

Offered: 4/23/86  
Referred: Finance

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1 IN THE HOUSE BY THE JUDICIARY COMMITTEE  
2 CS FOR HOUSE BILL NO. 589 (Judiciary)  
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 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a  
13 nonprofit incorporated legal entity to be known as the Comprehensive  
14 Disability Insurance Association. Membership consists of all licensed  
15 hospital or medical service corporations in the state that offer  
16 subscriber contracts for major medical coverage and all insurers  
17 licensed to transact disability insurance in the state that 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, or being able to offer subscriber  
21 contracts, in the state.  
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 for disability insurance for major medical

1 coverage on an expense incurred basis, or the member's subscriber  
2 fees, derived from or on behalf of state residents in the previous  
3 calendar year, as determined by the director. In approving members of  
4 the board, the director shall consider, among other things, whether  
5 all types of participating members are fairly represented. Members of  
6 the board other than the director or the director's designee may be  
7 reimbursed from the association for expenses incurred by them as  
8 members, but may not otherwise be compensated by the association for  
9 their services. The costs of conducting meetings of the association  
10 and its board of directors shall be borne by members of the associa-  
11 tion.

12 Sec. 21.55.030. GENERAL POWERS. The association may

13 (1) exercise the powers granted to insurers under the laws  
14 of the state;

15 (2) sue or be sued;

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

19 (4) establish administrative and accounting procedures for  
20 the operation of the association.

21 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall  
22 submit to the director a plan of operation and any amendments neces-  
23 sary or suitable to assure the fair, reasonable, and equitable admin-  
24 istration of the association. The plan of operation and amendments  
25 become effective upon approval in writing by the director. If the  
26 association fails to submit a suitable plan of operation by a date  
27 that is 180 days after the effective date of this Act, or if at any  
28 subsequent time the association fails to submit suitable amendments to  
29 the plan, the director may, after notice and hearing, adopt reasonable

1 regulations necessary or advisable to effectuate the provisions of  
2 this chapter. These regulations shall continue in force until mod-  
3 ified by the director or superseded by a plan submitted by the asso-  
4 ciation and approved by the director.

5 (b) All members of the association shall comply with the plan of  
6 operation.

7 (c) The plan of operation shall

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

10 (2) establish procedures for handling assets of the asso-  
11 ciation;

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

14 (4) establish regular places and times for meetings of the  
15 board of directors;

16 (5) establish procedures for records to be kept of all  
17 financial transactions of the association, its agents, and the board  
18 of directors;

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

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

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

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

28 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from  
29 the payment of fees and taxes levied by the state or any of its

1 political subdivisions except taxes levied on real or personal proper-  
2 ty.

3 ARTICLE 2. STATE DISABILITY INSURANCE PLANS.

4 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association  
5 shall make available to residents who are high risks an individual  
6 state plan of disability insurance. The association shall offer three  
7 alternatives related to deductibles as described in AS 21.55.120.

8 (b) The association shall make available to residents who are  
9 high risks and 65 years of age or older a medicare supplement plan  
10 that meets the minimum policy standards and minimum benefit standards  
11 established by regulations adopted by the director under AS 21.89.060.

12 (c) The association may not deny coverage under a state plan to  
13 a resident who satisfies the requirements of AS 21.55.300 - 21.55.310.  
14 The association shall determine whether a person is a high risk in  
15 accordance with AS 21.55.500(9) and the director's regulations.

16 Sec. 21.55.110. MINIMUM BENEFITS OF STATE DISABILITY INSURANCE  
17 PLAN. Except as provided in AS 21.55.120 - 21.55.140, the minimum  
18 standard benefits of a disability insurance plan offered under AS 21.-  
19 55.100(a) shall be benefits with a lifetime maximum of \$1,000,000 per  
20 individual, for usual, customary, reasonable, or prevailing charges  
21 or, when applicable, the allowance agreed upon between a provider and  
22 the writing carrier for charges, for the following medical services  
23 performed for an individual covered by the plan for the diagnosis or  
24 treatment of nonoccupational disease or nonoccupational injury:

25 (1) hospital services;

26 (2) subject to the limitations of AS 21.36.090(d), profes-  
27 sional services that are rendered by a physician or by a registered  
28 nurse at the physician's direction, other than services for mental or  
29 dental conditions;

