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BY THE LABOR AND
COMMERCE COMMITTEE

1 IN THE HOUSE

2

CS FOR HOUSE BILL NO. 589 (L&C)

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

FOURTEENTH LEGISLATURE - SECOND SESSION

5

A BILL

6 For an Act entitled: "An Act relating to disability insurance; and provid-
7 ing for an effective date."

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

9 * Section 1. AS 21 is amended by adding a new chapter to read:

10

CHAPTER 55. STATE DISABILITY INSURANCE.

11

ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

12

13 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a
14 nonprofit incorporated legal entity to be known as the Comprehensive
15 Disability Insurance Association. Membership consists of all licensed
16 hospital or medical service corporations in the state and all insurers
17 licensed to transact disability insurance in the state who offer
18 policies for major medical coverage on an expense incurred basis. All
19 members shall maintain membership in the association as a condition of
20 doing disability insurance business in the state.

21

22 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of
23 directors of the association shall be made up of seven individuals
24 selected by participating members, subject to approval by the director
25 of the division of insurance. The director or the director's designee
26 shall serve as a nonvoting ex officio member of the board. In deter-
27 mining voting rights at members' meetings, a member is entitled to
28 vote in person or proxy. The vote shall be a weighted vote based upon
29 the member's premiums or subscriber fees derived from or on behalf of
state residents in the previous calendar year, as determined by the
director. In approving members of the board, the director shall

1 consider, among other things, whether all types of participating
2 members are fairly represented. Members of the board other than the
3 director or the director's designee may be reimbursed from the asso-
4 ciation for expenses incurred by them as members, but may not other-
5 wise be compensated by the association for their services. The costs
6 of conducting meetings of the association and its board of directors
7 shall be borne by members of the association.

8 Sec. 21.55.030. GENERAL POWERS. The association may

9 (1) exercise the powers granted to insurers under the laws
10 of the state;

11 (2) sue or be sued;

12 (3) enter into contracts with insurers, similar associa-
13 tions in other states, or with other persons for the performance of
14 administrative functions;

15 (4) establish administrative and accounting procedures for
16 the operation of the association.

17 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall
18 submit to the director a plan of operation and any amendments neces-
19 sary or suitable to assure the fair, reasonable, and equitable admin-
20 istration of the association. The plan of operation and amendments
21 become effective upon approval in writing by the director. If the
22 association fails to submit a suitable plan of operation by a date
23 that is 120 days after the effective date of this Act, or if at any
24 subsequent time the association fails to submit suitable amendments to
25 the plan, the director shall, after notice and hearing, adopt reason-
26 able regulations necessary or advisable to effectuate the provisions
27 of this chapter. These regulations shall continue in force until
28 modified by the director or superseded by a plan submitted by the
29 association and approved by the director.

1 (b) All members of the association shall comply with the plan of
2 operation.

3 (c) The plan of operation shall

4 (1) establish the procedures whereby all the powers and
5 duties of the association under this chapter will be performed;

6 (2) establish procedures for handling assets of the asso-
7 ciation;

8 (3) establish the amount and method of reimbursing members
9 of the board of directors under AS 21.55.020;

10 (4) establish regular places and times for meetings of the
11 board of directors;

12 (5) establish procedures for records to be kept of all
13 financial transactions of the association, its agents, and the board
14 of directors;

15 (6) provide that any member insurer aggrieved by a final
16 action or decision of the association may appeal to the director
17 within 30 days after the action or decision;

18 (7) establish the procedures whereby selections for the
19 board of directors will be submitted to the director;

20 (8) contain additional provisions necessary or proper for
21 the execution of the powers and duties of the association.

22 Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association
23 is exempt from the Administrative Procedure Act (AS 44.62).

24 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from
25 the payment of fees and taxes levied by the state or any of its polit-
26 ical subdivisions except taxes levied on real or personal property.

