AAC 31.225; **and**

(2) **a** [ONE] copy of the filing materials and supporting documentation [; AND

(3) TWO SELF-ADDRESSED, STAMPED ENVELOPES].

3 AAC 31.215(b) is amended to read:

(b) The director will **respond to a filing submitted by electronic mail** [STAMP THE TRANSMITTAL DOCUMENTS OF A PAPER FILING] with the receipt date and with the assigned identification number under 3 AAC 31.210(j). [THE DIRECTOR WILL RETURN ONE COPY OF THE STAMPED TRANSMITTAL DOCUMENT TO THE FILER.] The appropriate timeline under AS 21.39.040, 21.39.041, 21.39.210, 21.39.220; AS 21.42.123, 21.42.125; AS 21.57.080; AS 21.66.370, 21.66.450; AS 21.84.255; AS 21.86.070; or

AS 21.87.180 will apply based upon the receipt date **stated in the director's response** [STAMPED ON THE TRANSMITTAL DOCUMENT].

3 AAC 31.215(d) is amended to read:

(d) A response to questions from the director must be submitted in **the same** [A] format **in which the filing was originally submitted** [SPECIFIED IN THE COMMUNICATION FROM THE DIVISION EMPLOYEE. A RESPONSE TO QUESTIONS FROM A DIVISION EMPLOYEE MAY BE SUBMITTED BY FACSIMILE TRANSMISSION OR BY ELECTRONIC MAIL IF SPECIFICALLY ALLOWED IN THE COMMUNICATION FROM THE DIVISION EMPLOYEE. AN INSURER SUBMITTING A PAPER FILING UNDER AS 21.42.125 SHALL SUBMIT ANY SUBSEQUENT COMMUNICATION WITH THE DIVISION BY ELECTRONIC MAIL OR FACSIMILE TRANSMISSION].

3 AAC 31.215(e) is amended to read:

(e) The director will review filings submitted under AS 21.39.210 and send the contact person **an electronic mail** [LISTED IN THE TRANSMITTAL DOCUMENT A] confirmation that the effective date requested by the insurer is authorized. An insurer shall retain evidence of the authorization for five years after the date the filing is no longer in use.

3 AAC 31.215(f) is amended to read:

(f) If the director approves a filing submitted under AS 21.39.041 or AS 21.42.123, the director will send the contact person **an electronic mail** [LISTED IN THE TRANSMITTAL

DOCUMENT AN] approval stating the effective date. An insurer shall retain evidence of the approval for five years after the date the filing is no longer in use.

3 AAC 31.215(g) is amended to read:

(g) If the director authorizes a filing submitted under AS 21.39.220 or AS 21.42.125 to become effective, the director will send the contact person **an electronic** [LISTED IN THE TRANSMITTAL DOCUMENT A] confirmation of the effective date. An insurer shall retain evidence of the confirmation for five years after the date the filing is no longer in use.

3 AAC 31.215(h) is amended to read:

(h) If the director disapproves a filing, the director will send the contact person **an electronic** [LISTED IN THE TRANSMITTAL DOCUMENT] notification that the filing has been disapproved. An insurer shall retain evidence of the disapproval for five years after the date of disapproval. (Eff. 11/12/2006, Register 180; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.42.123 AS 21.84.255
AS 21.39.040 AS 21.42.125 AS 21.86.070
AS 21.39.041 AS 21.57.080 AS 21.87.180
AS 21.39.210 AS 21.66.370 AS 21.87.190
AS 21.39.220 AS 21.66.450 **AS 21.96.080**
AS 21.42.120

3 AAC 31.217(c) is amended to read:

(c) If the electronic filing system becomes unavailable for use for an extended period of time, the director may authorize communication by **another available method** [ELECTRONIC MAIL OR BY FACSIMILE TRANSMISSION] in order to continue the review of the filing. When the electronic filing system again becomes available for use, the director and the filer will add their respective **filing** [ELECTRONIC MAIL AND FACSIMILE TRANSMISSION] communications to the electronic filing. (Eff. 11/12/2006, Register 180; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.39.040 AS 21.39.041 AS 21.39.210 AS 21.39.220 AS 21.42.120 AS 21.42.123 AS 21.42.125 AS 21.57.080 AS 21.66.370 AS 21.66.450 AS 21.84.255 AS 21.86.070 AS 21.87.180 AS 21.87.190 AS 21.96.080

3 AAC 31.221(a) is amended to read:

(a) The transmittal document **or transmittal document information in the case of filings submitted using an electronic filing system approved by the director under AS 21.96.080** required to be submitted with a life insurance, health insurance, or annuity filing under 3 AAC 31.210 is the National Association of Insurance Commissioners' *Life, Accident & Health, Annuity, Credit Transmittal Document* (LHTD-1), with the appropriate attachment (LH FFA-1 or LH RFA-1). For purposes of this section, the National Association of Insurance

Commissioners' *Life, Accident & Health, Annuity, Credit Transmittal Document* (LHTD-1) **effective as of July 1, 2009** and attachments (LH FFA-1 and LH RFA-1), effective [REVISED] as of January 1, **2009** [2006], are adopted by reference.