- 1                   (3) the diagnosis or treatment of mental conditions, as  
2 defined in regulations of the director, rendered during the year on  
3 other than an inpatient basis, up to a yearly maximum benefit of  
4 \$4,000;
- 5                   (4) legend drugs requiring a physician's prescription;
- 6                   (5) services of a skilled nursing facility for not more  
7 than 120 days in a policy year;
- 8                   (6) home health agency services up to a maximum of 270  
9 visits in a calendar year if the services commence within seven days  
10 following confinement in a hospital or skilled nursing facility of at  
11 least three consecutive days for the same condition, except that in  
12 the case of an individual diagnosed by a physician as terminally ill  
13 with a prognosis of six months or less to live, the home health agency  
14 services may commence irrespective of whether the covered person was  
15 previously confined or, if the covered person was confined, irrespec-  
16 tive of the seven-day period, and the yearly benefit for medical  
17 social services may not exceed \$200;
- 18                   (7) hospice services for up to six months in a calendar  
19 year;
- 20                   (8) use of radium or other radioactive materials;
- 21                   (9) outpatient chemotherapy;
- 22                   (10) oxygen;
- 23                   (11) anesthetics;
- 24                   (12) nondental prosthesis and maxillo-facial prosthesis used  
25 to replace any anatomic structure lost during treatment for head and  
26 neck tumors or additional appliances essential for the support of the  
27 prosthesis;
- 28                   (13) rental, or purchase if purchase is more cost effective  
29 than rental, of durable medical equipment that has no personal use in

1 the absence of the condition for which it was prescribed;

2 (14) diagnostic x-rays and laboratory tests;

3 (15) oral surgery for excision of partially or completely  
4 unerupted impacted teeth or excision of a tooth root without the  
5 extraction of the entire tooth;

6 (16) services of a licensed physical therapist rendered  
7 under the direction of a physician;

8 (17) transportation by a local ambulance operated by licen-  
9 sed or certified personnel to the nearest health care institution for  
10 treatment of the illness or injury and round trip transportation by  
11 air to the nearest health care institution for treatment of the ill-  
12 ness or injury if the treatment is not available locally; if the  
13 patient is a child under 12 years of age, the transportation charges  
14 of a parent or legal guardian accompanying the child may be paid if  
15 the attending physician certifies the need for the accompaniment;

16 (18) confinement in a licensed or certified facility estab-  
17 lished primarily for the treatment of alcohol or drug abuse or in a  
18 part of a hospital used primarily for this treatment, for a period of  
19 at least 45 days within any calendar year;

20 (19) alternatives to inpatient services as defined by the  
21 association in the state plan benefits;

22 (20) second surgical opinions;

23 (21) other services that are medically necessary in the  
24 treatment or diagnosis of an illness or injury as may be designated or  
25 approved by the director.

26 Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan  
27 other than a medicare supplement plan may require deductibles of \$200  
28 a person, \$500 a person, or \$1,000 a person. The amount of the deduc-  
29 tible may not be greater when a service is rendered on an outpatient

1 basis than when that service is offered on an inpatient basis. Ex-  
2 penses incurred during the last three months of a calendar year and  
3 actually applied to an individual's deductible for that year shall  
4 also be applied to that individual's deductible in the following  
5 calendar year. The \$200 maximum, the \$500 maximum, and the \$1,000  
6 maximum may be adjusted yearly to correspond with the change in the  
7 medical care component of the consumer price index, as adjusted by the  
8 director. The base year for the computation shall be the first full  
9 calendar year of operation of the association.

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

14 (c) The sum of the deductible and copayments required in any  
15 calendar year under a plan may not exceed a maximum limit of \$2,000  
16 per covered individual. Covered expenses incurred after the applica-  
17 ble maximum limit has been reached shall be paid at the rate of 100  
18 percent of usual, customary, reasonable, or prevailing charges, except  
19 that expenses incurred for treatment of mental and nervous conditions  
20 shall be paid at the rate of 50 percent. The \$2,000 maximum shall be  
21 adjusted yearly to correspond with the change in the medical care  
22 component of the consumer price index as adjusted by the director.

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

27 Sec. 21.55.130. PREEXISTING CONDITIONS. (a) A preexisting  
28 condition exclusion in a state plan may not exclude coverage of a  
29 preexisting condition unless

1           (1) the condition first manifested itself within the period  
2 of three months immediately before the effective date of coverage in a  
3 manner that would cause a reasonably prudent person to seek diagnosis,  
4 care, or treatment; or

5           (2) medical advice or treatment was recommended or received  
6 within the period of three months immediately before the effective  
7 date of coverage.

8           (b) A policy may not exclude coverage for a loss due to pre-  
9 existing conditions for a period greater than six months following the  
10 effective date of coverage.