27 ARTICLE 2. STATE DISABILITY INSURANCE PLANS.

28 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association
29 shall make available to residents the following types of disability

1 insurance plans:

2 (1) a group state plan for groups of from 3 - 25 residents;

3 (2) an individual state plan for residents who are not high
4 risks; and

5 (3) an individual state plan for residents who are high
6 risks.

7 (b) For each type of plan listed in (a) of this section, the
8 association shall offer three alternatives related to deductibles as
9 described in AS 21.55.130.

10 (c) The association shall make available to residents who are 65
11 years of age and older a minimum coverage medicare supplement plan and
12 an expanded coverage medicare supplement plan as these plans are
13 described in AS 21.55.120. Each type of medicare supplement plan
14 shall be made available to residents who are high risks and residents
15 who are not high risks.

16 (d) The association may not deny coverage under a state plan to
17 a resident who satisfies the requirements of AS 21.55.300 - 21.55.310.
18 The association shall determine whether a person is a high risk in
19 accordance with (e) of this section and the director's regulations.

20 (e) In this section, "residents who are high risks" means resi-
21 dents who

22 (1) have been rejected after applying for a policy of
23 disability insurance or a medicare supplement policy by at least one
24 association member within the six months immediately preceding the
25 date of application for a state plan;

26 (2) are rejected because of risk factors after applying for
27 a state plan offered to persons who are not high risks;

28 (3) have been treated for any of the following conditions
29 within the three years immediately preceding application for a state

1 plan: angina pectoris, ascites, chemical dependency, cirrhosis of the
2 liver, coronary insufficiency, coronary occlusion, cystic fibrosis,
3 Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's
4 chorea, juvenile diabetes, leukemia, metastatic cancer, motor or
5 sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia
6 gravis, myotonia, open heart surgery, Parkinson's disease, polycystic
7 kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, or
8 Wilson's disease.

9 Sec. 21.55.110. MINIMUM BENEFITS OF STATE DISABILITY INSURANCE
10 PLANS. Except as provided in AS 21.55.120 - 21.55.160, the minimum
11 standard benefits of a disability insurance plan offered under AS 21.-
12 55.100 shall be benefits with a lifetime maximum of \$1,000,000 per
13 individual, for usual, customary, reasonable, or prevailing charges
14 or, when applicable, the allowance agreed upon between a provider and
15 the writing carrier for charges actually incurred, for the following
16 medical services performed for an individual covered by the plan for
17 the diagnosis or treatment of nonoccupational disease or nonoccupa-
18 tional injury:

19 (1) hospital services;

20 (2) Subject to the limitations of AS 21.36.090(d), profes-
21 sional services that are rendered by a physician or by a registered
22 nurse at the physician's direction, other than services for mental or
23 dental conditions;

24 (3) the diagnosis or treatment of mental conditions, as
25 defined in regulations of the director, rendered during the year on
26 other than an inpatient basis, up to a yearly maximum benefit of
27 \$1,000;

28 (4) legend drugs requiring a physician's prescription;

29 (5) services of a skilled nursing facility for not more

1 than 120 days in a calendar year if the services commence within 14
2 days following a confinement of at least three consecutive days in a
3 hospital for the same condition;

4 (6) home health agency services up to a maximum of 180
5 visits in a calendar year if the services commence within seven days
6 following confinement in a hospital or skilled nursing facility of at
7 least three consecutive days for the same condition, except that in
8 the case of an individual diagnosed by a physician as terminally ill
9 with a prognosis of six months or less to live, the home health agency
10 services may commence irrespective of whether the covered person was
11 previously confined or, if the covered person was confined, irrespec-
12 tive of the seven-day period, and the yearly benefit for medical
13 social services may not exceed \$200; in this paragraph, "medical
14 social services" means services rendered under the direction of a
15 physician by a qualified social worker holding a master's degree from
16 an accredited school of social work, including assessment of the
17 social, psychological and family problems related to or arising out of
18 the covered person's illness and treatment, appropriate action and
19 utilization of community resources to assist in resolving the prob-
20 lems, and participation in the development of treatment for the cover-
21 ed person;