(Eff. 11/12/2006, Register 180; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.42.125 AS 21.87.190
AS 21.42.120 AS 21.86.070 **AS 21.96.080**
AS 21.42.123

The introductory language of 3 AAC 31.225(a) is amended to read:

(a) The transmittal document **or transmittal document information in the case of filings submitted using an electronic filing system approved by the director under AS 21.96.080** required under 3 AAC 31.210(a) must include

...

The introductory language of 3 AAC 31.225(d) is amended to read:

(d) Responses to the director's questions on a [PAPER] filing **submitted by electronic mail** must include

...

(Eff. 11/12/2006, Register 180; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.39.220 AS 21.66.370
AS 21.39.040 AS 21.42.120 AS 21.66.450
AS 21.39.041 AS 21.42.123 **AS 21.96.080**

AS 21.39.210 AS 21.43.125

3 AAC 31.230(3) is amended to read:

(3) **support showing** [AN EXPLANATION OF] how investment income was **incorporated into** [CONSIDERED IN] the proposed rate;

(Eff. 12/4/94, Register 132; am 11/12/2006, Register 180; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.39.060 AS 21.39.210

AS 21.09.200 AS 21.39.070 AS 21.39.220

AS 21.39.040 AS 21.39.130 AS 21.66.370

AS 21.39.041

3 AAC 31.235 is repealed and readopted to read:

3AAC 31.235. Health care insurance rate filings. (a) Except as provided in (b) of this section, an insurer may not use or change health care insurance premium rates unless the rates and supporting documentation as required by this section have been filed with and approved by the director. Rates and supporting documentation requested under this section must be filed with the director at least 45 days before the proposed effective date of the new or modified premium rates. A rate filing must be filed annually at least 45 days prior to the end of the rating period, even if no rate change is proposed.

(b) An insurer is not required to file for approval with the director health care insurance premium rates for a large employer health care insurance policy but must submit rates and supporting documentation with the director within 30 days after use for a large employer health insurance policy that is not fully experienced rated. In this subsection, "large employer" means

an employer that employs an average of at least 101 employees on the business days during the preceding calendar year and that employs at least two employees on the first day of a health benefit plan year.

(c) Except as provided in (b) of this section, an insurer shall submit separate filings for individual, small group, and large group policy forms, riders, or endorsements through the National Association of Insurance Commissioners' System for Electronic Rate and Form Filing (SERFF). All applicable filing and rate information fields in the System for Electronic Rate and Form Filing must be completed.

(d) An insurer shall propose the date upon which the proposed health care insurance rates will become effective and shall specify the annual rating period for which the proposed rates will be effective. The proposed effective date may be no later than six months after the date the rate filing is submitted to the director except to the extent necessary to meet any federal filing deadlines.

(e) To develop rates or rate revisions, the insurer shall use the most current reliable data available and to the extent that the experience is credible, an insurer shall use experience specific to the insurer's policyholders in this state and covered individuals in this state. If other experience is used in developing rates or rate revisions, the rates or rate revisions must be

(1) adjusted to be appropriate for this state's benefit, utilization, and cost levels; and

(2) described in the actuarial memorandum required under (g) of this section.

(f) Underwriting adjustments to rates must be documented in detail in the company records and must be objectively determined and actuarially justified.

(g) Except as provided in (h) of this section, a health care insurance rate filing must include an actuarial memorandum with information sufficient to demonstrate that rates are not excessive, inadequate, or unfairly discriminatory. The actuarial memorandum must include the following:

(1) a list of policy forms, riders, and endorsements to which the rates apply, including

(A) a summary of benefits for each policy form, rider, and endorsement;

(B) an indication of whether the policy form, rider, or endorsement is open or closed to new sales;

(C) a description of the marketing method for each policy form, rider, and endorsement;

(D) a description of applicable underwriting standards for each policy form, rider, and endorsement; and

(E) a description of any benefit changes from the previous year for each policy form, rider, and endorsement;

