

1 IN THE HOUSE

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2

HOUSE BILL NO. 474

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

FIFTEENTH 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. LEGISLATIVE INTENT. It is the intent of the legislature
10 to provide access to disability insurance coverage to all residents of the
11 state who are denied adequate disability insurance coverage for any reason
12 or who are otherwise considered uninsurable. It is the further intent of
13 the legislature that AS 21.55 provide a mechanism to ensure the availabil-
14 ity of comprehensive disability insurance to persons unable to obtain
15 disability insurance coverage on either an individual or a group basis
16 under any health plan.

17 * Sec. 2. AS 21 is amended by adding a new chapter to read:

18 CHAPTER 55. STATE DISABILITY INSURANCE.

19 ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

20 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a
21 nonprofit incorporated legal entity to be known as the Comprehensive
22 Disability Insurance Association. Membership consists of all licensed
23 hospital or medical service corporations in the state that offer
24 subscriber contracts for major medical coverage and all insurers
25 licensed to transact disability insurance in the state that offer
26 policies for major medical coverage on an expense incurred basis. All
27 members shall maintain membership in the association as a condition of
28 doing disability insurance business, or being able to offer subscriber
29 contracts for major medical coverage, in the state.

1 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of
2 directors of the association shall be made up of seven individuals
3 selected by participating members, subject to approval by the director
4 of the division of insurance. The director or the director's designee
5 shall serve as a nonvoting ex officio member of the board. In deter-
6 mining voting rights at members' meetings, a member is entitled to
7 vote in person or proxy. The vote shall be a weighted vote based upon
8 the member's premiums for disability insurance for major medical
9 coverage on an expense incurred basis, or the member's subscriber
10 fees, derived from or on behalf of state residents in the previous
11 calendar year, as determined by the director. In approving members of
12 the board, the director shall consider, among other things, whether
13 all types of participating members are fairly represented. Members of
14 the board other than the director or the director's designee may be
15 reimbursed from the association for expenses incurred by them as
16 members, but may not otherwise be compensated by the association for
17 their services. The costs of conducting meetings of the association
18 and its board of directors shall be borne by members of the associa-
19 tion.

20 Sec. 21.55.030. GENERAL POWERS. The association may

21 (1) exercise the powers granted to insurers under the laws
22 of the state;

23 (2) sue or be sued;

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

27 (4) establish administrative and accounting procedures for
28 the operation of the association.

29 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall

1 submit to the director a plan of operation and any amendments neces-
2 sary or suitable to assure the fair, reasonable, and equitable admin-
3 istration of the association. The plan of operation and amendments
4 become effective upon approval in writing by the director. If the
5 association fails to submit a suitable plan of operation by a date
6 that is 180 days after the effective date of this Act, or if at any
7 subsequent time the association fails to submit suitable amendments to
8 the plan, the director may, after notice and hearing, adopt reasonable
9 regulations necessary or advisable to effectuate the provisions of
10 this chapter. These regulations shall continue in force until mod-
11 ified by the director or superseded by a plan submitted by the asso-
12 ciation and approved by the director.

13 (b) All members of the association shall comply with the plan of
14 operation.

15 (c) The plan of operation shall

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

18 (2) establish procedures for handling assets of the asso-
19 ciation;

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

22 (4) establish regular places and times for meetings of the
23 board of directors;

24 (5) establish procedures for records to be kept of all
25 financial transactions of the association, its agents, and the board
26 of directors;

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

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

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

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

7 Sec. 21.55.060. TAX EXEMPTION. (a) The association is exempt
8 from the payment of fees and taxes levied by the state or any of its
9 political subdivisions except taxes levied on real or personal proper-
10 ty.

11 (b) A member of the association is entitled to receive a credit
12 against taxes levied by the state on disability insurance premiums as
13 provided in AS 21.09.210(j).

14 ARTICLE 2. STATE DISABILITY INSURANCE PLANS.

15 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association
16 shall make available to residents eligible under AS 21.55.300 an
17 individual state plan of disability insurance. The association shall
18 offer two alternatives related to deductibles as described in
19 AS 21.55.120.

20 (b) The association shall make available to residents eligible
21 under AS 21.55.300 who are 65 years of age or older a medicare
22 supplement plan that meets the minimum policy standards and minimum
23 benefit standards established by regulations adopted by the director
24 under AS 21.89.060.

25 (c) The association may not deny coverage under a state plan to
26 a resident who satisfies the requirements of AS 21.55.300 - 21.55.310.

