HOUSE

COMMITTEE REPORT

(11)

Date referred: 4/23/86

FURTHER REFERRALS:

DATE: 4-28-86

The FINANCE Committee has considered HB 589

"An Act relating to participation in the state group life and health insurance policies by residents; and providing for an effective date."

and recommends:

[ ] do pass

[ ] do not pass

[ ] do pass with attached amendment(s)

[ ] no recommendation

[X] replace with CS HB 589 (Fin) [ ] same title [X] new title

and recommends Individual Recommendations

[ ] further referral to the ______ Committee

and attaches:
[ ] letter of intent
[ ] first fiscal note
[ ] new fiscal note
[✓] zero fiscal note 4-28-86

SIGNING DO PASS:

[signatures]

SIGNING OTHER RECOMMENDATIONS:

[signature]

[signature] (no rec)

Ronald [signature] No Rec.

[signature] (No Rec)

[signature] Do Not Pass

[signature] Do Not Pass unless actuarially sound

[signature]

Chairman

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: ______

REQUEST

Bill/Resolution No.: CS HB 589 (FIN)
Title: High risk insurance

Sponsor: Representative Sund
Requestor: House Finance Committee
Date of Request: 4/28/86

FISCAL DETAIL

Agency Affected: Commerce & Economic Delelopment
BRU: Division of Insurance

Components: ______

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		-0-	-0-	-0-	-0-	-0-
TRAVEL		-0-	-0-	-0-	-0-	-0-
CONTRACTUAL		-0-	-0-	-0-	-0-	-0-
SUPPLIES		-0-	-0-	-0-	-0-	-0-
EQUIPMENT		-0-	-0-	-0-	-0-	-0-
LAND & STRUCTURES		-0-	-0-	-0-	-0-	-0-
GRANTS, CLAIMS		-0-	-0-	-0-	-0-	-0-
MISCELLANEOUS		-0-	-0-	-0-	-0-	-0-
TOTAL OPERATING		-0-	-0-	-0-	-0-	-0-
CAPITAL		-0-	-0-	-0-	-0-	-0-
REVENUE		-0-	-0-	-0-	-0-	-0-

FUNDING : (Thousands of Dollars)

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
GENERAL FUND		-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS		-0-	-0-	-0-	-0-	-0-
OTHER		-0-	-0-	-0-	-0-	-0-
TOTAL		-0-	-0-	-0-	-0-	-0-

POSITIONS :

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
FULL-TIME		-0-	-0-	-0-	-0-	-0-
PART-TIME		-0-	-0-	-0-	-0-	-0-
TEMPORARY		-0-	-0-	-0-	-0-	-0-

ANALYSIS : Attach a separate page if necessary

The costs reflected in the division's fiscal note are overstated. If funds are needed to implement this bill, they can be absorbed in the division's FY 87 Budget.

Prepared by: Representative Adams - Chairman
Phone: 465-3706
Division: House Finance Committee
Date: 4/28/86

Approved by Commissioner: ______
Date: ______
Agency: ______

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

10/25/85

Original sponsors: Sund, M.M.Miller,
Hurley, et al

1 IN THE HOUSE BY THE FINANCE COMMITTEE

2 CS FOR HOUSE BILL NO. 589 (Finance)

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

regulations necessary or advisable to effectuate the provisions of this chapter. These regulations shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

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

(c) The plan of operation shall

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

(2) establish procedures for handling assets of the association;

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

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

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

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

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

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

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

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

political subdivisions except taxes levied on real or personal property.

ARTICLE 2. STATE DISABILITY INSURANCE PLANS.

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

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

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

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

(1) hospital services;

(2) subject to the limitations of AS 21.36.090(d), professional ‹ices that are rendered by a physician or by a registered nurse ‹ ‹ne physician's direction, other than services for mental or dental conditions;

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

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

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

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

(7) hospice services for up to six months in a calendar year;

(8) use of radium or other radioactive materials;

(9) outpatient chemotherapy;

(10) oxygen;

(11) anesthetics;

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

(13) rental, or purchase if purchase is more cost effective 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

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

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

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

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

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

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

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

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

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

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

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

fitting of them;

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

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

(14) experimental procedures; and

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

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

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

(c) The five members of the association that insure, or have subscriber contracts with, the largest number of individuals in the state under plans with benefits substantially equivalent to the state plan benefits shall submit to the association an estimate of the rate that would be actuarially sound for a person who is a standard risk for coverage substantially equivalent to the state plan. The premium for a state plan may not exceed 150 percent of the average of those five estimates during the first year that the state plan is offered. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses using sound actuarial methods. In no event shall rates for the state plan exceed 200 percent of rates applicable to individual standard risks. Any change in rates shall be applied to the next quarterly billing with prior notice of the increase.

ARTICLE 3. ADMINISTRATION OF PLANS.

Sec. 21.55.200. SELECTION OF WRITING CARRIERS. The association

shall develop bid specifications for members that wish to be selected as a writing carrier to administer a state plan. The selection of the writing carrier shall be based upon criteria including the member's proven ability to handle a large number of disability insurance cases or subscriber contracts, efficient claim paying capacity, and the estimate of total charges for administering the plan.

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

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

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

(d) Claims shall be paid by the writing carrier and shall

indicate that the claim was paid under a state plan. A claim payment shall include a telephone number that can be used for inquiries regarding the claim.

(e) The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses for administering the plan. Direct and indirect expenses shall include a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses that are assignable to the maintenance and administration of the state plans. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms before selection as the writing carrier.

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

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

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

(c) Each member of the association shall share the losses due to claims expenses of the state plans for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan that exceed the premium payments allocated to the

payment of benefits shall be the liability of the members. Each member shall share in the claims expense of the state plans and operating and administrative expenses of the association in an amount equal to the ratio of the member's total fees for subscriber contracts or total disability insurance premiums, received from or on behalf of state residents, as divided by the total subscriber fees and disability insurance premiums received by all members from or on behalf of state residents, as determined by the director.

(d) The association shall make an annual determination of each member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the director, provide for interim assessments against the members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plans and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment is due within 30 days of receipt by a member of a written notice of a fiscal year end or interim assessment. Failure by a member to tender to the association the assessment within 30 days shall be grounds for revocation of a member's certificate of authority. A member that ceases to do disability insurance business in the state, or ceases to offer subscriber contracts in the state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains liable for assessments through the calendar year during which the disability insurance business ceased. The association may decline to levy an assessment against a member if the assessment would not exceed $10. Assessments paid by a member are a general expense of the member.