(2) a signed certification by a member of the American Academy of Actuaries stating that, in the opinion of the actuary, the rates are in compliance with the law of this state and are not excessive, inadequate, or unfairly discriminatory;

(3) a description of the reason for the rate revision, if applicable;

(4) by policy form or, if experience is combined for multiple policy forms, for the combined forms, the number of policyholders in this state and covered individuals in this state that will be affected by the proposed rate revision;

(5) by policy form or, if experience is combined for multiple policy forms, for the combined forms, the average, minimum, and maximum rate revision that any policyholder or covered individual would receive;

(6) a description of the rating formula, including each rating assumption and any changes in the rating formula or rating assumptions from the previous year;

(7) the methodology for determining, and the actuarial justification for, each rating assumption or change in rating assumption including a description and a summary of the experience data used in developing the rates or rate revisions;

(8) rate schedules for the specified rating period;

(9) the cost and utilization trend analysis by major service category;

(10) a comparison of the prior year projected experience and actual experience as well as actual-to-expected cost, utilization, and claim trends for the experience period used in developing rates;

(11) the pricing or target loss ratio;

(12) the impact on rates or rate revisions of state or federally mandated benefit changes and the impact of other benefit changes for both essential and non-essential health benefits, including the impact of changes in cost-sharing requirements by major service category on rates or rate revisions;

(13) the impact on rates or rate revisions of changes in actual or expected enrollee risk profile including federal rating limitations on age and tobacco;

(14) the impact of any overestimate or underestimate of medical trend for previous years on proposed rates or rate revisions;

(15) the impact of changes in reserve needs on rates or rate revisions;

(16) the impact of changes in administrative costs related to programs that improve health care quality;

(17) the impact of changes in other administrative costs on rates or rate revisions;

(18) the impact of changes in applicable taxes, licensing, or regulatory fees on rates or rate revisions;

(19) projected rebates to policyholders in this state under 42 U.S.C. 300gg - 300gg-95;

(20) for each of the most recent 48 months for each policy form or, if experience is combined for multiple policy forms, for the combined forms:

(A) earned premiums;

(B) paid claims;

(C) incurred claims;

(D) incurred loss ratio;

(E) the number of covered individuals in this state;

(F) the number of member-months;

(G) expected loss ratio;

(21) rate revisions and implementation dates by policy form for the four years before the date of filing;

(22) company capital and surplus, company revenues, and company liabilities for the four years before the date of filing;

(23) rebates paid to policyholders in this state under 42 U.S.C. 300gg - 300gg-95;

(24) the impact of

(A) geographic factors and variations;

(B) changes within a single risk pool to all products or plans within the risk pool;

(C) any reinsurance or risk adjustment payments and charges under 42 U.S.C. 300gg;

(25) other information requested by the director.

(h) If an insurer does not actively market health care insurance in this state but provides health care insurance coverage to a resident of this state through an out-of-state single employer insured group plan, the insurer must submit the rates applicable to the residents of this state and in lieu of the information required under (g) of this section may submit the rate filing approved by the state where the group is located. If the state where the group is located does not require filing and approval of rates, the insurer must submit the information required under (g) of this section.

(i) If an insurer's response to a request for additional information by the director is inadequate or is submitted to the director later than five days before the expiration of the waiting or extension period under AS 21.51.405 or AS 21.54.015, the director may disapprove the filing.

(j) The director will hold a rate filing confidential until the date that the rates become effective and under AS 21.06.060(g) will continue to hold the following rate filings or information provided within a rate filing confidential on and after the effective date:

(1) a large group rate filing;

(2) a rate filing for a specific group including as association rate filing;

(3) a grandfathered plan rate filing;

(4) third party data and analysis purchased by the insurer and used in developing the rates. (Eff. 1/1/2012, Register 200; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.51.405 AS 21.54.015

3 AAC 31.250(b) is repealed and readopted to read:

(b) Text or numbers in a form that may vary must be bracketed or otherwise clearly and consistently identified in the form and a statement of variability must be submitted with the form that describes the conditions under which each variable text or number may change and describes any relationship between the variable text or numbers. All ranges or options for text or numbers that are subject to a statutory mandate or that define coverage must be identified in the statement of variability. Benefit schedules must not be entirely variable or illustrative.

3 AAC 31.250(c) is amended to read:

(c) A blank endorsement, rider, or form may not be submitted in a filing **unless included with the filing are the full range of possible variable language options along with a description of when each variable language option will be used**.

The introductory language of 3 AAC 31.250(e)(2) is amended to read:

(2) **a new** [AN] optional component may be submitted separately from the base policy form if the filing clearly states the [DIRECTOR'S] assigned filing numbers for

...

