



# LAWS OF ALASKA

1992

**Source**

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**Chapter No.**

126

**AN ACT**

Relating to pooled health insurance for individuals who are uninsured or denied adequate coverage; and providing for an effective date.

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

THE ACT FOLLOWS ON PAGE 1

**Approved by the Governor:** June 24, 1992

**Actual Effective Date:** June 25, 1992

AN ACT

1 Relating to pooled health insurance for individuals who are uninsured or denied adequate coverage; and  
2 providing for an effective date.

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4 \* **Section 1. PURPOSE.** It is the purpose of this Act to provide access to health insurance to all  
5 residents of the state who are presently denied adequate health insurance or who are considered  
6 uninsurable.

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

8 CHAPTER 55. STATE HEALTH INSURANCE.

9 ARTICLE 1. COMPREHENSIVE HEALTH INSURANCE ASSOCIATION.

10 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit  
11 incorporated legal entity to be known as the Comprehensive Health Insurance Association.  
12 Membership consists of all licensed hospital or medical service corporations in the state that offer  
13 subscriber contracts for major medical coverage and all insurers licensed to transact health  
14 insurance in the state that offer policies for major medical coverage on an expense incurred basis.

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1 All members shall maintain membership in the association as a condition of doing health  
2 insurance business, or being able to offer subscriber contracts, in the state.

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

18 (b) The board shall study and report to the legislature at least once every three years on  
19 the effectiveness of this chapter. The report must include an analysis of the effectiveness of this  
20 chapter in promoting rate stability, product availability, and affordability of coverage. The report  
21 may contain recommendations for legislative or other regulatory action.

22 Sec. 21.55.030. GENERAL POWERS. The association may  
23 (1) exercise the powers granted to insurers under the laws of the state;  
24 (2) sue or be sued;  
25 (3) enter into contracts with insurers, similar associations in other states, or with  
26 other persons for the performance of administrative functions;  
27 (4) establish administrative and accounting procedures for the operation of the  
28 association; and  
29 (5) receive funds from sources other than members of the association.

30 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the  
31 director a plan of operation and amendments necessary or suitable to assure the fair, reasonable,

1 and equitable administration of the association. The plan of operation and amendments become  
2 effective upon approval in writing by the director. If the association fails to submit a suitable  
3 plan of operation by a date that is 180 days after the effective date of this Act, or if at subsequent  
4 time the association fails to submit suitable amendments to the plan, the director may, after notice  
5 and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of  
6 this chapter. These regulations shall continue in force until modified by the director or  
7 superseded by a plan submitted by the association and approved by the director.

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

9 (c) The plan of operation shall

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

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

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

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

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

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

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

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

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

26 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from the payment of fees  
27 and taxes levied by the state or any of its political subdivisions except taxes levied on real or  
28 personal property.

29 ARTICLE 2. STATE HEALTH INSURANCE PLANS.

30 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association shall make  
31 available to residents who are high risks an individual state plan of health insurance. The

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1 association shall offer three alternatives related to deductibles as described in AS 21.55.120 and  
2 may offer additional deductible alternatives.

3 (b) The association shall make available to residents who are high risks, eligible for and  
4 covered by Medicare, 65 years of age or older, and eligible under this chapter at least one  
5 Medicare supplement plan that meets the minimum policy standards and minimum benefit  
6 standards established by regulations adopted by the director under AS 21.89.060.

7 (c) The association may not refuse to offer coverage under a state plan to residents who  
8 are high risks and who are eligible under this chapter. The association may not refuse coverage  
9 under a state plan to residents who are high risks, are eligible under this chapter, apply for  
10 coverage, and pay the required premium.

11 Sec. 21.55.110. MINIMUM BENEFITS OF STATE HEALTH INSURANCE PLAN.

12 Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health  
13 insurance plan offered under AS 21.55.100(a) shall be benefits with a lifetime maximum of  
14 \$1,000,000 per individual for usual, customary, reasonable, or prevailing charges or, when  
15 applicable, the allowance agreed upon between a provider and the writing carrier for charges, for  
16 the following medical services performed for an individual covered by the plan for the diagnosis  
17 or treatment of nonoccupational disease or nonoccupational injury:

18 (1) hospital services;

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

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

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

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

28 (6) home health agency services up to a maximum of 270 visits in a calendar year  
29 if the services commence within seven days following confinement in a hospital or skilled  
30 nursing facility of at least three consecutive days for the same condition, except that in the case  
31 of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less

1 to live, the home health agency services may commence irrespective of whether the covered  
2 person was previously confined or, if the covered person was confined, irrespective of the seven-  
3 day period, and the yearly benefit for medical social services may not exceed \$200;

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

5 (8) use of radium or other radioactive materials;

6 (9) outpatient chemotherapy;

7 (10) oxygen;

8 (11) anesthetics;