(e) Net gains, if any, from the operation of the state plans

shall be held at interest and used by the association to offset future losses due to claims expenses of a state plan or allocated to reduce state plan premiums.

ARTICLE 4 ENROLLMENT IN THE STATE DISABILITY INSURANCE PLAN.

Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a) Except as provided in (b) of this section, a state resident who is a high risk is eligible to enroll in a state plan described in AS 21.-55.100.

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

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

Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON. A person may enroll in a state plan by applying to the writing carrier. The application must include the following:

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

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

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

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

1 Sec. 21.55.330. EFFECTIVE DATE OF POLICIES. (a) Except as
2 provided in (b) of this section and AS 21.55.130(c), insurance under a
3 state plan is effective immediately upon receipt of the first
4 quarterly premium, and is retroactive to the date of the application,
5 if the applicant otherwise complies with the requirements of this
6 chapter.
7 (b) Insurance under a state plan is effective retroactively to
8 the date on which the person's previous contract or policy terminated
9 if the person
10 (1) applies for a state plan within 60 days after the
11 previous contract or policy terminated;
12 (2) is accepted by the writing carrier; and
13 (3) pays a specified premium for the period of retroactive
14 coverage.
15 Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The
16 association, under a plan approved by the director, shall disseminate
17 appropriate information to the residents of the state regarding the
18 existence of the state plans and the means of enrollment. Means of
19 communication may include use of the press, radio, and television, as
20 well as publication in appropriate state offices and publications.
21 (b) The association shall devise and implement means of main-
22 taining public awareness of the provisions of this chapter regarding
23 the state plans and shall administer this chapter in a manner that
24 facilitates public participation in the state plans.
25 (c) Selling or marketing of qualified state plans is limited to
26 licensed disability insurance agents.
27 (d) An insurer or hospital or medical service corporation that
28 rejects or applies underwriting restrictions to an applicant for a
29 subscriber contract, a disability insurance policy, or a medicare

supplement plan in the state shall notify the applicant of the existence of the state plans, the requirements for being accepted, and the procedure for applying.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

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

(2) contract with the federal government or another unit of government to ensure coordination of the state plans with other governmental assistance programs;

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

(4) adopt regulations necessary to administer this chapter.

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

Sec. 21.55.500. DEFINITIONS. In this chapter

(1) "association" means the Comprehensive Disability Insurance Association created in AS 21.55.010;

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

(3) "deductible" means the portion of eligible expenses for which the insured is responsible in each calendar year under AS 21.55.120(a);

(4) "home health agency services" means any of the following services provided upon recommendation of a licensed physician as

1 part of a treatment plan:

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

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

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

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

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

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

29 (6) "major medical coverage" means a disability insurance

contract, or a subscriber contract, that provides benefits for hospital and medical care with potential lifetime maximum benefits per insured of at least $10,000;

(7) "medical social services" means services rendered the patient under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including assessment of the social, psychological and family problems related to or arising out of the covered person's illness and treatment, appropriate action and utilization of community resources to assist in resolving the problems, and participation in the development of treatment for the covered person;

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

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

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

(B) have had a restrictive rider placed on a subscriber contract, a disability insurance policy, or a medicare

supplement policy;

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

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

(A) the billed amount for the medical service provider's actual charge;

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

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

(12) "writing carrier" means the insurer or insurers selected by the association and approved by the director to administer a state plan.

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

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

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: ______

REQUEST

Bill/Resolution No.: CSHB 589 (L&C)
Title: Relating to disability insurance.

Sponsor: Labor & Commerce Committee
Requester:
Date of Request:

FISCAL DETAIL

Agency Affected: Commerce & Economic Development
BRU: Insurance

Components: Public Protection

EXPENDITURES / REVENUES: (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
TRAVEL	-0-	10.0	2.0	2.6	3.2	4.0
CONTRACTUAL	-0-	25.0	25.0	25.0	25.0	25.0
SUPPLIES	-0-	2.0	1.0	1.0	1.0	1.0
EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
GRANTS, CLAIMS	-0-	-0-	-0-	-0-	-0-	-0-
MISCELLANEOUS	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL OPERATING	-0-	37.0	28.0	28.6	29.2	30.0
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of dollars)

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
GENERAL FUND	-0-	37.0	28.0	28.6	29.2	30.0
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	37.0	28.0	28.6	29.2	30.0

POSITIONS:

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary.

While there is an increase of the duties of the Director in this legislation, additional positions will not be necessary. Start-up costs cause a higher fiscal impact than subsequent years. The formative needs require more attention by the Director in the form

Prepared by: John L. George. Director
Division: Division of Insurance
Phone: 465-2515
Date: April 7, 1986

Approved by Commissioner: [signature]
Agency: Commerce and Economic Development
Date: April 7, 1986

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

10/25/85

0274K

of increased travel to attend formation meetings and monitor activities of the Association. Most of the major insurers expected to be involved in the Association are in the east. The fiscal note contemplates that the formation meetings will occur in the east. After the first year the travel necessary for monitoring the Association will probably be on the order of one per year.

The contractual monies are primarily for the purpose of securing actuarial assistance for review of the rate structures that will be subject to review by the Director of Insurance.

The director has the duty to contract with the federal government or another unit of government to ensure coordination of the state plan with other governmental assistance programs and to undertake directly or through contracts with other persons, studies or demonstration programs to develop awareness of the benefits of the proposed legislation. The bulk of this activity is expected to be borne by the Association. The state share of this cost is included in the $25.0 shown for contractual. The amount needed for this specific area is really a guess, but we believe that, if anything, it is substantially understated.

The supplies amounts are needed to support mailings necessary to insurers when establishing the Association and for advising insurers of their ongoing role and requirements under this legislation.

It is possible that the division may find it necessary to promulgate regulations to facilitate the formation of the Association. If this is necessary, some of the travel will be moved over to the appropriate areas on the theory that it will reduce travel. Addition of a sum for that purpose would be duplicative.