22 (7) use of radium or other radioactive materials;

23 (8) outpatient chemotherapy for the removal of tumors and
24 treatment of leukemia, including outpatient chemotherapy;

25 (9) oxygen;

26 (10) anesthetics;

27 (11) nondental prosthesis and maxillo-facial prosthesis used
28 to replace any anatomic structure lost during treatment for head and
29 neck tumors or additional appliances essential for the support of the

1 prosthesis;

2 (12) rental, or purchase if purchase is more cost effective
3 than rental, of durable medical equipment that has no personal use in
4 the absence of the condition for which it was prescribed;

5 (13) diagnostic x-rays and laboratory tests;

6 (14) oral surgery for excision of partially or completely
7 unerupted impacted teeth or excision of a tooth root without the
8 extraction of the entire tooth;

9 (15) services of a licensed physical therapist rendered
10 under the direction of a physician;

11 (16) transportation by air or by a local licensed or certifi-
12 ed ambulance to and from the nearest health care institution qualif-
13 ied to treat the illness or injury;

14 (17) confinement in a facility established primarily for the
15 treatment of alcohol or drug abuse and licensed by the state, or in a
16 part of a hospital used primarily for this treatment, for a period of
17 at least 45 days within any calendar year;

18 (18) other services that are medically necessary in the
19 treatment or diagnosis of an illness or injury as may be designated or
20 approved by the director.

21 Sec. 21.55.120. MEDICARE SUPPLEMENT PLANS. (a) The minimum
22 coverage medicare supplement plan must meet the minimum policy stan-
23 dards and the minimum benefit standards established by regulations
24 adopted by the director under AS 21.89.060.

25 (b) The expanded coverage medicare supplement plan must include
26 the coverage required under (a) of this section and, in addition,

27 (1) must provide coverage of 50 percent of the deductible
28 and copayment required under medicare and 80 percent of the charges
29 covered in AS 21.55.110 to the extent that the charges are not paid by

1 medicare;

2 (2) coverage shall be based on usual, customary, reason-
3 able, or prevailing charges for services specified in AS 21.55.110 and
4 may not be limited to medicare eligible expenses or medicare schedules
5 of coverage.

6 Sec. 21.55.130. DEDUCTIBLES AND COPAYMENTS. (a) A state plan
7 other than a medicare supplement plan may require deductibles of \$200
8 a person, \$500 a person, or \$750 a person. The amount of the deduct-
9 ible may not be greater when a service is rendered on an outpatient
10 basis than when that service is offered on an inpatient basis. Ex-
11 penses incurred during the last three months of a calendar year and
12 actually applied to an individual's deductible for that year shall
13 also be applied to that individual's deductible in the following
14 calendar year. The \$200 maximum, the \$500 maximum, and the \$750
15 maximum may be adjusted yearly to correspond with the change in the
16 medical care component of the consumer price index, as adjusted by the
17 director. The base year for the computation shall be the first full
18 calendar year of operation of the association.

19 (b) A state plan other than a medicare supplement plan shall
20 require a maximum copayment of 20 percent for charges for all types of
21 health care in excess of the deductible and 50 percent for services
22 described in AS 21.55.110(3) in excess of the deductible.

23 (c) The sum of the deductible and copayments required in any
24 calendar year under a plan may not exceed a maximum limit of \$2,000
25 per covered individual or \$4,000 per covered family. Covered expenses
26 incurred after the applicable maximum limit has been reached shall be
27 paid at the rate of 100 percent, except that expenses incurred for
28 treatment of mental and nervous conditions shall be paid at the rate
29 of 50 percent. The \$2,000 and \$4,000 maximums shall be adjusted

1 yearly to correspond with the change in the medical care component of
2 the consumer price index as adjusted by the director.