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

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

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

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

18 (16) services of a licensed physical therapist rendered under the direction of a  
19 physician;

20 (17) transportation by a local ambulance operated by licensed or certified  
21 personnel to the nearest health care institution for treatment of the illness or injury and round trip  
22 transportation by air to the nearest health care institution for treatment of the illness or injury if  
23 the treatment is not available locally; if the patient is a child under 12 years of age, the  
24 transportation charges of a parent or legal guardian accompanying the child may be paid if the  
25 attending physician certifies the need for the accompaniment;

26 (18) confinement in a licensed or certified facility established primarily for the  
27 treatment of alcohol or drug abuse or in a part of a hospital used primarily for this treatment, for  
28 a period of at least 45 days within any calendar year;

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

31 (20) second surgical opinions;

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

3 Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan other than a  
4 Medicare supplement plan may require deductibles of \$200 a person, \$500 a person, or \$1,000  
5 a person. The amount of the deductible may not be greater when a service is rendered on an  
6 outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during  
7 the last three months of a calendar year and actually applied to an individual's deductible for that  
8 year shall also be applied to that individual's deductible in the following calendar year. The  
9 \$200 maximum, the \$500 maximum, and the \$1,000 maximum may be adjusted yearly to  
10 correspond with the change in the medical care component of the Consumer Price Index, as  
11 adjusted by the director. The base year for the computation shall be the first full calendar year  
12 of operation of the association.

13 (b) A state plan other than a Medicare supplement plan shall require a maximum  
14 copayment of 20 percent for charges for all types of health care in excess of the deductible and  
15 50 percent for services described in AS 21.55.110(3) in excess of the deductible.

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

23 (d) In this section, "Consumer Price Index" means the Consumer Price Index for all  
24 urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor  
25 Statistics, United States Department of Labor.

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

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

31 (2) medical advice or treatment was recommended or received within the period

1 of three months immediately before the effective date of coverage.

2 (b) A policy may not exclude coverage for a loss due to preexisting conditions for a  
3 period greater than six months following the effective date of coverage.

4 (c) A state plan issued to a person whose previous subscriber contract, health policy, or  
5 Medicare supplement policy was involuntarily terminated shall credit the time covered under the  
6 previous contract or policy toward an exclusion for preexisting conditions under the state plan  
7 if the previous contract or policy had a similar preexisting condition exclusion and the person  
8 applies for a state plan within 31 days after termination of the previous contract or policy. If a  
9 person covered by this subsection is accepted by the writing carrier and pays a specified premium  
10 for retroactive coverage, the state plan is effective retroactively to the date that the person's  
11 previous contract or policy terminated.

12 Sec. 21.55.140. PERSONS, CARE, AND SERVICES NOT COVERED. (a) A state plan  
13 may not provide benefits for charges for the following:

14 (1) care for an injury or disease either

15 (A) arising out of and in the course of an employment subject to a  
16 workers' compensation or similar law or where the benefit is available to be provided  
17 under a workers' compensation policy or equivalent self-insurance to a sole proprietor,  
18 business partner, or corporation officer; or

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

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

25 (3) travel, other than transportation covered under AS 21.55.110(17);

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

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

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

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1 section;

2 (7) services or articles that are not within the scope of the license or certificate  
3 of the institution or individual rendering the services or articles;

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

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

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

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

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

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

15 (14) experimental procedures; and

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

17 (b) A state plan may not provide coverage for a person eligible for major medical  
18 coverage under

19 (1) another state or federal law, including veterans' benefits, Native health care,  
20 or Medicaid; or

21 (2) another health benefit program, including a self-insurance plan, health care  
22 trust, or welfare trust.

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

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

28 (c) The five members of the association that insure, or have subscriber contracts with,  
29 the largest number of individuals in the state under plans with benefits substantially equivalent  
30 to the state plan benefits shall submit to the association an estimate of the rate that would be  
31 actuarially sound for a person who is a standard risk for coverage substantially equivalent to the

1 state plan. The premium for a state plan may not exceed 200 percent of the average of those five  
2 estimates.

### 3 ARTICLE 3. ADMINISTRATION OF PLANS.

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

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

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

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

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

28 (e) The writing carrier shall be reimbursed from the state plan premiums received for its  
29 direct and indirect expenses for administering the plan. Direct and indirect expenses shall include  
30 a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims  
31 administration, management and building overhead expenses that are assignable to the

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1 maintenance and administration of the state plans. The association shall approve cost accounting  
2 methods to substantiate the writing carrier's cost reports consistent with generally accepted  
3 accounting principles. Direct and indirect expenses may not include costs directly related to the  
4 original submission of policy forms before selection as the writing carrier.