27 Sec. 21.55.110. MINIMUM BENEFITS OF STATE DISABILITY INSURANCE
28 PLAN. Except as provided in AS 21.55.120 - 21.55.140, the minimum
29 standard benefits of a disability insurance plan offered under

1 AS 21.55.100(a) shall be benefits with a lifetime maximum of
2 \$1,000,000 per individual for usual, customary, reasonable, or pre-
3 vailing charges or, when applicable, the allowance agreed upon between
4 a provider and the writing carrier for charges, for the following
5 medical services performed for an individual covered by the plan for
6 the diagnosis or treatment of nonoccupational disease or nonoccupa-
7 tional injury:

8 (1) hospital services;

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

13 (3) the diagnosis or treatment of mental conditions, as
14 defined in regulations of the director, rendered during the year on
15 other than an inpatient basis, up to a yearly maximum benefit of
16 \$4,000;

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

18 (5) services of a skilled nursing facility for not more
19 than 120 days in a policy year;

20 (6) home health agency services up to a maximum of 270
21 visits in a calendar year if the services commence within seven days
22 following confinement in a hospital or skilled nursing facility of at
23 least three consecutive days for the same condition, except that in
24 the case of an individual diagnosed by a physician as terminally ill
25 with a prognosis of six months or less to live, the home health agency
26 services may commence irrespective of whether the covered person was
27 previously confined or, if the covered person was confined, irrespec-
28 tive of the seven-day period, and the yearly benefit for medical
29 social services may not exceed \$200;

- 1 (7) hospice services for up to six months in a calendar
2 year;
- 3 (8) use of radium or other radioactive materials;
- 4 (9) outpatient chemotherapy;
- 5 (10) oxygen;
- 6 (11) anesthetics;
- 7 (12) nondental prosthesis and maxillo-facial prosthesis used
8 to replace any anatomic structure lost during treatment for head and
9 neck tumors or additional appliances essential for the support of the
10 prosthesis;
- 11 (13) rental, or purchase if purchase is more cost effective
12 than rental, of durable medical equipment that has no personal use in
13 the absence of the condition for which it was prescribed;
- 14 (14) diagnostic x-rays and laboratory tests;
- 15 (15) oral surgery for excision of partially or completely
16 unerupted impacted teeth or excision of a tooth root without the
17 extraction of the entire tooth;
- 18 (16) services of a licensed physical therapist rendered
19 under the direction of a physician;
- 20 (17) transportation by a local ambulance operated by licen-
21 sed or certified personnel to the nearest health care institution for
22 treatment of the illness or injury and round trip transportation by
23 air to the nearest health care institution for treatment of the ill-
24 ness or injury if the treatment is not available locally; if the
25 patient is a child under 12 years of age, the transportation charges
26 of a parent or legal guardian accompanying the child may be paid if
27 the attending physician certifies the need for the accompaniment;
- 28 (18) confinement in a licensed or certified facility estab-
29 lished primarily for the treatment of alcohol or drug abuse or in a

1 part of a hospital used primarily for this treatment, for a period of
2 at least 45 days within any calendar year;

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

5 (20) second surgical opinions;

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

9 Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan
10 other than a medicare supplement plan may require deductibles of \$500
11 a person or \$1,000 a person. The amount of the deductible may not be
12 greater when a service is rendered on an outpatient basis than when
13 that service is offered on an inpatient basis. Expenses incurred
14 during the last three months of a calendar year and actually applied
15 to an individual's deductible for that year shall also be applied to
16 that individual's deductible in the following calendar year. The \$500
17 maximum and the \$1,000 maximum may be adjusted yearly to correspond
18 with the change in the medical care component of the consumer price
19 index, as adjusted by the director. The base year for the computation
20 shall be the first full calendar year of operation of the association.

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

25 (c) The sum of the deductible and copayments required in any
26 calendar year under a plan may not exceed a maximum limit of \$2,000
27 per covered individual. Covered expenses incurred after the applica-
28 ble maximum limit has been reached shall be paid at the rate of 100
29 percent of usual, customary, reasonable, or prevailing charges, except

1 that expenses incurred for treatment of mental and nervous conditions
2 shall be paid at the rate of 50 percent. The \$2,000 maximum shall be
3 adjusted yearly to correspond with the change in the medical care
4 component of the consumer price index as adjusted by the director.