3 (d) In this section, "consumer price index" means the consumer
4 price index for all urban consumers for the Anchorage Metropolitan
5 Area compiled by the Bureau of Labor Statistics, United States Depart-
6 ment of Labor.

7 Sec. 21.55.140. PREEXISTING CONDITIONS. (a) A preexisting
8 condition exclusion in a state plan may not exclude coverage of a
9 preexisting condition unless

10 (1) the condition first manifested itself within the period
11 of six months immediately before the effective date of coverage in a
12 manner that would cause a reasonably prudent person to seek diagnosis,
13 care, or treatment; or

14 (2) medical advice or treatment was recommended or received
15 within the period of six months immediately before the effective date
16 of coverage.

17 (b) A policy may not exclude coverage for a loss due to pre-
18 existing conditions for a period greater than 12 months following the
19 effective date of coverage. An individual state plan issued as a
20 result of conversion from a group state plan shall credit the time
21 covered under the group state plan toward the exclusion for preexist-
22 ing conditions. An individual high risk plan issued as a result of
23 conversion from an individual standard risk plan shall credit the time
24 covered under the standard risk plan toward the exclusion for preex-
25 isting conditions.

26 Sec. 21.55.150. CARE AND SERVICES NOT COVERED. A state plan may
27 not provide benefits for charges for the following:

28 (1) care for an injury or disease either

29 (A) arising out of and in the course of an employment

1 subject to a workers' compensation or similar law or where the
2 benefit is required to be provided under a workers' compensation
3 policy to a sole proprietor, business partner, or corporation
4 officer; or

5 (B) to the extent benefits are payable without regard
6 to fault under a coverage statutorily required to be contained in
7 a motor vehicle or other liability insurance policy or equivalent
8 self-insurance;

9 (2) treatment for cosmetic purposes other than surgery for
10 the prompt repair of an accidental injury sustained while covered or
11 for replacement of an anatomic structure removed during treatment of
12 tumors;

13 (3) travel, other than transportation by air or by a local
14 licensed or certified ambulance to and from the nearest health care
15 institution qualified to treat the illness or injury;

16 (4) private room accommodations to the extent it is in
17 excess of the institution's most common charge for a semiprivate room;

18 (5) services or articles to the extent that the charge
19 exceeds the reasonable charge in the locality for the service;

20 (6) services or articles that are determined not to be
21 medically necessary, except for the fabrication or placement of the
22 prosthesis as specified in AS 21.55.110(11) and (2) of this section;

23 (7) services or articles the provision of which is not
24 within the scope of the license or certificate of the institution or
25 individual rendering the services or articles;

26 (8) services or articles furnished, paid for or reimbursed
27 directly by or under any law of a government, except as otherwise
28 provided in this chapter;

29 (9) services or articles for custodial care or designed

1 primarily to assist an individual in the activities of daily living;
2 (10) service charges that would not have been made if no
3 insurance existed or for which the covered individual is not legally
4 obligated to pay;
5 (11) eyeglasses, contact lenses, or hearing aids or the
6 fitting of them;
7 (12) dental care not specifically covered by this chapter;
8 (13) services of a registered nurse who ordinarily resides
9 in the covered individual's home, or who is a member of the
10 covered individual's family or the family of the covered indi-
11 vidual's spouse; and
12 (14) experimental procedures.

13 Sec. 21.55.160. COORDINATED COVERAGE. The association shall
14 adopt a procedure for coordination of benefits with other insurance
15 coverage, subject to the approval of the director.

16 Sec. 21.55.170. STATE PLAN PREMIUMS. (a) The association may
17 not charge a rate for coverage issued by or through the association
18 that is excessive, inadequate, or unfairly discriminatory.

19 (b) The association shall use separate scales of premium rates
20 based on age of the insured for individual risks and group risks. The
21 association may charge a higher premium for a high risk plan than for
22 a standard risk plan. The association shall charge a flat rate for
23 coverage of dependents of an insured.