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

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

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

12 (c) Each member of the association shall share the losses due to claims expenses of the  
13 state plans issued or approved for issuance by the association, and shall share in the operating  
14 and administrative expenses incurred or estimated to be incurred by the association incident to  
15 the conduct of its affairs. Claims expenses of the state plan that exceed the premium payments  
16 allocated to the payment of benefits shall be the liability of the members. Each member shall  
17 share in the claims expense of the state plans and operating and administrative expenses of the  
18 association in an amount equal to the ratio of the member's total fees for subscriber contracts or  
19 total health insurance premiums, received from or on behalf of state residents, as divided by the  
20 total subscriber fees and health insurance premiums received by all members from or on behalf  
21 of state residents, as determined by the director.

22 (d) The association shall make an annual determination of each member's liability, if any,  
23 and may make an annual fiscal year end assessment if necessary. The association may also,  
24 subject to the approval of the director, provide for interim assessments against the members as  
25 may be necessary to assure the financial capability of the association in meeting the incurred or  
26 estimated claims expenses of the state plans and operating and administrative expenses of the  
27 association until the association's next annual fiscal year end assessment. Payment of an  
28 assessment is due within 30 days of receipt by a member of written notice of a fiscal year end  
29 or interim assessment. Failure by a member to tender to the association the assessment within  
30 30 days shall be grounds for revocation of a member's certificate of authority. A member that  
31 ceases to do health insurance business in the state, or ceases to offer subscriber contracts in the

1 state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains  
2 liable for assessments through the calendar year that the health insurance business ceased. The  
3 association may decline to levy an assessment against a member if the assessment would not  
4 exceed \$10. Assessments paid by a member are a general expense of the member.

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

#### 8 ARTICLE 4. ENROLLMENT IN THE STATE HEALTH INSURANCE PLAN.

9 Sec. 21.55.300. ELIGIBILITY FOR STATE HEALTH INSURANCE. (a) Except as  
10 provided in (b) of this section, a state resident who is a high risk is eligible to enroll in a state  
11 plan described in AS 21.55.100.

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

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

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

- 20 (1) name, address, age, and length of residency of the applicant;
- 21 (2) a designation of the plan desired, including deductible option chosen;
- 22 (3) information relevant to whether the person is a high risk.

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

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

31 (b) Insurance under a state plan is effective retroactively to the date that the person's

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1 previous contract or policy terminated if the person

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

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

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

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

11 (b) The association shall devise and implement means of maintaining public awareness  
12 of the provisions of this chapter regarding the state plans and shall administer this chapter in a  
13 manner that facilitates public participation in the state plans.

14 (c) A person may not sell or market a qualified state plan unless the person is acting  
15 within the scope of a license issued in this state.

16 (d) An insurer or hospital or medical service corporation that rejects or applies  
17 underwriting restrictions to an applicant for a subscriber contract, a health insurance policy, or  
18 a Medicare supplement plan in the state shall notify the applicant of the existence of the state  
19 plans, the requirements for being accepted, and the procedure for applying.

20 ARTICLE 5. GENERAL PROVISIONS.

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

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

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

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

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

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

1 claim under a state plan issued by a writing carrier.

2 Sec. 21.55.500. DEFINITIONS. In this chapter

3 (1) "association" means the Comprehensive Health Insurance Association created  
4 in AS 21.55.010;

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

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

9 (4) "health insurance" means an individual or group contract or other plan  
10 providing coverage of health care services that is issued by a health insurance company, a  
11 hospital service corporation, a medical service corporation, or a health maintenance organization;  
12 "health insurance" includes disability insurance under AS 21.12.050;

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

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

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

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

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

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

29 (6) "hospice services" means services provided under a coordinated comprehensive  
30 program of palliative and supportive care on a 24-hour, seven days per week basis for persons  
31 who have been diagnosed as terminally ill and their families by an interdisciplinary team of

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1 professionals or volunteers under an incorporated central administration that has a physician as  
2 medical director;

3 (7) "major medical coverage" means a health insurance contract, or a subscriber  
4 contract, that provides benefits for hospital and medical care with potential lifetime maximum  
5 benefits per insured of at least \$10,000;

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

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

19 (10) "residents who are high risks" means residents who

20 (A) have been rejected for medical reasons after applying for a subscriber  
21 contract, a policy of health insurance, or a Medicare supplement policy by at least two  
22 association members within the six months immediately preceding the date of application  
23 for a state plan; medical reasons may include preexisting medical conditions, a family  
24 history that predicts future medical conditions, or an occupation that generates a frequency  
25 or severity of injury or disease that results in coverage not being generally available; or

26 (B) have had a restrictive rider placed on a subscriber contract, a health  
27 insurance policy, or a Medicare supplement policy that substantially reduces coverage;

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

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

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

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

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

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

10 \* Sec. 3. The association established by sec. 2 of this Act shall make available to residents the plans  
11 required by AS 21.55.100, enacted in sec. 2 of this Act, by January 1, 1993.

12 \* Sec. 4. This Act takes effect immediately under AS 01.10.070(c).