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OFFICE OF THE LIEUTENANT GOVERNOR
ALASKA

MEMORANDUM

TO: Chip Wagoner, Division of Insurance

FROM: Scott Meriwether, Office of the Lieutenant Governor
465-4081

DATE: July 21, 2016

RE: Filed Permanent Regulations: Division of Insurance

omnibus update to insurance regulations, particularly regarding record-keeping (3 AAC 21.480; 3 AAC 23.860(a); 3 AAC 25.060; 3 AAC 26.040(d); 3 AAC 26.050(c); 3 AAC 26.070(d),(e); 3 AAC 26.075; 3 AAC 26.110; 3 AAC 26.300; 3 AAC 26.755(a),(e); 3 AAC 26.769; 3 AAC 28.370; 3 AAC 29.500; 3 AAC 29.550(2)(F); 3 AAC 30.200; 3 AAC 31.050; 3 AAC 31.060(a)(34); 3 AAC 31.205 - 3 AAC 31.250)

Attorney General File:	JU2015200862
Regulation Filed:	July 21, 2016
Effective Date:	August 20, 2016
Print:	Register 219, October 2016

cc with enclosures: Linda Miller, Department of Law
Dianne Blumer, Administrative Regulation Review Committee
Judy Herndon, LexisNexis

ORDER RA 16-01a ADOPTING CHANGES TO
REGULATIONS OF THE DIVISION OF INSURANCE

The attached 34 pages of regulations dealing with filings, recordkeeping, licensee renewal dates, delivery of evidence of insurance, insurance claims, annuity contract disclosures, definitions, and the imposition of a return check fee are hereby adopted and certified to be a correct copy of the regulation changes that the Division of Insurance adopts to 3 AAC 21.480; 3 AAC 23.860; 3 AAC 25.060; 3 AAC 26.040; 3 AAC 26.050; 3 AAC 26.070: 3 AAC 26.075; 3 AAC 26.110; 3 AAC 26.300; 3 AAC 26.755; 3 AAC 26.769; 3 AAC 28.370; 3 AAC 29.500; 3 AAC 29.550; 3 AAC 30.200; 3 AAC 31.050; 3 AAC 31.060; 3 AAC 31.205; 3 AAC 31.210; 3 AAC 31.215; 3 AAC 31.217; 3 AAC 31.221; 3 AAC 31.225; 3 AAC 31.230; 3 AAC 31.235; and 3 AAC 31.250, under the authority of AS 21.06.090; AS 21.06.250; AS 21.27.380; AS 21.34.250; AS 21.36.125; AS 21.39.040; AS 21.39.130; AS 21.39.210; AS 21.42.120; AS 21.42.205; AS 21.54.015; AS 21.66.370; AS 21.69.390; AS 21.96.080, and implementing, interpreting, or making specific AS 21.09.200; AS 21.12.050; AS 21.12.130; AS 21.27.380; AS 21.34.100; AS 21.36.020; AS 21.36.030; AS 21.36.040; AS 21.36.050; AS 21.36.125; AS 21.36.495; AS 21.36.910; AS 21.39.040; AS 21.39.041; AS 21.39.060; AS 21.39.070; AS 21.39.130; AS 21.42.120; AS 21.42.123; AS 21.42.125; AS 21.42.205; AS 21.51.405; AS 21.54.015; AS 21.54.020; AS 21.57.080; AS 21.66.080; AS 21.66.370; AS 21.66.450; AS 21.69.390; AS 21.84.255; AS 21.86.070; AS 21.87.180; AS 21.87.190; AS 21.96.030; and AS 21.96.080, and after compliance with the Administrative Procedure Act (AS 44.62), specifically including notice under AS 44.62.190 and 44.62.200 and opportunity for public comment under AS 44.62.210.

This action is not expected to require an increased appropriation.

In considering public comments, the Division of Insurance paid special attention to the cost to private persons of the regulatory action being taken.

The regulations adopted under this order take effect on the 30th day after they have been filed by the lieutenant governor.