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: ____________

REQUEST Attached draft of 3/28/86
Bill/Resolution No. CSHB589 (L&C)
Title: "An Act Relating to Disability Insurance"

Sponsor: Sund, et al
Requestor:
Date of Request:

FISCAL DETAIL
Agency Affected: All State Agencies
BRU: Retirement & Benefits

Components: Retirement & Benefits (GHLB)

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES						
RTMNT & BNFTS						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
TRS MATCH						
TOTAL OPERATING		-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL		-0-	-0-	-0-	-0-	-0-

POSITIONS:		-0-	-0-	-0-	-0-	-0-
FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

See attached

Prepared By: J.K. Humphreys, Director
Division: Retirement & Benefits
Phone: 465-4470
Date: 4/7/86

Approved by Commissioner: Eleanor Andrews
Date: 4/9/86
Agency: Department of Administration

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Rev. 11/15/85

Draft CSHB 589 (03/28/86)
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration

ANALYSIS: The work draft of CSHB 589 (L&C) dated March 28, 1986 creates a Comprehensive Disability Insurance Commission to offer health coverage to residents of the State of Alaska. This proposed bill has no apparent effect on the group health plans offered by the State of Alaska to its employees.

CS HB 589 (Judiciary)

An Act relating to disability insurance;
and providing for an effective date.

OVERVIEW

Prepared by Rep. John Sund's office; April 26, 1986

Objective

The primary purpose of HB 589 is to ensure medical insurance availability to those Alaskan residents who are considered too high of a health risk for standard insurance in the open marketplace.

What This Bill Does

HB 589 would establish a nonprofit, statewide association of all disability insurers in the state. Participation in the association would be mandatory in order to do business in the state.

The association would offer major medical insurance and medicare supplement insurance as described in the bill to any Alaskan who cannot get standard coverage or has excessive restrictions placed on his or her insurance. Certain eligibility requirements would be set.

The association members would share the cost of claim payments in excess of premium income through periodic assessments. The association would administer the plan under the monitoring of the director of the Division of Insurance. Little cost would be born by the state. (The bill carries a $37,000 fiscal note that reduces over subsequent years.)

Premium rates would be capped at 150% of the average rate of the plan if it were offered to standard risk people by the five largest disability insurers in the state.

Why This Bill Is Needed

Standard disability insurance is often denied people who are considered high risks, such as older individuals and those who are suffering or have suffered from serious illnesses. Comprehensive insurance should be available to these people. Moreover, providing them insurance should eventually decrease costs to society.

CS HB 589 (Judiciary)

An Act relating to disability insurance; and providing for an effective date.

SECTIONAL ANALYSIS

Prepared by Rep. John Sund's office; April 26, 1986

Section 1
ARTICLE 1
Sec. 21.55.010. Page 1, line 12: creates the Comprehensive Disability Insurance Association, a nonprofit corporation with membership consisting of all licensed disability insurers and licensed hospital or medical service corporations in the state that write on an expense incurred basis. Insurers must be members of the association in order to do business in the state.

Sec. 21.55.020. Page 1, line 22: sets a seven-member board of directors selected by association members and approved by the director of the state Division of Insurance. The director or a designee will be a nonvoting, ex officio member of the board.

Sec. 21.55.030. Page 2, line 12: describes the association's general powers.

Sec. 21.55.040. Page 2, line 21: subjects association articles, bylaws and operating rules to the approval of the director of the Division of Insurance.

Sec. 21.55.050. Page 3, line 26: exempts the association from the Administrative Procedure Act.

Sec. 21.55.060. Page 3, line 28: exempts the association from taxes.

ARTICLE 2
Sec. 21.55.100. Page 4, line 4: offers the state plan, including the medicare supplement plan, on an individual basis to high-risk residents. The association may not deny coverage to any eligible resident.

Sec. 21.55.110. Page 4, line 16: explains the minimum benefits of the state plan, which is a basic major medical plan. Lifetime maximum benefit is $1 million.

Sec. 21.55.120. Page 6, line 26: offers deductibles of $200, $500 or $1,000 per person. The maximum copayment by enrollees would be 20% once the deductible is met for all health care and 50% for mental health care. Maximum annual payments of

deductible and copayments cannot exceed $2,000 per insured. The plan would pay 100% once that limit is reached.

Sec. 21.55.130. Page 7, line 27: excludes coverage for preexisting conditions if the condition began within the three months just preceding the effective date of coverage. Preexisting conditions would not be covered for the first six months of a plan. The limitation can be waived if the insured's previous insurance was terminated and the state plan application is made within 31 days following termination.

Sec. 21.55.140. Page 8, line 22: describes care and services that are not covered by the plan.

Sec. 21.55.150. Page 10, line 9: sets separate scales of premium rates based on age and geographic location of the insured. It also caps the premiums at 150% of the average rate of the plan if it were offered to standard risk people as determined by the five largest disability insurers in the state.

ARTICLE 3

Sec. 21.55.200. Page 10, line 23: sets guidelines for the association's selection of a writing carrier through a bidding process.

Sec. 21.55.210. Page 11, line 1: explains the duties of the writing carrier who will be contracted for three-year terms unless earlier termination is approved by the director.

The carrier will perform the administrative and claims payment functions of the plan and report quarterly to the association. The carrier will be reimbursed for direct and indirect expenses of administering the plan.

Sec. 21.55.220. Page 12, line 11: requires that association members be assessed to share the claim losses and administrative expenses that exceed premium payments. Each member will contribute to the association an amount based on that member's share of all disability insurance premiums paid in the state. Assessments will be made yearly, unless interim assessments are desired.

A member's failure to pay an assessment within 30 days could cease that member's certification to operate in the state.

Net gains will be held at interest to offset future losses.

ARTICLE 4

Sec. 21.55.300. Page 13, line 28: states that all high-risk residents are eligible for the state plan unless covered by another disability insurance policy. A person loses eligibility upon ceasing residency.

Sec. 21.55.310. Page 14, line 10: explains the enrollment procedure.

Sec. 21.55.320. Page 14, line 19: requires the state plan writer to respond to the applicant within 30 days of receiving the application.

Sec. 21.55.330. Page 14, line 24: sets the policy effective date at the day of application once the first premium is paid. It also permits 60 day retroactive coverage for those individuals whose previous insurance terminated, if premiums are paid for the retroactive period.

Sec. 21.55.340. Page 15, line 9: requires that the association advertise the state plan to the public. An insurer who rejects or restricts a policy must tell the applicant about the state plan.

ARTICLE 5

Sec. 21.55.400. Page 15, line 28: explains the duties of the director of the Division of Insurance in regard to the state plan.

Sec. 21.55.410. Page 16, line 10: states the state is not liable for association actions.

Sec. 21.55.500. Page 16, line 14: offers chapter definitions.

Resident is defined as a person who has lived in the state at least six consecutive months prior to application and intends to remain. Absence from the state is permitted for medical and educational reasons.

A high risk resident is defined as someone who has been rejected for disability coverage by at least two association members or has had a restrictive rider placed on a policy.