3 AAC 31.250(e)(3) is repealed:

(3) repealed ____/____/____;

3 AAC 31.250(e)(4) is repealed:

(4) repealed ____/____/____.

3 AAC 31.250 is amended by adding new subsections to read:

(f) A filing for a revision to a base policy form or an optional component must include a listing of all associated forms and their state filing numbers or a copy of all associated forms and corresponding state filing numbers.

(g) For life and health insurance eligibility rules must be specified in the form.

(h) For life and health insurers insurance company contact information including company address, telephone number, Internet address and officer signatures must be specified in the form and made variable following the requirements under (b) of this section.

(i) Insurance department contact information that may be included in a form must be variable following the requirements under (b) of this section.

(j) A contract may not contain discretionary language under which the insurer reserves discretion to interpret a provision of the insurance policy. (Eff. 11/12/2006, Register 180; am ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.42.125 AS 21.86.070

AS 21.42.120 AS 21.66.450 AS 21.87.180

AS 21.42.123

Article 6. Health Discount Plans

3 AAC 31 is amended by adding new sections to read:

Section

700. Applicability

710. Term of registration period; renewal

720. Health discount plan registration

730. Examinations

740. Reinstatement, suspension, or revocation of registration

750. Records

790. Definitions

3 AAC 31.700. Applicability. 3 AAC 31.700 – 3 AAC 31.760 apply to all health discount plans subject to AS 21.36.505. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.505

3 AAC 31.710. Term of registration period; renewal. (a) An initial health discount plan biennial registration period ends on June 30 of the renewal year assigned by the division at the time the director approves initial health discount plan registration. Except as provided in (b) of this section, the initial health discount plan biennial registration period consists the remainder

of the calendar year in which the health discount plan registration is approved and the first six months of the following calendar year.

(b) If the director approves a health discount plan registration on or after April 1, but before January 1, the health discount plan registration period consists of the remainder of the calendar year in which the health discount plan registration is approved and all of the following 18 months.

(c) A health discount plan registrant's biennial registration period ends on June 30 of the provider's biennial registration period. A registrant is responsible for knowing the date that a registrant's biennial registration period ends. To renew a registration, a registrant must submit a renewal health discount plan registration application for the next health discount plan biennial registration period June 1 of the year the registrant's biennial registration period ends. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.505

3 AAC 31.720. Health discount plan registration. (a) A person may not sell, solicit or negotiate a health discount plan in this state unless registered as a health discount plan under this section. Renewal health discount plan registration applications must be filed on or before June 1 of the year the registrant's current health discount plan biennial registration period ends.

(b) An initial health discount plan registration application must include

(1) payment of the initial biennial registration application fee under 3 AAC 31.060(a)(34);

(2) a completed health discount plan application form prescribed by director that includes

(A) a listing of all states in which the applicant holds or has applied for a license, registration, or certificate of authority to transact business as a health discount plan along with the license, registration or certification number for each state;

(B) complete physical address, mailing address, electronic mail address, phone number, and facsimile number of the

(i) applicant's principal place of business in the applicant's state of domicile; and

(ii) applicant's principal place of business in this state;

(C) electronic mail address the applicant wants the division to use to communicate with the applicant;

(D) Internet address of the applicant;

(E) federal employer identification number of the applicant;

(F) current number of health discount plan members in this state;

(G) the name, address and telephone number of each person the health discount plan registrant has authorized to market the health discount plan in this state; and

(H) a certification by an officer or authorized representative of the health discount plan that the information provided to the director in the application for registration is accurate and complete;

(3) a biographical information affidavit for each officer, director, and person acting in a fiduciary capacity that includes

(A) the affiant's full name;

(B) the physical address, mailing address, electronic mail address, telephone number, and facsimile number where the affiant works;

(C) the affiant's employment record for the past 10 years which includes for each office and position held the

(i) affiant's title;

(ii) beginning and ending dates;

(iii) employer's name, address, and telephone number;

(iv) type of business; and

(v) name of the affiant's supervisor or contact person;

(D) description of any judicial, administrative, regulatory, or disciplinary action during the past 10 years taken against any occupational, professional, or vocational license or permit the affiant holds or has held;

(E) any guilty or nolo contendere plea, or conviction of a crime during the past 10 years, other than a minor traffic violation; and

(F) any civil action in which the affiant is or was a party during the past 10 years involving dishonesty, breach of trust, or a financial dispute;

(4) all health discount plan forms including member applications, member contracts, and preferred provider agreements;