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

9 Sec. 21.55.130. PREEXISTING CONDITIONS. (a) A policy may not
10 exclude coverage for a loss due to a preexisting condition for a
11 period greater than six months following the effective date of cover-
12 age.

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

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

26 (1) care for an injury or disease either

27 (A) arising out of and in the course of an employment
28 subject to a workers' compensation or similar law or where the
29 benefit is required to be provided under a workers' compensation

1 policy to a sole proprietor, business partner, or corporation
2 officer; or

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

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

11 (3) travel, other than transportation covered under AS 21.-
12 55.110(17);

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

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

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

20 (7) services or articles that are not within the scope of
21 the license or certificate of the institution or individual rendering
22 the services or articles;

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

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

28 (10) service charges that would not have been made if no
29 insurance existed or that the covered individual is not legally

1 obligated to pay;

2 (11) eyeglasses, contact lenses, or hearing aids or the
3 fitting of them;

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

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

8 (14) experimental procedures; and

9 (15) services and supplies for which the patient was not
10 charged.

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

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

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

24 ARTICLE 3. ADMINISTRATION OF PLANS.

25 Sec. 21.55.200. SELECTION OF WRITING CARRIERS. The association
26 shall develop bid specifications for members that wish to be selected
27 as a writing carrier to administer a state plan. The selection of the
28 writing carrier shall be based upon criteria including the member's
29 proven ability to handle a large number of disability insurance cases

1 or subscriber contracts, efficient claim paying capacity, and the
2 estimate of total charges for administering the plan.

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

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

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

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

29 (e) The writing carrier shall be reimbursed from the state plan

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

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

13 Sec. 21.55.220. OPERATION OF THE PLAN. (a) Upon notification
14 of eligibility under AS 21.55.320, a person may enroll in a state plan
15 by payment of the appropriate state plan premium to the writing carri-
16 er.

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

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

1 disability insurance premiums, received from or on behalf of state
2 residents, as divided by the total subscriber fees and disability
3 insurance premiums received by all members from or on behalf of state
4 residents, as determined by the director.

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

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

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

1 Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a)

2 Except as provided in (b) of this section, a person who is a resident
3 of the state is eligible for coverage upon providing evidence of

4 (1) rejection for medical reasons, a requirement of re-
5 strictive riders, an up-rated premium, or a preexisting conditions
6 limitation on disability insurance, the effect of which is to substan-
7 tially reduce coverage from that received by a person considered a
8 standard risk, by at least one member within six months of the date of
9 application; or

10 (2) involuntary termination of disability insurance cover-
11 age for any reason other than nonpayment of premium.

12 (b) The following persons are not eligible for coverage:

13 (1) a person who is at the time of application eligible for
14 medical assistance;

15 (2) a person who terminated coverage under this chapter
16 unless

17 (A) 12 months have lapsed since termination; or

18 (B) that person can show other continuous coverage
19 that has been involuntarily terminated for any reason other than
20 nonpayment of premiums;

21 (3) a person on whose behalf the state has paid out
22 \$1,000,000 in benefits; and

23 (4) inmates of public institutions and persons whose bene-
24 fits are duplicated under public programs.

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

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

1 (1) name, address, age, and length of residency of the
2 applicant; and

3 (2) a designation of the plan desired, including deductible
4 option chosen.

5 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days
6 after receiving the application described in AS 21.55.310, the writing
7 carrier shall either reject the application for failing to comply with
8 the requirements of AS 21.55.300 and 21.55.310 or forward the eligible
9 person a notice of acceptance and billing information.

10 Sec. 21.55.330. EFFECTIVE DATE OF POLICIES. (a) Except as
11 provided in (b) of this section and AS 21.55.130(b), insurance under a
12 state plan is effective immediately upon receipt of the first quar-
13 terly premium, and is retroactive to the date of the application, if
14 the applicant otherwise complies with the requirements of this chap-
15 ter.

16 (b) Insurance under a state plan is effective retroactively to
17 the date that the person's previous contract or policy terminated if
18 the person

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

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

22 (3) pays a specified premium for the period of retroactive
23 coverage.

24 Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The
25 association, under a plan approved by the director, shall disseminate
26 appropriate information to the residents of the state regarding the
27 existence of the state plans and the means of enrollment. Means of
28 communication may include use of the press, radio, and television, as
29 well as publication in appropriate state offices and publications.

1 (b) The association shall devise and implement means of main-
2 taining public awareness of the provisions of this chapter regarding
3 the state plans and shall administer this chapter in a manner that
4 facilitates public participation in the state plans. The association
5 shall prepare a brochure outlining the benefits and exclusions of the
6 state plan in plain language.