Section 2. Page 19, line 14: requires that the state plan be available by July 1, 1987.

Section 3. Page 19, line 17: sets an immediate effective date.

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: ______

REQUEST	FISCAL DETAIL
Bill/Resolution No.: HB 589	Agency Affected: All State Agencies
Title: An Act relating to participation in state group life and health insurance	BRU: Retirement & Benefits
Sponsor: Sund	Components: Retirement & Benefits (GHLB)
Requestor:	
Date of Request:	

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		109.4	113.8	118.3	123.1	128.0
RTMNT & BNFTS		13310.0	14374.8	15524.8	16766.8	18108.1
TRAVEL						
CONTRACTUAL		3.9	4.1	4.2	4.4	4.6
SUPPLIES		1.5	.5	.5	.6	.6
EQUIPMENT		15.8	16.4	17.1	17.8	18.5
LAND & STRUCTURES						
GRANTS, CLAIMS						
TRS MATCH						
TOTAL OPERATING		13440.6	14509.6	15664.9	16912.7	18259.8
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
GENERAL FUND		12150.3	13116.7	14161.1	15289.1	16506.9
FEDERAL FUNDS		618.3	667.4	720.6	778.0	839.9
OTHER		672.0	725.5	783.2	845.6	913.0
TOTAL		13440.6	14509.6	15664.9	16912.7	18259.8

POSITIONS:

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
FULL-TIME		3	3	3	3	3
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

See attached

Prepared By: J.K. Humphreys, Director — Phone: 465-4470
Division: Retirement & Benefits — Date: 3/4/86

Approved by Commissioner: Eleanor Andrews — Date: 3/5/86
Agency: Department of Administration

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

 Rev. 11/15/85

House Bill 589
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration

March 4, 1986

Analysis:

Passage of this bill would allow all Alaskans to take advantage of group rates to obtain the health and life coverage as provided to State of Alaska employees.

The State of Alaska now provides health and life insurance coverage to all permanent employees at no cost to the employee. Permanent part-time employees must pay one-half the cost. This analysis does not address any cost increase due to residents enrolling in the life insurance plan. Without requiring evidence of insurability as a condition of enrollment, the cost could heavily impact premiums. It is therefore assumed that this requirement could be imposed or the bill would be amended to allow health coverage only.

We have identified two large groups in the state that would contain individuals likely to enroll in this coverage:

1) Uninsured residents of the state
2) Insured residents of the state other than employees who have equal or comparable levels of health coverage.

The uninsured residents would be considered a higher risk group than state employees or employees insured under other group plans. They could range from young, healthy individuals with no interest or need for insurance to older, chronically ill individuals who are unable to obtain insurance elsewhere. For purposes of this analysis we have assumed medical costs to be 100% higher for these individuals than that of state employees.

The insured residents would also be considered a higher risk group than state employees since those who would enroll would probably be after a higher level of benefits than the insurance plan they were covered by. For purposes of this analysis, we have assumed insurance costs for these individuals to be 25% higher than that of state employees.

We have assumed an equal number of each of the above groups would enroll in this coverage. The FY 87 cost to the state due to the resulting increase in premiums for employees is estimated to be $13.31 million.

House Bill 589
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration

March 4, 1986

In addition to this premium cost increase would be the necessity of adding three permanent full-time positions to collect premiums, administrative fees, report eligibility, and answer questions on plan coverage.

These FY 87 administrative costs are as follows:

Personal Services:		
	1 permanent Retirement & Benefit Specialist for 12 months	$37.2
	2 permanent retirement technicians for 12 months	$72.2
Contractual:		
	Telephone and other contractual costs for 3 positions	3.9
Supplies:		
	Supplies for 3 positions	1.5
Equipment:		
	Equipment accommodations for 3 non-permanent positions	15.8
	Total FY 87 administrative costs	$130.6

The cost for these positions would be paid by participants as provided in the bill. The assumed enrollment of 16,400 would require an $8.00 enrollment fee for each participant. This fee could vary with enrollment.

Position Title	Retirement and Benefits Technician II	
Time Status	**Staff Months**	**RP Number**
1 (PE/FT)	12.0	5

No. of Positions	Range/Step	Barg. Unit	Gov.	Approv.	Disapp.
2	12B	GGU			
Location	**Election District**		**Leg.**		
Juneau	4				

Type of Expenditure		Amount
1	2	3
Salary	53.2	
Benefits	19.0	
Premium Pay		
Other		
Total Personal Services		72.2
Travel		.0
Contractual		2.6
Commodities		1.0
Equipment		9.4
Other		
Total Cost		85.2

Receipt Code	Funding Source		
	Federal Receipts	1002	
	G. F. Match	1003	
	General Funds	1004	
	I-A Receipts	1005	
	Program Receipts	1028	85.2
	CIP Receipts	1061	
	Other		

For B&M Use Only
Key Number __ __ - __ __ - __ __ - __ __ - __ __

Justification

The passage of HB 589 would necessitate the addition of three permanent full-time positions (2 Retirement and Benefits Technicians and 1 Specialist) to collect premiums, administrative fees, report eligibility and answer questions on plan coverage.

3/6B1/0305-01/3

Request For New Position

Agency: Department of Administration
BRU: Retirement and Benefits
Component: Retirement and Benefits

Page 1 of 1
Revised Date

FY 87

Position Title	Retirement and Benefits Specialist I		No. of Positions	Range/Step	Barg. Unit	Gov.	Approv.	Disapp.
Time Status: 1 (PE/FT)	Staff Months: 12.0	RP Number: 5	1	13A	GGU	Leg.		
			Location: Juneau	Election District: 4				

Type of Expenditure		Amount
1	2	3
Salary	27.5	
Benefits	9.7	
Premium Pay		
Other		
Total Personal Services		37.2
Travel		.0
Contractual		1.3
Commodities		.5
Equipment		6.4
Other		
Total Cost		45.4

Receipt Code	Funding Source		
	Federal Receipts	1002	
	G. F. Match	1003	
	General Funds	1004	
	I-A Receipts	1005	
	Program Receipts	1028	45.4
	CIP Receipts	1061	
	Other		

For B&M Use Only
Key Number __ __ - __ __ - __ __ - __ __ - __ __

Justification

The passage of HB 589 would necessitate the addition of three permanent full-time positions (2 Retirement and Benefits Technicians and 1 Specialist) to collect premiums, administrative fees, report eligibility and answer questions on plan coverage.