11           (c) A state plan issued to a person whose previous subscriber  
12 contract, disability policy, or medicare supplement policy was invol-  
13 untarily terminated shall credit the time covered under the previous  
14 contract or policy toward an exclusion for preexisting conditions  
15 under the state plan if the previous contract or policy had a similar  
16 preexisting condition exclusion and the person applies for a state  
17 plan within 31 days after termination of the previous contract or  
18 policy. If a person covered by this subsection is accepted by the  
19 writing carrier and pays a specified premium for retroactive coverage,  
20 the state plan is effective retroactively to the date on which the  
21 person's previous contract or policy terminated.

22           Sec. 21.55.140. CARE AND SERVICES NOT COVERED. A state plan may  
23 not provide benefits for charges for the following:

24           (1) care for an injury or disease either

25           (A) arising out of and in the course of an employment  
26 subject to a workers' compensation or similar law or where the  
27 benefit is required to be provided under a workers' compensation  
28 policy to a sole proprietor, business partner, or corporation  
29 officer; or

1 (B) to the extent benefits are payable without regard  
2 to fault under a coverage statutorily required to be contained in  
3 a motor vehicle or other liability insurance policy or equivalent  
4 self-insurance;

5 (2) treatment for cosmetic purposes other than surgery for  
6 the prompt repair of an accidental injury sustained while covered or  
7 for replacement of an anatomic structure removed during treatment of  
8 tumors;

9 (3) travel, other than transportation covered under AS 21.-  
10 55.110(17);

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

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

15 (6) services or articles that are determined not to be  
16 medically necessary, except for the fabrication or placement of the  
17 prosthesis as specified in AS 21.55.110(12) and (2) of this section;

18 (7) services or articles the provision of which is not  
19 within the scope of the license or certificate of the institution or  
20 individual rendering the services or articles;

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

24 (9) services or articles for custodial care or designed  
25 primarily to assist an individual in the activities of daily living;

26 (10) service charges that would not have been made if no  
27 insurance existed or for which the covered individual is not legally  
28 obligated to pay;

29 (11) eyeglasses, contact lenses, or hearing aids or the

1 fitting of them;

2 (12) dental care not specifically covered by this chapter;

3 (13) services of a registered nurse who ordinarily resides  
4 in the covered individual's home, or who is a member of the covered  
5 individual's family or the family of the covered individual's spouse;

6 (14) experimental procedures; and

7 (15) services and supplies for which the patient was not  
8 charged.

9 Sec. 21.55.150. STATE PLAN PREMIUMS. (a) The association may  
10 not charge a rate for coverage issued by or through the association  
11 that is excessive, inadequate, or unfairly discriminatory.

12 (b) The association shall use separate scales of premium rates  
13 based on age and geographic location of the insured.

14 (c) The five members of the association that insure, or have  
15 subscriber contracts with, the largest number of individuals in the  
16 state under plans with benefits substantially equivalent to the state  
17 plan benefits shall submit to the association an estimate of the rate  
18 that would be actuarially sound for a person who is a standard risk  
19 for coverage substantially equivalent to the state plan. The premium  
20 for a state plan may not exceed 150 percent of the average of those  
21 five estimates.

22 ARTICLE 3. ADMINISTRATION OF PLANS.

23 Sec. 21.55.200. SELECTION OF WRITING CARRIERS. The association  
24 shall develop bid specifications for members that wish to be selected  
25 as a writing carrier to administer a state plan. The selection of the  
26 writing carrier shall be based upon criteria including the member's  
27 proven ability to handle a large number of disability insurance cases  
28 or subscriber contracts, efficient claim paying capacity, and the  
29 estimate of total charges for administering the plan.

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

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

19           (c) The writing carrier shall submit to the association and the  
20 director on a quarterly basis a report on the operation of the state  
21 plans. Specific information to be contained in the report shall be  
22 determined by the association.

23           (d) Claims shall be paid by the writing carrier and shall indi-  
24 cate that the claim was paid under a state plan. A claim payment  
25 shall include a telephone number that can be used for inquiries regard-  
26 ing the claim.

27           (e) The writing carrier shall be reimbursed from the state plan  
28 premiums received for its direct and indirect expenses for administer-  
29 ing the plan. Direct and indirect expenses shall include a pro rata

1 reimbursement for that portion of the writing carrier's administra-  
2 tive, printing, claims administration, management and building over-  
3 head expenses that are assignable to the maintenance and administra-  
4 tion of the state plans. The association shall approve cost account-  
5 ing methods to substantiate the writing carrier's cost reports consis-  
6 tent with generally accepted accounting principles. Direct and in-  
7 direct expenses may not include costs directly related to the original  
8 submission of policy forms before selection as the writing carrier.

