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1 IN THE HOUSE

BY SUND, KOPONEN, BROWN,
ELLIS AND HOFFMAN

2

HOUSE BILL NO. 72

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

FIFTEENTH LEGISLATURE - FIRST 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 that offer
17 subscriber contracts for major medical coverage and all insurers
18 licensed to transact disability insurance in the state that offer
19 policies for major medical coverage on an expense incurred basis. All
20 members shall maintain membership in the association as a condition of
21 doing disability insurance business, or being able to offer subscriber
contracts, in the state.

22

23 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of
24 directors of the association shall be made up of seven individuals
25 selected by participating members, subject to approval by the director
26 of the division of insurance. The director or the director's designee
27 shall serve as a nonvoting ex officio member of the board. In deter-
28 mining voting rights at members' meetings, a member is entitled to
29 vote in person or proxy. The vote shall be a weighted vote based upon
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 procedures whereby all the powers and duties
9 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 procedures whereby selections for the board
23 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 or,
21 when applicable, the allowance agreed upon between a provider and the
22 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 that the per-
21 son'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 that are not within the scope of
19 the license or certificate of the institution or individual rendering
20 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 that 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 125 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 of eligibility under AS 21.55.320, a person may enroll in a state plan
13 by payment of the appropriate state plan premium to the writing
14 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 issued or approved for issuance by
20 the association, and shall share in the operating and administrative
21 expenses incurred or estimated to be incurred by the association
22 incident to the conduct of its affairs. Claims expenses of the state
23 plan that exceed the premium payments allocated to the payment of
24 benefits shall be the liability of the members. Each member shall
25 share in the claims expense of the state plans and operating and
26 administrative expenses of the association in an amount equal to the
27 ratio of the member's total fees for subscriber contracts or total
28 disability insurance premiums, received from or on behalf of state
29 residents, as divided by the total subscriber fees and disability

1 insurance premiums received by all members from or on behalf of state
2 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 written notice of a fiscal year end or interim assess-
13 ment. Failure by a member to tender to the association the assessment
14 within 30 days shall be grounds for revocation of a member's certifi-
15 cate of authority. A member that ceases to do disability insurance
16 business in the state, or ceases to offer subscriber contracts in the
17 state, due to revocation, suspension, or voluntary surrender of its
18 certificate of authority remains liable for assessments through the
19 calendar year that the disability insurance business ceased. The
20 association may decline to levy an assessment against a member if the
21 assessment would not exceed \$10. Assessments paid by a member are a
22 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 residency of the
14 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 that the person's previous contract or policy terminated if
3 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 sub-
23 scriber 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 January 1, 1988.

17 * Sec. 3. This Act takes effect immediately under AS 01.10.070(c).