3/6B1/0305-01

Request For New Position

Agency: Department of Administration
BRU: Retirement and Benefits
Component: Retirement and Benefits

Revised Date

FY 87

POSITION PAPER

House Bill 589

The apparent goal of HB 589, to make available high quality health insurance and basic life insurance coverage at attractive group rates to all Alaskans who are willing to pay for it themselves is hard to argue with. However, there appears to be an underlying misconception that somehow the fact that there are existing policies of group insurance being provided to state employees presents an opportunity for a "free lunch." In fact, when the number of people to be served is large, as it presumably is in this case, there is little if any advantage in combining groups and there are compelling reasons to separate the claims experience of the two groups (state employees and citizens who elect to participate).

Certainly the State of Alaska could make a group health policy available to citizens of the state but it would seem to make more sense to offer a basic, no frills major medical package and price it according to the claims experience of those who choose to enroll in the plan. Bids to provide the coverage could be solicited and a servicing carrier chosen who would collect premiums, pay claims and maintain records. This would provide the maximum advantage to citizens, ensuring a competitive, fair rate without any significant state subsidy and without getting the state

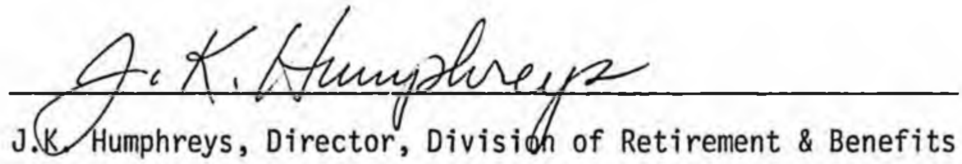
into the insurance business.

Our analysis and position on this bill is based on the assumption that residents would be required to furnish evidence of insurability as a requirement for enrollment in the life insurance coverage or that the bill would be amended to allow for resident participation in the health plan only. Without these requirements, the impact on life insurance premiums would be significant due to the high possibility of adverse selection from the new group.

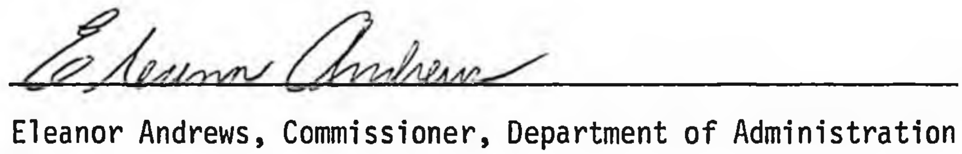
The question that must be answered is, "What possible advantages does the plan in HB 589 have when compared with the scenario described above?" We think there are no real advantages and several serious disadvantages. One might ask if the rates the state enjoys because of a large group of relatively good risks couldn't be passed on to citizens who enroll. This could only be done at the expense of those rates; in other words, if the experience of those who signed up was worse than the state average (and we are reasonably certain it would be), the rate would be driven up for everyone and the state would be in the position of subsidizing coverage for those individuals. We have tried to show this effect in our Fiscal Note analysis. Also, the coverage [illegible] employees, regardless of bargaining unit, is first rate and includes audio, visual and dental coverage; we do not feel it would be appropriate for a general offering in any event.

For these reasons the Department of Administration is opposed to HB 589. If the legislature feels that this issue must be addressed, we feel a

non-subsidized approach such as the one indicated above would be more appropriate.



J.K. Humphreys, Director, Division of Retirement & Benefits — 3/5/86 — Date



Eleanor Andrews, Commissioner, Department of Administration — 3/5/86 — Date

Offered: 4/23/86
Referred: Finance

Original sponsors: Sund, M.M.Miller,
Hurley, et al

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 regar-
26 ding 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 ff[illegible]ed 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).

Offered: 4/8/86
Referred: Judiciary and Finance

Original sponsors: Sund, M.M.Miller, Hurley, et al

1 IN THE HOUSE BY THE LABOR AND COMMERCE COMMITTEE

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

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FOURTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

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

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

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

10 CHAPTER 55. STATE DISABILITY INSURANCE.

11 ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

12 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 and all insurers
16 licensed to transact disability insurance in the state who offer
17 policies for major medical coverage on an expense incurred basis. All
18 members shall maintain membership in the association as a condition of
19 doing disability insurance business in the state.

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

1 consider, among other things, whether all types of participating
2 members are fairly represented. Members of the board other than the
3 director or the director's designee may be reimbursed from the asso-
4 ciation for expenses incurred by them as members, but may not other-
5 wise be compensated by the association for their services. The costs
6 of conducting meetings of the association and its board of directors
7 shall be borne by members of the association.
8 Sec. 21.55.030. GENERAL POWERS. The association may
9 (1) exercise the powers granted to insurers under the laws
10 of the state;
11 (2) sue or be sued;
12 (3) enter into contracts with insurers, similar associa-
13 tions in other states, or with other persons for the performance of
14 administrative functions;
15 (4) establish administrative and accounting procedures for
16 the operation of the association.
17 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall
18 submit to the director a plan of operation and any amendments neces-
19 sary or suitable to assure the fair, reasonable, and equitable admin-
20 istration of the association. The plan of operation and amendments
21 become effective upon approval in writing by the director. If the
22 association fails to submit a suitable plan of operation by a date
23 that is 120 days after the effective date of this Act, or if at any
24 subsequent time the association fails to submit suitable amendments to
25 the plan, the director shall, after notice and hearing, adopt reason-
26 able regulations necessary or advisable to effectuate the provisions
27 of this chapter. These regulations shall continue in force until
28 modified by the director or superseded by a plan submitted by the
29 association and approved by the director.

1 (b) All members of the association shall comply with the plan of
2 operation.
3 (c) The plan of operation shall
4 (1) establish the procedures whereby all the powers and
5 duties of the association under this chapter will be performed;
6 (2) establish procedures for handling assets of the asso-
7 ciation;
8 (3) establish the amount and method of reimbursing members
9 of the board of directors under AS 21.55.020;
10 (4) establish regular places and times for meetings of the
11 board of directors;
12 (5) establish procedures for records to be kept of all
13 financial transactions of the association, its agents, and the board
14 of directors;
15 (6) provide that any member insurer aggrieved by a final
16 action or decision of the association may appeal to the director
17 within 30 days after the action or decision;
18 (7) establish the procedures whereby selections for the
19 board of directors will be submitted to the director;
20 (8) contain additional provisions necessary or proper for
21 the execution of the powers and duties of the association.
22 Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association
23 is exempt from the Administrative Procedure Act (AS 44.62).
24 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from
25 the payment of fees and taxes levied by the state or any of its polit-
26 ical subdivisions except taxes levied on real or personal property.
27 ARTICLE 2. STATE DISABILITY INSURANCE PLANS.
28 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association
29 shall make available to residents the following types of disability

1 insurance plans:

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

3 (2) an individual state plan for residents who are not high

4 risks; and

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

6 risks.