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

9 (d) An insurer or hospital or medical service corporation that
10 rejects or applies underwriting restrictions to an applicant for a
11 subscriber contract, a disability insurance policy, or a medicare
12 supplement plan in the state shall notify the applicant of the exis-
13 tence of the state plans, the requirements for being accepted, and the
14 procedure for applying.

15 ARTICLE 5. GENERAL PROVISIONS.

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

17 (1) approve the selection of the writing carrier by the
18 association and approve the association's contract with the writing
19 carrier including the coverages and premiums to be charged;

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

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

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

27 Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for
28 acts or omissions of the association or a writing carrier under this
29 chapter, nor is the state liable for payment of a claim under a state

1 plan issued by a writing carrier.

2 Sec. 21.55.500. DEFINITIONS. In this chapter

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

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

7 (3) "deductible" means the portion of eligible expenses for
8 which the insured is responsible in each calendar year under AS 21.-
9 55.120(a);

10 (4) "disability insurance" means a group or individual
11 disability insurance policy, health care service contract, or health
12 maintenance agreement;

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

16 (A) intermittent or part-time nursing services of a
17 registered professional nurse or a licensed practical nurse, that
18 are provided to a person under the continued direction of the
19 person's physician and within the limitation of the nurse's
20 license;

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

25 (C) home health aide services that are prescribed by
26 and under the continued direction of a physician and supervised
27 by a professional nurse;

28 (D) home health aide services that are provided to a
29 person at the person's residence, as described in (B) of this

1 paragraph;

2 (E) physical and occupational therapy services, speech
3 pathology, and audiology services that are prescribed by a physi-
4 cian and provided to a person by or under the supervision of a
5 qualified practitioner; these services may be provided to a
6 person who is a patient in an intermediate care facility or
7 skilled nursing facility;

8 (6) "hospice services" means services provided under a
9 coordinated comprehensive program of palliative and supportive care on
10 a 24-hour, seven days per week basis for persons who have been diag-
11 nosed as terminally ill and their families by an interdisciplinary
12 team of professionals or volunteers under an incorporated central
13 administration that has a physician as medical director;

14 (7) "major medical coverage" means a disability insurance
15 contract or subscriber contract that provides benefits for hospital
16 and medical care with potential lifetime maximum benefits per insured
17 of at least \$1,000,000;

18 (8) "medical social services" means services rendered the
19 patient under the direction of a physician by a qualified social
20 worker holding a master's degree from an accredited school of social
21 work, including assessment of the social, psychological and family
22 problems related to or arising out of the covered person's illness and
23 treatment, appropriate action and utilization of community resources
24 to assist in resolving the problems, and participation in the develop-
25 ment of treatment for the covered person;

26 (9) "resident" means a person who is physically present in
27 the state, has lived in the state for at least the six consecutive
28 months immediately preceding application for a state plan, and intends
29 to remain permanently in the state; "resident" also includes a person

1 who is not physically present in the state if the person lived in the
2 state for at least six of the nine months immediately preceding appli-
3 cation for a state plan and the person's absence from the state is for
4 medical treatment or education; a person ceases to be a resident if
5 the person is absent from the state for more than 90 consecutive days
6 for reasons other than for medical treatment or education;

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

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

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

14 (B) the charge usually made by that provider for
15 performing that procedure or service or for providing the supply
16 item; or

17 (C) the customary charge, based on a profile of char-
18 ges made for the same medical procedure, service, or supply item
19 in the same geographical area by other providers that have per-
20 formed the same procedure or service or can provide the same
21 supply item;

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

25 * Sec. 3. AS 21.09.210 is amended by adding a new subsection to read:

26 (j) A member of the Comprehensive Disability Insurance Asso-
27 ciation created in AS 21.55.010 may credit against a premium tax
28 imposed under this section, an amount equal to an assessment against
29 the member under AS 21.55.220(d). Any portion of the credit allowed

1 in this subsection that cannot be taken in a tax year without reducing
2 taxable premiums below zero may be carried forward and credited in
3 successive years until the credit is exhausted.

4 * Sec. 4. The association established by sec. 2 of this Act shall make
5 available to residents the plans required by AS 21.55.100, enacted in
6 sec. 2 of this Act, by January 1, 1989.

7 * Sec. 5. This Act takes effect immediately under AS 01.10.070(c).