24 (c) Notwithstanding (a) of this section, the schedule of premi-
25 ums for coverage under each type of state plan described in AS 21.55.-
26 100 shall be designed so that each type of plan is self-supporting.
27 The premiums shall be based on generally accepted actuarial princi-
28 ples.

29

ARTICLE 3. ADMINISTRATION OF PLANS.

1 Sec. 21.55.200. SELECTION OF WRITING CARRIERS. The association
2 shall develop bid specifications for members that wish to be selected
3 as a writing carrier to administer a state plan. The selection of the
4 writing carrier shall be based upon criteria including the member's
5 proven ability to handle large group disability insurance cases,
6 efficient claim paying capacity, and the estimate of total charges for
7 administering the plan.

8 Sec. 21.55.210. DUTIES OF WRITING CARRIERS. (a) The writing
9 carrier shall perform the administrative and claims payment functions
10 required by this section. The writing carrier shall provide these
11 services for a period of three years, unless a request to terminate is
12 approved by the director. The director shall approve or deny a re-
13 quest to terminate within 90 days of its receipt. A failure to make a
14 final decision on a request to terminate within the specified period
15 shall be considered an approval. Six months before the expiration of
16 each three-year period, the association shall invite submissions of
17 policy forms from members of the association, including the writing
18 carrier. The association shall follow the provisions of AS 21.55.210
19 in selecting a writing carrier for the subsequent three-year period.

20 (b) The writing carrier shall provide to all eligible persons
21 enrolled in a state plan an individual policy or certificate, setting
22 out a statement of the insurance protection to which the person is
23 entitled, with whom claims are to be filed, and to whom benefits are
24 payable. The policy or certificate must indicate that coverage was
25 obtained through the association.

26 (c) The writing carrier shall submit to the association and the
27 director on a monthly basis a report on the operation of the state
28 plans. Specific information to be contained in the report shall be
29 determined by the association.

1 (d) Claims shall be paid by the writing carrier and shall indi-
2 cate that the claim was paid under a state plan. A claim payment
3 shall include information specifying the procedure to be followed in
4 the event of a dispute over the amount of payment and a contact per-
5 son's name and telephone number that can be used for inquiries regard-
6 ing the claim.

7 (e) The writing carrier shall be reimbursed from the state plan
8 premiums received for its direct and indirect expenses for administer-
9 ing the plan. Direct and indirect expenses shall include a pro rata
10 reimbursement for that portion of the writing carrier's administra-
11 tive, printing, claims administration, management and building over-
12 head expenses that are assignable to the maintenance and administra-
13 tion of the state plans. The association shall approve cost account-
14 ing methods to substantiate the writing carrier's cost reports consis-
15 tent with generally accepted accounting principles. Direct and in-
16 direct expenses may not include costs directly related to the original
17 submission of policy forms before selection as the writing carrier.

18 (f) The writing carrier shall at all times when carrying out its
19 duties under this chapter be considered an agent of the association.

20 Sec. 21.55.220. OPERATION OF THE PLAN. (a) Upon notification
21 as an eligible person or group under AS 21.55.320, a person or group
22 may enroll in a state plan by payment of the appropriate state plan
23 premium to the writing carrier.

24 (b) An employer that has in its employ one or more eligible
25 persons enrolled in a state plan may make all or a portion of a state
26 plan premium payment directly to the writing carrier.

27 (c) At least 85 percent of the state plan premiums paid to the
28 writing carrier shall be used to pay claims; not more than 15 percent
29 may be used for the payment of agent referral fees under this chapter

1 and for payment of the writing carrier's direct and indirect expenses
2 under this chapter.