7 (b) For each type of plan listed in (a) of this section, the

8 association shall offer three alternatives related to deductibles as

9 described in AS 21.55.130.

10 (c) The association shall make available to residents who are 65

11 years of age and older a minimum coverage medicare supplement plan and

12 an expanded coverage medicare supplement plan as these plans are

13 described in AS 21.55.120. Each type of medicare supplement plan

14 shall be made available to residents who are high risks and residents

15 who are not high risks.

16 (d) The association may not deny coverage under a state plan to

17 a resident who satisfies the requirements of AS 21.55.300 - 21.55.310.

18 The association shall determine whether a person is a high risk in

19 accordance with (e) of this section and the director's regulations.

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

21 dents who

22 (1) have been rejected after applying for a policy of

23 disability insurance or a medicare supplement policy by at least one

24 association member within the six months immediately preceding the

25 date of application for a state plan;

26 (2) are rejected because of risk factors after applying for

27 a state plan offered to persons who are not high risks;

28 (3) have been treated for any of the following conditions

29 within the three years immediately preceding application for a state

1 plan: angina pectoris, ascites, chemical dependency, cirrhosis of the
2 liver, coronary insufficiency, coronary occlusion, cystic fibrosis,
3 Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's
4 chorea, juvenile diabetes, leukemia, metastatic cancer, motor or
5 sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia
6 gravis, myotonia, open heart surgery, Parkinson's disease, polycystic
7 kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, or
8 Wilson's disease.
9 Sec. 21.55.110. MINIMUM BENEFITS OF STATE DISABILITY INSURANCE
10 PLANS. Except as provided in AS 21.55.120 - 21.55.160, the minimum
11 standard benefits of a disability insurance plan offered under AS 21.-
12 55.100 shall be benefits with a lifetime maximum of $1,000,000 per
13 individual, for usual, customary, reasonable, or prevailing charges
14 or, when applicable, the allowance agreed upon between a provider and
15 the writing carrier for charges actually incurred, for the following
16 medical services performed for an individual covered by the plan for
17 the diagnosis or treatment of nonoccupational disease or nonoccupa-
18 tional injury:
19 (1) hospital services;
20 (2) Subject to the limitations of AS 21.36.090(d), profes-
21 sional services that are rendered by a physician or by a registered
22 nurse at the physician's direction, other than services for mental or
23 dental conditions;
24 (3) the diagnosis or treatment of mental conditions, as
25 defined in regulations of the director, rendered during the year on
26 other than an inpatient basis, up to a yearly maximum benefit of
27 $1,000;
28 (4) legend drugs requiring a physician's prescription;
29 (5) services of a skilled nursing facility for not more

1 than 120 days in a calendar year if the services commence within 14
2 days following a confinement of at least three consecutive days in a
3 hospital for the same condition;
4 (6) home health agency services up to a maximum of 180
5 visits in a calendar year if the services commence within seven days
6 following confinement in a hospital or skilled nursing facility of at
7 least three consecutive days for the same condition, except that in
8 the case of an individual diagnosed by a physician as terminally ill
9 with a prognosis of six months or less to live, the home health agency
10 services may commence irrespective of whether the covered person was
11 previously confined or, if the covered person was confined, irrespec-
12 tive of the seven-day period, and the yearly benefit for medical
13 social services may not exceed $200; in this paragraph, "medical
14 social services" means services rendered under the direction of a
15 physician by a qualified social worker holding a master's degree from
16 an accredited school of social work, including assessment of the
17 social, psychological and family problems related to or arising out of
18 the covered person's illness and treatment, appropriate action and
19 utilization of community resources to assist in resolving the prob-
20 lems, and participation in the development of treatment for the cover-
21 ed person;
22 (7) use of radium or other radioactive materials;
23 (8) outpatient chemotherapy for the removal of tumors and
24 treatment of leukemia, including outpatient chemotherapy;
25 (9) oxygen;
26 (10) anesthetics;
27 (11) nondental prosthesis and maxillo-facial prosthesis used
28 to replace any anatomic structure lost during treatment for head and
29 neck tumors or additional appliances essential for the support of the

1 prosthesis;

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

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

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

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

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

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

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

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

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

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

1 medicare;

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

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

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

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

1 yearly to correspond with the change in the medical care component of
2 the consumer price index as adjusted by the director.
3 (d) In this section, "consumer price index" means the consumer
4 price index for all urban consumers for the Anchorage Metropolitan
5 Area compiled by the Bureau of Labor Statistics, United States Depart-
6 ment of Labor.
7 Sec. 21.55.140. PREEXISTING CONDITIONS. (a) A preexisting
8 condition exclusion in a state plan may not exclude coverage of a
9 preexisting condition unless
10 (1) the condition first manifested itself within the period
11 of six months immediately before the effective date of coverage in a
12 manner that would cause a reasonably prudent person to seek diagnosis,
13 care, or treatment; or
14 (2) medical advice or treatment was recommended or received
15 within the period of six months immediately before the effective date
16 of coverage.
17 (b) A policy may not exclude coverage for a loss due to pre-
18 existing conditions for a period greater than 12 months following the
19 effective date of coverage. An individual state plan issued as a
20 result of conversion from a group state plan shall credit the time
21 covered under the group state plan toward the exclusion for preexist-
22 ing conditions. An individual high risk plan issued as a result of
23 conversion from an individual standard risk plan shall credit the time
24 covered under the standard risk plan toward the exclusion for preex-
25 isting conditions.
26 Sec. 21.55.150. CARE AND SERVICES NOT COVERED. A state plan may
27 not provide benefits for charges for the following:
28 (1) care for an injury or disease either
29 (A) arising out of and in the course of an employment

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

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

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

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

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

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

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

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

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

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

1 primarily to assist an individual in the activities of daily living;

2 (10) service charges that would not have been made if no

3 insurance existed or for which the covered individual is not legally

4 obligated to pay;

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

6 fitting of them;

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

8 (13) services of a registered nurse who ordinarily resides

9 in the covered individual's home, or who is a member of the

10 covered individual's family or the family of the covered indi-

11 vidual's spouse; and

12 (14) experimental procedures.