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

11 Sec. 21.55.220. OPERATION OF THE PLAN. (a) Upon notification  
12 as an eligible person under AS 21.55.320, a person may enroll in a  
13 state plan by payment of the appropriate state plan premium to the  
14 writing carrier.

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

18 (c) Each member of the association shall share the losses due to  
19 claims expenses of the state plans for plans issued or approved for  
20 issuance by the association, and shall share in the operating and  
21 administrative expenses incurred or estimated to be incurred by the  
22 association incident to the conduct of its affairs. Claims expenses  
23 of the state plan that exceed the premium payments allocated to the  
24 payment of benefits shall be the liability of the members. Each  
25 member shall share in the claims expense of the state plans and opera-  
26 ting and administrative expenses of the association in an amount equal  
27 to the ratio of the member's total fees for subscriber contracts or  
28 total disability insurance premiums, received from or on behalf of  
29 state residents, as divided by the total subscriber fees and

1 disability insurance premiums received by all members from or on  
2 behalf of state residents, as determined by the director.

3 (d) The association shall make an annual determination of each  
4 member's liability, if any, and may make an annual fiscal year end  
5 assessment if necessary. The association may also, subject to the  
6 approval of the director, provide for interim assessments against the  
7 members as may be necessary to assure the financial capability of the  
8 association in meeting the incurred or estimated claims expenses of  
9 the state plans and operating and administrative expenses of the  
10 association until the association's next annual fiscal year end as-  
11 sessment. Payment of an assessment is due within 30 days of receipt  
12 by a member of a written notice of a fiscal year end or interim  
13 assessment. Failure by a member to tender to the association the  
14 assessment within 30 days shall be grounds for revocation of a mem-  
15 ber's certificate of authority. A member that ceases to do disability  
16 insurance business in the state, or ceases to offer subscriber con-  
17 tracts in the state, due to revocation, suspension, or voluntary  
18 surrender of its certificate of authority remains liable for assess-  
19 ments through the calendar year during which the disability insurance  
20 business ceased. The association may decline to levy an assessment  
21 against a member if the assessment would not exceed \$10. Assessments  
22 paid by a member are a general expense of the member.

23 (e) Net gains, if any, from the operation of the state plans  
24 shall be held at interest and used by the association to offset future  
25 losses due to claims expenses of a state plan or allocated to reduce  
26 state plan premiums.

27 **ARTICLE 4. ENROLLMENT IN THE STATE DISABILITY INSURANCE PLAN.**

28 **Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a)**  
29 **Except as provided in (b) of this section, a state resident who is a**

1 high risk is eligible to enroll in a state plan described in AS 21.-  
2 55.100.

3 (b) A person may not be covered by the state plan while covered  
4 by another disability policy or subscriber contract. Upon ceasing to  
5 be a resident a person is not eligible to purchase or renew coverage  
6 under a state plan, but previously purchased coverage remains in  
7 effect for the period covered by payments made while a resident.

8 (c) Additional eligibility requirements may not be imposed by  
9 the director, the association, or a writing carrier.

10 Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON. A person may  
11 enroll in a state plan by applying to the writing carrier. The appli-  
12 cation must include the following:

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

15 (2) a designation of the plan desired, including deductible  
16 option chosen;

17 (3) information relevant to whether the person is a high  
18 risk.

19 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days  
20 after receiving the certificate described in AS 21.55.310, the writing  
21 carrier shall either reject the application for failing to comply with  
22 the requirements of AS 21.55.300 and 21.55.310 or forward the eligible  
23 person a notice of acceptance and billing information.

24 Sec. 21.55.330. EFFECTIVE DATE OF POLICIES. (a) Except as  
25 provided in (b) of this section and AS 21.55.130(c), insurance under a  
26 state plan is effective immediately upon receipt of the first  
27 quarterly premium, and is retroactive to the date of the application,  
28 if the applicant otherwise complies with the requirements of this  
29 chapter.

1 (b) Insurance under a state plan is effective retroactively to  
2 the date on which the person's previous contract or policy terminated  
3 if the person

4 (1) applies for a state plan within 60 days after the  
5 previous contract or policy terminated;

6 (2) is accepted by the writing carrier; and

7 (3) pays a specified premium for the period of retroactive  
8 coverage.

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 and the means of enrollment. Means of  
13 communication may include use of the press, radio, and television, as  
14 well as publication in appropriate state offices and publications.

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

19 (c) Selling or marketing of qualified state plans is limited to  
20 licensed disability insurance agents.