(5) a description of the proposed method of marketing and a copy of all sales scripts and other marketing materials including all Internet addresses;

(6) a description of any consideration charged in exchange for discount plan access, including any fee, due, or charge;

(7) a listing of each participating provider included in the network that provides medical services in this state and a list of the services each provider offers;

(8) a copy of the form of all contracts made or to be made between the health discount plan and a provider regarding the provision of health care services to members;

(9) a copy of the form of any contract made or to be made between the health discount plan and a person for the performance on the applicant's behalf of any function, including marketing, administration, enrollment and subcontracting for the provision of health care services to members;

(10) a description of the member complaint procedures established and used by the health discount plan;

(11) a description of the health discount plan's experience and expertise to operate a health discount plan;

(12) a detailed description of the criteria used in determining who is eligible for a health discount plan;

(13) a copy of the applicant's articles of incorporation, bylaws or other enabling documents, including amendments, that establish the organizational structure and governance of the applicant;

(14) a statement generally describing the applicant, the applicant's facilities and personnel, and the medical services for which discounts will be available;

(15) a plan demonstrating actions the applicant will take should the applicant cease operations;

(16) the name and address of the applicant's agent for service of process, notice or demand, or an executed power of attorney appointing the director as the attorney of the applicant in this state for service of process for a cause of action arising in this state; and

(17) other information the director reasonably requires.

(c) In complying with (b)(3)(D), (E), and (F) of this section, no response is required if a record has been sealed or expunged, and the affiant has personally verified that the record was sealed of expunged. If a response is required, the affiant shall provide the

(1) nature of the action or crime;

(2) date;

(3) location; and

(4) disposition.

(d) A renewal health discount plan registration application must include

(1) the renewal biennial registration application fee under 3 AAC 31.060(a)(35); and

(2) all of the requirements under (b)(2) – (17) and (c) of this section.

(e) If a change occurs in the information submitted to the director in a registration application, a health discount plan registrant shall update the information in the registration application by sending the changes to the director in writing within 30 days after the change. If

an officer, director, or person acting in a fiduciary capacity is appointed after the registration application has been filed with the director, the health discount plan registrant shall file a biographical information affidavit not later than 30 days after the appointment of the person.

(f) The following information received by the director under this section is confidential and not subject to public inspection:

(1) biographical information affidavits;

(2) information that is confidential under AS 21.06.060. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.505

3 AAC 31.730. Examinations. (a) The director may examine or investigate the business and affairs of a health discount plan and may

(1) order a health discount plan registrant or applicant for registration under 3 AAC 31.720 to produce records, books, files, advertising and solicitation materials, and other information; and

(2) take statements under oath to determine whether the health discount plan registrant or applicant is in violation of the law or is acting contrary to the public interest.

(b) A health discount plan registrant or applicant for registration under 3 AAC 31.720 that is examined or investigated under (a) of this section shall pay any expense incurred by the division in conducting the examination or investigation. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.505

3 AAC 31.740. Reinstatement, suspension, or revocation of registration. (a) If a registrant fails to file its registrant renewal biennial registration application for the next biennial renewal period by July 30 in the year the registrant's biennial registration period ends, the registrant may not solicit or write a new agreement in this state until the registrant submits a registrant renewal biennial registration application under 3 AAC 31.710 and pays the fee under 3 AAC 31.060(a).

(b) The director, after a hearing, may suspend or revoke a health discount plan registration for any of the following causes:

(1) failure to meet the health discount plan registration application requirements under 3 AAC 31.720;

(2) failure to comply with AS 21.36.505, 3 AAC 31.730, and 3 AAC 31.750;

(c) Suspension of a health discount plan's registration shall be for a fixed period of time determined by the director, or until the occurrence of a specific event necessary for remedying the reasons for suspension. The director may modify, rescind or reverse a suspension under this section.

(d) During the period of suspension, the health discount plan registrant

(1) may not solicit or write any new member agreements in this state;

(2) shall file its renewal biennial health discount plan registration application and pay the renewal biennial registration application fee required under 3 AAC 31.060; and

(3) may service its outstanding member agreements in force in this state as if the registration had continued in full force. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.505 AS 21.36.910

3 AAC 31.750. Records. (a) A health discount plan registrant shall establish and maintain on an annual basis complete and accurate records and accounts of the health discount plan's transactions and operations in this state.

(b) A health discount plan registrant shall reply in writing within 10 working days to a records inquiry of the director. The director may inspect or request summary or detailed copies of records and accounts for examination by the division. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.36.505

3 AAC 31.790. Definition. The term "health discount plan" has the meaning given in AS 21.97.900.