DATED July 18th, 2016

Lori Wing-Heier
Director
Division of Insurance
Department of Commerce, Community, and
Economic Development

v Claire Richardson for

FILING CERTIFICATION

I, Byron Mallott, Lieutenant Governor for the State of Alaska, certify that on July 21, 2016, at 12:14 p.m., I filed the attached regulations according to the provisions of AS 44.62.040 - 44.62.120.

for Lieutenant Governor Byron Mallott

Effective August 20, 2016

Register 219, October 2016

FOR DELEGATION OF THE LIEUTENANT GOVERNOR'S AUTHORITY

I, BYRON MALLOTT, LIEUTENANT GOVERNOR OF THE STATE OF ALASKA, designate the following state employee to perform the Administrative Procedures Act filing functions of the Office of the Lieutenant Governor:

Claire Richardson, Special Assistant

IN TESTIMONY WHEREOF, I have signed and affixed the Seal of the State of Alaska, in Juneau, on January 7th 2015.

.....

BYRON MALLOTT
LIEUTENANT GOVERNOR

Title 3. Commerce, Community, and Economic Development.

Part 2. Division of Insurance.

Chapter 21. Insurer - Financial.

Article 3. Record and Financial Reporting.

(((Publisher: To reflect the addition of new 3 AAC 21.480(b), please make the existing text of 3 AAC 21.480 subsection (a).)))

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 **proceedings** [MEETINGS] of **shareholders, members,** the board of directors, and **each committee of the board of directors** [THE 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 **committee** [SUBCOMMITTEE] of the board **of directors** that must be adopted or approved by the board [OR A SUBCOMMITTEE OF THE BOARD] under AS 21.

3 AAC 21.480 is amended by adding a new subsection to read:

(b) In this section, "committee of the board of directors" means a committee in which a majority of the members of the committee are members of the board of directors. (Eff. 10/21/92, Register 124; am 8/20/2016, Register 219)

Authority: AS 21.06.090 AS 21.69.390

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

Article 6. General Provisions.

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** [BIRTHDAY] 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 8/20/2016, Register 219)

Authority: AS 21.06.090 AS 21.27.380

Chapter 25. Surplus Lines – Unauthorized Insurers.

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 **not** [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 8/20/2016, Register 219)

Authority: AS 21.06.090 AS 21.34.100 AS 21.34.250

Chapter 26. Trade Practices.

Article 1. Unfair Claims Settlement Acts or 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 8/20/2016, Register 219)

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 8/20/2016, Register 219)

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, the check 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 8/20/2016, Register 219)

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 include an arbitration provision in an insurance contract subject to the following:

(1) the insurer and the insured must agree to the arbitration provision;

(2) the arbitration provision must describe the manner for

(A) initiating the arbitration process; and

(B) appointing the arbitrator; the descriptions required in (A) of this paragraph and this subparagraph may be accomplished by reference to a specific arbitration entity or arbitration rules;

(3) the insurer and the insured must agree to the venue of an arbitration proceeding before the proceeding begins; if no agreement on the venue of an arbitration proceeding is reached, the insurer, insured, or both jointly may request the director to make the venue determination after a hearing;

(4) a participant in an arbitration proceeding must have the option of participating by telephone;

(5) except as otherwise provided in AS 21.96.020(f), AS 09.43 must govern the agreement to arbitrate; and

(6) the insurer must retain in the insurer's records documentation to establish the insurer or the insurer's agent specifically informed the insured, before the insured entering into the insurance contract, of

(A) the arbitration provision in the insurance contract; and

(B) the right of a participant in an arbitration proceeding to participate by telephone; the insurer shall retain the documentation required under this paragraph for the longer of four years or until the arbitration provision is no longer in effect or contested. (Eff. 8/20/2016, Register 219)

Authority: AS 21.06.090 AS 21.42.120 AS 21.42.130
AS 21.36.125

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

(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 and a delay in receiving the drug would threaten the efficacy of treatment or the life of the covered individual.

(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 and a delay in receiving the transplant services would threaten the efficacy of treatment or the life of the covered individual.