21 (d) An insurer or hospital or medical service corporation that  
22 rejects or applies underwriting restrictions to an applicant for a  
23 subscriber contract, a disability insurance policy, or a medicare  
24 supplement plan in the state shall notify the applicant of the exis-  
25 tence of the state plans, the requirements for being accepted, and the  
26 procedure for applying.

27 ARTICLE 5. GENERAL PROVISIONS.

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

29 (1) approve the selection of the writing carrier by the

1 association and approve the association's contract with the writing  
2 carrier including the coverages and premiums to be charged;

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

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

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

10 Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for  
11 acts or omissions of the association or a writing carrier under this  
12 chapter, nor is the state liable for payment of a claim under a state  
13 plan issued by a writing carrier.

14 Sec. 21.55.500. DEFINITIONS. In this chapter

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

17 (2) "copayment" means the portion of the eligible expenses,  
18 in excess of the deductible, for which the insured is responsible;

19 (3) "deductible" means the portion of eligible expenses for  
20 which the insured is responsible in each calendar year under AS 21.-  
21 55.120(a);

22 (4) "home health agency services" means any of the follow-  
23 ing services provided upon recommendation of a licensed physician as  
24 part of a treatment plan:

25 (A) intermittent or part-time nursing services of a  
26 registered professional nurse or a licensed practical nurse, that  
27 are provided to a person under the continued direction of the  
28 person's physician and within the limitation of the nurse's  
29 license;

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

5 (C) home health aide services that are prescribed by  
6 and under the continued direction of a physician and supervised  
7 by a professional nurse;

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

11 (E) physical and occupational therapy services, speech  
12 pathology, and audiology services that are prescribed by a physi-  
13 cian and provided to a person by or under the supervision of a  
14 qualified practitioner; these services may be provided to a  
15 person who is a patient in an intermediate care facility or  
16 skilled nursing facility;

17 (5) "hospice services" means services provided under a  
18 coordinated comprehensive program of palliative and supportive care on  
19 a 24-hour, seven days per week basis for persons who have been diag-  
20 nosed as terminally ill and their families by an interdisciplinary  
21 team of professionals or volunteers under an incorporated central  
22 administration that has a physician as medical director;

23 (6) "major medical coverage" means a disability insurance  
24 contract, or a subscriber contract, that provides benefits for hospi-  
25 tal and medical care with potential lifetime maximum benefits per  
26 insured of at least \$10,000;

27 (7) "medical social services" means services rendered the  
28 patient under the direction of a physician by a qualified social  
29 worker holding a master's degree from an accredited school of social

1 work, including assessment of the social, psychological and family  
2 problems related to or arising out of the covered person's illness and  
3 treatment, appropriate action and utilization of community resources  
4 to assist in resolving the problems, and participation in the develop-  
5 ment of treatment for the covered person;

6 (8) "resident" means a person who is physically present in  
7 the state, has lived in the state for at least the six consecutive  
8 months immediately preceding application for a state plan, and intends  
9 to remain permanently in the state; "resident" also includes a person  
10 who is not physically present in the state if the person lived in the  
11 state for at least six of the nine months immediately preceding appli-  
12 cation for a state plan and the person's absence from the state is for  
13 medical treatment or education; a person ceases to be a resident if  
14 the person is absent from the state for more than 90 consecutive days  
15 for reasons other than for medical treatment or education;

16 (9) "residents who are high risks" means residents who

17 (A) have been rejected for medical reasons after  
18 applying for a subscriber contract, a policy of disability insur-  
19 ance, or a medicare supplement policy by at least two association  
20 members within the six months immediately preceding the date of  
21 application for a state plan; or

22 (B) have had a restrictive rider placed on a  
23 subscriber contract, a disability insurance policy, or a medicare  
24 supplement policy;

25 (10) "state plan" means a policy of insurance offered by the  
26 association through a writing carrier;

27 (11) "usual, customary, reasonable, or prevailing charge"  
28 means the charge for a medical care procedure, service, or supply item  
29 that is the lowest of the following amounts:

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

3 (B) the charge usually made by that provider for  
4 performing that procedure or service or for providing the supply  
5 item; or

6 (C) the customary charge, based on a profile of char-  
7 ges made for the same medical procedure, service, or supply item  
8 in the same geographical area by other providers that have per-  
9 formed the same procedure or service or can provide the same  
10 supply item;

11 (12) "writing carrier" means the insurer or insurers select-  
12 ed by the association and approved by the director to administer a  
13 state plan.

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

17 \* Sec. 3. This Act takes effect immediately in accordance with AS 01.-  
18 10.070(c).