13 Sec. 21.55.160. COORDINATED COVERAGE. The association shall

14 adopt a procedure for coordination of benefits with other insurance

15 coverage, subject to the approval of the director.

16 Sec. 21.55.170. STATE PLAN PREMIUMS. (a) The association may

17 not charge a rate for coverage issued by or through the association

18 that is excessive, inadequate, or unfairly discriminatory.

19 (b) The association shall use separate scales of premium rates

20 based on age of the insured for individual risks and group risks. The

21 association may charge a higher premium for a high risk plan than for

22 a standard risk plan. The association shall charge a flat rate for

23 coverage of dependents of an insured.

24 (c) Notwithstanding (a) of this section, the schedule of premi-

25 ums for coverage under each type of state plan described in AS 21.55.-

26 100 shall be designed so that each type of plan is self-supporting.

27 The premiums shall be based on generally accepted actuarial princi-

28 ples.

29 ARTICLE 3. ADMINISTRATION OF PLANS.

1 Sec. 21.55.200. SELECTION OF WRITING CARRIERS. The association
2 shall develop bid specifications for members that wish to be selected
3 as a writing carrier to administer a state plan. The selection of the
4 writing carrier shall be based upon criteria including the member's
5 proven ability to handle large group disability insurance cases,
6 efficient claim paying capacity, and the estimate of total charges for
7 administering the plan.
8 Sec. 21.55.210. DUTIES OF WRITING CARRIERS. (a) The writing
9 carrier shall perform the administrative and claims payment functions
10 required by this section. The writing carrier shall provide these
11 services for a period of three years, unless a request to terminate is
12 approved by the director. The director shall approve or deny a re-
13 quest to terminate within 90 days of its receipt. A failure to make a
14 final decision on a request to terminate within the specified period
15 shall be considered an approval. Six months before the expiration of
16 each three-year period, the association shall invite submissions of
17 policy forms from members of the association, including the writing
18 carrier. The association shall follow the provisions of AS 21.55.210
19 in selecting a writing carrier for the subsequent three-year period.
20 (b) The writing carrier shall provide to all eligible persons
21 enrolled in a state plan an individual policy or certificate, setting
22 out a statement of the insurance protection to which the person is
23 entitled, with whom claims are to be filed, and to whom benefits are
24 payable. The policy or certificate must indicate that coverage was
25 obtained through the association.
26 (c) The writing carrier shall submit to the association and the
27 director on a monthly basis a report on the operation of the state
28 plans. Specific information to be contained in the report shall be
29 determined by the association.

1 (d) Claims shall be paid by the writing carrier and shall indi-
2 cate that the claim was paid under a state plan. A claim payment
3 shall include information specifying the procedure to be followed in
4 the event of a dispute over the amount of payment and a contact per-
5 son's name and telephone number that can be used for inquiries regard-
6 ing the claim.
7 (e) The writing carrier shall be reimbursed from the state plan
8 premiums received for its direct and indirect expenses for administer-
9 ing the plan. Direct and indirect expenses shall include a pro rata
10 reimbursement for that portion of the writing carrier's administra-
11 tive, printing, claims administration, management and building over-
12 head expenses that are assignable to the maintenance and administra-
13 tion of the state plans. The association shall approve cost account-
14 ing methods to substantiate the writing carrier's cost reports consis-
15 tent with generally accepted accounting principles. Direct and in-
16 direct expenses may not include costs directly related to the original
17 submission of policy forms before selection as the writing carrier.
18 (f) The writing carrier shall at all times when carrying out its
19 duties under this chapter be considered an agent of the association.
20 Sec. 21.55.220. OPERATION OF THE PLAN. (a) Upon notification
21 as an eligible person or group under AS 21.55.320, a person or group
22 may enroll in a state plan by payment of the appropriate state plan
23 premium to the writing carrier.
24 (b) An employer that has in its employ one or more eligible
25 persons enrolled in a state plan may make all or a portion of a state
26 plan premium payment directly to the writing carrier.
27 (c) At least 85 percent of the state plan premiums paid to the
28 writing carrier shall be used to pay claims; not more than 15 percent
29 may be used for the payment of agent referral fees under this chapter

1 and for payment of the writing carrier's direct and indirect expenses
2 under this chapter.
3 (d) Each contributing member of the association shall share the
4 losses due to claims expenses of the state plans for plans issued or
5 approved for issuance by the association, and shall share in the
6 operating and administrative expenses incurred or estimated to be
7 incurred by the association incident to the conduct of its affairs.
8 Claims expenses of the state plan that exceed the premium payments
9 allocated to the payment of benefits shall be the liability of the
10 contributing members. Contributing members shall share in the claims
11 expense of the state plans and operating and administrative expenses
12 of the association in an amount equal to the ratio of the contributing
13 member's total disability insurance premium, received from or on
14 behalf of state residents, as divided by the total disability insur-
15 ance premium received by all contributing members from or on behalf of
16 state residents, as determined by the director.
17 (e) The association shall make an annual determination of each
18 contributing member's liability, if any, and may make an annual fiscal
19 year end assessment if necessary. The association may also, subject
20 to the approval of the director, provide for interim assessments
21 against the contributing members as may be necessary to assure the
22 financial capability of the association in meeting the incurred or
23 estimated claims expenses of the state plans and operating and admin-
24 istrative expenses of the association until the association's next
25 annual fiscal year end assessment. Payment of an assessment is due
26 within 30 days of receipt by a contributing member of a written notice
27 of a fiscal year end or interim assessment. Failure by a contributing
28 member to tender to the association the assessment within 30 days
29 shall be grounds for termination of the contributing member's

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

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

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

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

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

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

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

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

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

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

1 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days
2 after receiving the certificate described in AS 21.55.310, the writing
3 carrier shall either reject the application for failing to comply with
4 the requirements of AS 21.55.300 and 21.55.310 or forward the eligible
5 person a notice of acceptance and billing information. Insurance is
6 effective immediately upon receipt of the first quarterly premium, and
7 is retroactive to the date of the application, if the applicant other-
8 wise complies with the requirements of this chapter.
9 Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The
10 association, under a plan approved by the director, shall disseminate
11 appropriate information to the residents of the state regarding the
12 existence of the state plans for persons who are high risks and the
13 means of enrollment. Means of communication may include use of the
14 press, radio, and television, as well as publication in appropriate
15 state offices and publications.
16 (b) The association shall devise and implement means of main-
17 taining public awareness of the provisions of this chapter and shall
18 administer this chapter in a manner that facilitates public participa-
19 tion in e state plans.
20 (c) he writing carrier shall pay an agent's referral fee of $50
21 to each insurance agent who refers an applicant to a state plan, if
22 the application is accepted. Selling or marketing of qualified state
23 plans is limited to licensed disability insurance agents. The refer-
24 ral fees shall be paid by the writing carrier from money received as
25 premiums for a state plan.
26 (d) An insurer that rejects or applies underwriting restrictions
27 to an applicant for disability insurance or a medicare supplement plan
28 in the state shall notify the applicant of the existence of the state
29 plans, the requirements for being accepted, and the procedure for

1 applying.