(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 under AS 21.36.495, the insurer is subject to the 15 percent interest penalty under AS 21.36.495(c) or (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 12/16/2015, Register 216; am 8/20/2016, Register 219)

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 8/20/2016;

3 AAC 26.300(9) is repealed:

(9) repealed 8/20/2016;

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

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

(17) "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;

(18) "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent person who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in serious impairment of bodily functions, serious

dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

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

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

(21) "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;

(22) "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; am 6/6/2015, Register 214; am 8/20/2016, Register 219)

Authority: AS 21.06.090 AS 21.36.125 **AS 21.36.495**

AS 21.12.050

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 8/20/2016, Register 219)

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*, DATED 1999] and adopted by reference;

3 AAC 26.769(4) is repealed:

(4) repealed 8/20/2016;

(Eff. 7/25/2008, Register 187; am 8/20/2016, Register 219)

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

Editor's note: The National Association of Insurance Commissioners' ***Buyer's Guide for Deferred Annuities Fixed*, dated 2013 and adopted by reference in 3 AAC 26.769** [*BUYER'S GUIDE TO FIXED DEFERRED ANNUITIES*, DATED 1999 AND *BUYER'S GUIDE TO FIXED DEFERRED ANNUITIES WITH APPENDIX FOR EQUITY-INDEXED ANNUITIES*, DATED 1999], 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 8/20/2016, Register 219)

Chapter 29. Property, Casualty, and Related Insurance.

Article 6. 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 8/20/2016, Register 219)

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 8/20/2016, Register 219)

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) is amended by adding new a paragraph to read:

(34) 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 180; am 10/13/2011, Register 200; am 1/1/2014, Register 208; am 9/4/2014, Register 211; am 11/26/2015, Register 216; am 8/20/2016, Register 219)

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 8/20/2016, Register 219)

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

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 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 under (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. Before 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 the director's approval for each association or trust through which a resident of this state will be issued coverage subject to the following:

(1) if the constitution or bylaws 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 subject to filing under AS 21.42.120 that will be issued to the association or trust unless the forms 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 8/20/2016, Register 219)

Authority:

AS 21.06.090	AS 21.42.125	AS 21.66.450
AS 21.39.040	**AS 21.48.010**	AS 21.84.255
AS 21.39.041	**AS 21.54.060**	AS 21.86.070
AS 21.39.210	**AS 21.54.070**	AS 21.87.180
AS 21.39.220	AS 21.57.080	AS 21.87.190
AS 21.42.120	AS 21.66.370	**AS 21.96.080**
AS 21.42.123		

[**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

(1) in the same format in which the filing was originally submitted; or

(2) in a different format if the format is approved by the director [IN A FORMAT 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 8/20/2016, Register 219)

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 8/20/2016, Register 219)

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 8/20/2016, Register 219)

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 8/20/2016, Register 219)

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 8/20/2016, Register 219)

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:

3 AAC 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 before 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 not later than 30 days after use for a large employer health insurance policy that is not fully experience-rated. In this subsection, "large employer" means an employer that employs an average of at least 51 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 not 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, 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 under (g) of this section.

(f) Underwriting adjustments to rates must be

(1) documented in detail in the company records;

(2) objectively determined; and

(3) 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

(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. 18061 and 18063; and

(25) other information requested by the director.

(h) An insurer that 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 is exempt from the requirements 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 an 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 8/20/2016, Register 219)

Authority: **AS 21.06.060** AS 21.51.405 AS 21.54.015

AS 21.06.090

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 may 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 is 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

...

(((Publisher : To reflect the repeal of 3 AAC 31.250(e)(3) and (4), please relocate the "and" connector at the end of 3 AAC 31.250(e)(3) so that it follows 3 AAC 31.250(e)(1)(B)(ii), to reflect that 3 AAC 31.250(e) now breaks out into only two "live" paragraphs.)))

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

(3) repealed 8/20/2016;

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

(4) repealed 8/20/2016.

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

(f) For life and health insurance, a filing for a revision to a base policy form or an optional component must include a listing of all associated forms and their assigned filing numbers or a copy of all associated forms and corresponding assigned 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 the company address, telephone number, Internet address, and officer signatures must be

(1) specified in the form; and

(2) 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. In this subsection, "insurance department" means an insurance regulatory organization whose chief insurance regulator is a member of the National Association of Insurance Commissioners.

(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 3/26/2015, Register 213; am 8/20/2016, Register 219)

Authority: AS 21.06.090 AS 21.42.125 AS 21.86.070
AS 21.42.120 AS 21.42.160 AS 21.87.180

AS 21.42.123 AS 21.66.450