3 (d) Each contributing member of the association shall share the
4 losses due to claims expenses of the state plans for plans issued or
5 approved for issuance by the association, and shall share in the
6 operating and administrative expenses incurred or estimated to be
7 incurred by the association incident to the conduct of its affairs.
8 Claims expenses of the state plan that exceed the premium payments
9 allocated to the payment of benefits shall be the liability of the
10 contributing members. Contributing members shall share in the claims
11 expense of the state plans and operating and administrative expenses
12 of the association in an amount equal to the ratio of the contributing
13 member's total disability insurance premium, received from or on
14 behalf of state residents, as divided by the total disability insur-
15 ance premium received by all contributing members from or on behalf of
16 state residents, as determined by the director.

17 (e) The association shall make an annual determination of each
18 contributing member's liability, if any, and may make an annual fiscal
19 year end assessment if necessary. The association may also, subject
20 to the approval of the director, provide for interim assessments
21 against the contributing members as may be necessary to assure the
22 financial capability of the association in meeting the incurred or
23 estimated claims expenses of the state plans and operating and admin-
24 istrative expenses of the association until the association's next
25 annual fiscal year end assessment. Payment of an assessment is due
26 within 30 days of receipt by a contributing member of a written notice
27 of a fiscal year end or interim assessment. Failure by a contributing
28 member to tender to the association the assessment within 30 days
29 shall be grounds for termination of the contributing member's

1 membership. A contributing member that ceases to do disability insur-
2 ance business in the state remains liable for assessments through the
3 calendar year during which the disability insurance business ceased.
4 The association may decline to levy an assessment against a contribut-
5 ing member if the assessment would not exceed \$10.

6 (f) Net gains, if any, from the operation of the state plans
7 shall be held at interest and used by the association to offset future
8 losses due to claims expenses of a state plan or allocated to reduce
9 state plan premiums.

10 ARTICLE 4. ENROLLMENT IN THE STATE DISABILITY INSURANCE PLAN.

11 Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a)
12 A state resident or a group of from 3 to 25 state residents is eligi-
13 ble to enroll in a state plan described in AS 21.55.100.

14 (b) Additional eligibility requirements may not be imposed by
15 the director, the association, or a writing carrier.

16 Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON OR GROUP. (a)
17 A person or group may enroll in a state plan by applying to the writ-
18 ing carrier. The application must include the following:

19 (1) name, address, age, and length of time at residence of
20 the applicant;

21 (2) name, address, and age of spouse and children if any,
22 if they are to be insured; and

23 (3) a designation of the plan desired, including deductible
24 option chosen.

25 (b) A person may not be covered by more than one policy under
26 this chapter at any one time. Upon ceasing to be a resident of the
27 state a person is not eligible to purchase or renew coverage under a
28 state plan, but previously purchased coverage remains in effect for
29 the period covered by payments made while a resident.

1 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days
2 after receiving the certificate described in AS 21.55.310, the writing
3 carrier shall either reject the application for failing to comply with
4 the requirements of AS 21.55.300 and 21.55.310 or forward the eligible
5 person a notice of acceptance and billing information. Insurance is
6 effective immediately upon receipt of the first quarterly premium, and
7 is retroactive to the date of the application, if the applicant other-
8 wise complies with the requirements of this chapter.

9 Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The
10 association, under a plan approved by the director, shall disseminate
11 appropriate information to the residents of the state regarding the
12 existence of the state plans for persons who are high risks and the
13 means of enrollment. Means of communication may include use of the
14 press, radio, and television, as well as publication in appropriate
15 state offices and publications.

16 (b) The association shall devise and implement means of main-
17 taining public awareness of the provisions of this chapter and shall
18 administer this chapter in a manner that facilitates public participa-
19 tion in the state plans.

20 (c) The writing carrier shall pay an agent's referral fee of \$50
21 to each insurance agent who refers an applicant to a state plan, if
22 the application is accepted. Selling or marketing of qualified state
23 plans is limited to licensed disability insurance agents. The refer-
24 ral fees shall be paid by the writing carrier from money received as
25 premiums for a state plan.