2 ARTICLE 5. GENERAL PROVISIONS.

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

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

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

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

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

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

18 Sec. 21.55.500. DEFINITIONS. In this chapter

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

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

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

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

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

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

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

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

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

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

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

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

1 association through a writing carrier;

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

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

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

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

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

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

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

23

Introduced: 2/14/86
Referred: Labor & Commerce
Judiciary and Finance

1 IN THE HOUSE — BY SUND, M.M. MILLER, HURLEY, DUNCAN, NAVARRE, AND DAVIS

2 HOUSE BILL NO. 589

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 participation in the state group
7 life and health insurance policies by residents; and
8 providing for an effective date."

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

10 * Section 1. AS 39.30.090 is amended to read:

11 Sec. 39.30.090. PROCUREMENT OF GROUP INSURANCE. The Department
12 of Administration may obtain a policy or policies of group insurance
13 covering state employees, persons entitled to coverage under AS 14.-
14 25.168, AS 22.25.090, AS 39.35.535 or former AS 39.37.145, [OR] em-
15 ployees of other participating governmental units, <u>or eligible resi-</u>
16 <u>dents,</u> subject to the following conditions:

17 (1) A group insurance policy shall provide one or more of
18 the following benefits: life insurance, accidental death and dismem-
19 berment insurance, weekly indemnity insurance, hospital expense insur-
20 ance, surgical expense insurance, dental expense insurance, audio-
21 visual insurance, or other medical care insurance.

22 (2) Each eligible employee of the state, the spouse and the
23 unmarried children chiefly dependent on the eligible employee for
24 support, and each eligible employee of another participating govern-
25 mental unit shall be covered by the group policy, unless exempt under
26 regulations adopted by the commissioner of administration.

27 (3) A governmental unit may participate under a group
28 policy if

29 (A) its governing body adopts a resolution authorizing

1 participation, and payment of required premiums;

2 (B) a certified copy of the resolution is filed with

3 the Department of Administration; and

4 (C) the commissioner of administration approves the

5 participation in writing.

6 (4) The Department of Administration shall obtain the

7 insurance policy from an [ANY] insurer authorized to transact business

8 in the state under AS 21.09 and AS 21.90.

9 (5) The Department of Administration shall make available

10 bid specifications for desired insurance benefits to all insurance

11 carriers licensed in the state and qualified to provide the desired

12 benefits. The specifications shall be made available on or before

13 July 1, 1965, and at least once every succeeding five years. The

14 lowest responsible bid submitted by an insurance carrier with adequate

15 servicing facilities shall govern selection of a carrier under this

16 section.

17 (6) If the aggregate of dividends payable under the group

18 insurance policy exceeds the governmental unit's share of the premium,

19 the excess shall be applied by the governmental unit for the sole

20 benefit of the employees.

21 (7) A person receiving benefits under AS 14.25.110,

22 AS 22.25, AS 39.35, or former AS 39.37 may continue the life insurance

23 coverage that was in effect under this section at the time of termina-

24 tion of employment with the state or participating governmental unit.

25 (8) A person electing to have insurance under (7) of this

26 section shall pay the cost of this insurance.

27 (9) For each permanent part-time employee electing coverage

28 under this section, the state shall contribute one-half the state

29 contribution rate for permanent full-time state employees, and the

1 permanent part-time employee shall contribute the other one-half.

2 (10) A person receiving benefits under AS 14.25, AS 22.25,
3 AS 39.35, cr former AS 39.37 may obtain auditory, visual, and dental
4 insurance for that person and eligible dependents under this section.
5 The level of coverage for persons over 65 shall be the same as that
6 available before reaching age 65 except that the benefits payable
7 shall be supplemental to any benefits provided under the federal old
8 age, survivors, and disability insurance program. A person electing
9 to have insurance under this paragraph shall pay the cost of the
10 insurance. The commissioner of administration shall adopt regulations
11 implementing this paragraph.

12 (11) An eligible resident may participate if the resident
13 applies on forms provided by the department, pays the cost of the
14 insurance and the administrative fee set by the department, and the
15 commissioner of administration approves the application in writing.

16 * Sec. 2. AS 39.30.095(a) is amended to read:

17 (a) The commissioner of administration shall establish the group
18 health and life benefits fund as a special account in the general fund
19 to provide for group life and health insurance under AS 39.30.090 and
20 39.30.160. The commissioner shall maintain accounts and records for
21 the fund. The fund consists of employer contributions, employee
22 contributions, resident contributions, appropriations from the legis-
23 lature, and interest earned on investment of the fund as provided in
24 (d) of this section.

25 * Sec. 3. AS 23.30.095(b) is amended to read:

26 (b) After obtaining the advice of an actuary, the commissioner
27 of administration shall determine the amount necessary to provide
28 benefits under AS 39.30.090 and 39.30.160 and shall set the rate of
29 employer contribution, resident contribution, and employee contri-

1 bution, if any. The commissioner of administration shall pay premiums
2 and claims in accordance with the insurance policies in effect under
3 AS 39.30.090 and 39.30.160 with money in the fund.

4 * Sec. 4. AS 39.30.100 is amended by adding a new paragraph to read:
5 (4) "eligible resident" means a person who is a resident
6 and who has been a resident, except for absences from the state for
7 military service or necessary medical care, for the 12 consecutive
8 months immediately preceding the date of application.

9 * Sec. 5. By January 1, 1987, the commissioner of administration shall
10 secure a group health and life policy or policies to provide coverage for
11 persons who will become eligible for coverage under amendments made by this
12 Act.

13 * Sec. 6. Sections 1 - 4 of this Act take effect on the date that the
14 commissioner of administration has secured coverage under sec. 5 of this
15 Act.

16 * Sec. 7. Section 5 of this Act takes effect immediately in accordance
17 with AS 01.10.070(c).