26 (d) An insurer that rejects or applies underwriting restrictions
27 to an applicant for disability insurance or a medicare supplement plan
28 in the state shall notify the applicant of the existence of the state
29 plans, the requirements for being accepted, and the procedure for

1 applying.

2 ARTICLE 5. GENERAL PROVISIONS.

3 Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

4 (1) approve the selection of the writing carrier by the
5 association and approve the association's contract with the writing
6 carrier including the coverages and premiums to be charged;

7 (2) contract with the federal government or another unit of
8 government to ensure coordination of the state plans with other gov-
9 ernmental assistance programs;

10 (3) undertake directly or through contracts with other
11 persons studies or demonstration programs to develop awareness of the
12 benefits of this chapter; and

13 (4) adopt regulations necessary to administer this chapter.

14 Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for
15 acts or omissions of the association or a writing carrier under this
16 chapter, nor is the state liable for payment of a claim under a state
17 plan issued by a writing carrier.

18 Sec. 21.55.500. DEFINITIONS. In this chapter

19 (1) "association" means the Comprehensive Disability Insur-
20 ance Association created in AS 21.55.010;

21 (2) "child" includes a biological child, an adopted child,
22 and a stepchild;

23 (3) "copayment" means out-of-pocket costs for which the
24 insured is responsible;

25 (4) "dependent" means a spouse, an unmarried child younger
26 than 19 years of age if not a full-time student and younger than 23
27 years of age if a full-time student, and an unmarried child of any age
28 who is dependent upon the child's parents due to a physical or mental
29 disability of the child;

1 (5) "home health agency services" means any of the follow-
2 ing services provided upon recommendation of a licensed physician as
3 part of a treatment plan:

4 (A) intermittent or part-time nursing services of a
5 registered professional nurse or a licensed practical nurse, that
6 are provided to a person under the continued direction of the
7 person's physician and within the limitation of the nurse's
8 license;

9 (B) nursing services that are provided to a person at
10 the person's residence, including a residential care facility or
11 adult boarding home; a hospital, skilled nursing facility or
12 intermediate care facility is not considered a residence;

13 (C) home health aide services that are prescribed by
14 and under the continued direction of a physician and supervised
15 by a professional nurse;

16 (D) home health aide services that are provided to a
17 person at the person's residence, as described in (B) of this
18 paragraph;

19 (E) physical and occupational therapy services, speech
20 pathology, and audiology services that are prescribed by a physician
21 and provided to a person by or under the supervision of a qualified
22 practitioner; these services may be provided to a person who is a
23 patient in an intermediate care facility or skilled nursing facility;

24 (6) "resident" means a person who has lived in the state
25 for at least the 12 consecutive months immediately preceding applying
26 for a state plan; a person ceases to be a resident if the person is
27 absent from the state for more than 90 consecutive days for reasons
28 other than verifiable medical reasons.

29 (7) "state plan" means a policy of insurance offered by the

1 association through a writing carrier;

2 (8) "usual, customary, reasonable, or prevailing charge"
3 means the charge for a medical care procedure, service, or supply item
4 that is the lowest of the following amounts:

5 (A) the billed amount for the medical service pro-
6 vider's actual charge;

7 (B) the charge usually made by that provider for
8 performing that procedure or service or for providing the supply
9 item; or

10 (C) the customary charge, based on a profile of
11 charges made for the same medical procedure, service, or supply
12 item in the same geographical area by other providers that have
13 performed the same procedure or service or can provide the same
14 supply item;

15 (9) "writing carrier" means the insurer or insurers select-
16 ed by the association and approved by the director to administer a
17 state plan.

18 * Sec. 2. The association established by sec. 1 of this Act shall make
19 available to residents the plans required by AS 21.55.100, enacted in
20 sec. 1 of this Act, by July 1, 1987.

21 * Sec. 3. This Act takes effect immediately in accordance with AS 01.-
22 10.070(c).

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