THE REGULATIONS REPRODUCED HERE HAVE BEEN PROVIDED BY THE DIVISION OF INSURANCE AS A PUBLIC COURTESY. WHILE EVERY EFFORT HAS BEEN MADE TO ASSURE THE ACCURACY OF THE REPRODUCED VERSION, THE DIVISION OF INSURANCE CANNOT GUARANTEE ITS ABSOLUTE ACCURACY. A COPY OF THE REGULATIONS AS ORIGINALLY FILED BY THE LIEUTENANT GOVERNOR ARE AVAILABLE FROM THE DIVISION OF INSURANCE OR ON THE ALASKA ONLINE PUBLIC NOTICE SYSTEM.

THE REGULATIONS HAVE AN EFFECTIVE DATE OF DECEMBER 22, 2016, ARE IN REGISTER 220, AND WILL APPEAR IN OFFICIAL PUBLISHED FORM IN THE JANUARY 2016 SUPPLEMENT TO THE ALASKA ADMINISTRATIVE CODE.

Title 3. Commerce, Community, and Economic Development.

Part 2. Division of Insurance.

Chapter 31. Miscellaneous.

Article 4. Comprehensive Health Insurance Association Reinsurance Program.

Section

3 AAC 31.500 is repealed and readopted to read:

3 AAC 31.500. Purpose and applicability. (a) The purpose of 3 AAC 31.500 – 3 AAC 31.549 is to

(1) implement a reinsurance program for high risk residents in the individual health care insurance market in order to stabilize health care insurance premiums;

(2) encourage participation in this state's individual health care insurance market; and

(3) allow the director to apply to the United States Secretary of Health and Human Services under 42 U.S.C. 18052 for a waiver of applicable provisions of P.L. 111-148 (Patient Protection and Affordable Care Act).

(b) Except for a health care insurance plan providing grandfathered health care coverage and a health care insurance plan providing transitional health care coverage, 3 AAC 31.500 – 3 AAC 31.549 applies to a health care insurance plan in the individual market offered on or off a health care exchange.

(c) A health care insurer shall cede to the program the risk associated with insuring an eligible high risk resident who is issued a health care insurance plan in the individual market on or after January 1, 2017 and before the cessation of the program.

(d) Nothing in 3 AAC 31.500 - 3 AAC 31.549 requires a health care insurer to offer or issue a health care insurance plan in the individual market. (Eff. 2/2/2013, Register 205; am ___/___/____, Register ____)

Authority: AS 21.06.090 AS 21.55.400 **AS 21.96.120**

AS 21.55.220

3 AAC 31 is amended by adding a new section to read:

3 AAC 31.505. Establishment of high risk reinsurance program. (a) There is established within the Comprehensive Health Insurance Association a program to reinsure high risk residents of this state diagnosed with one or more of the covered conditions under 3 AAC 31.540. The program will be referred to as the Alaska Reinsurance Program.

(b) The Alaska Reinsurance Program will have a segregated fund established within the association. The segregated fund will hold all receipts and make all disbursements related to the program. All obligations of the Alaska Reinsurance Program, including payment or reimbursements of claims and expenses, will be limited to the monies available within the program fund.

(c) The association shall administer the reinsurance program under a contract with the director. The program will have its own plan of operation to establish administrative and accounting procedures necessary or proper to implement and administer the program.

(d) The Alaska Reinsurance Program becomes effective January 1, 2017. (Eff. ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.430
AS 21.55.040 AS 21.55.400

3 AAC 31.510 is amended to read:

3 AAC 31.510. Association duties. (a) The association shall establish **a plan of operation** [ADMINISTRATIVE AND ACCOUNTING PROCEDURES] for

the **administration and** operation of **the Alaska Reinsurance Program** [A REINSURANCE PROGRAM] under which a health care insurer **shall** [MAY] cede the risk of **a high risk resident** [ELIGIBLE INDIVIDUALS] to the **program** [ASSOCIATION]. **The plan of operation must include**

(1) a description of the data a health care insurer submitting a reinsurance payment request must provide to the association for the association to implement and administer the reinsurance program, including data necessary for the association to determine a health care insurer's eligibility for reinsurance payments;

(2) guidance to insurers relating to diagnosis codes for identifying residents with covered conditions under the program;

(3) the manner and time period in which a health care insurer must provide the data described under (1) of this subsection;

(4) requirements for reporting and processing reports submitted by health care insurers as required by the association;

(5) requirements for conducting audits under 3 AAC 31.530; and

(6) details of an annual actuarial study of this state's individual market that

(A) measures the impact of the program;

(B) recommends funding levels; and

(C) reveals emerging conditions within the market.

(b) The association shall accept a risk ceded to it **with respect to a high risk resident** in compliance with 3 AAC 31.500 – 3 AAC 31.549 effective on the date coverage becomes effective with the health care insurer and shall continue to accept a risk ceded to it **until March 1**

of the year following the calendar year in which the high risk resident's coverage becomes effective with the health care insurer or, if earlier, the date on which the coverage terminates or the reinsurance program ceases active operation [AS LONG AS THE INDIVIDUAL REMAINS INSURED UNDER THE SAME HEALTH CARE INSURANCE PLAN WITH THE SAME HEALTH CARE INSURER].

3 AAC 31.510 is amended by adding a new subsection to read:

(c) The association shall establish a process to reimburse, on a quarterly basis, participating health insurers for claims paid with respect to risk ceded to the program. (Eff. 2/2/2013, Register 205; am ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 **AS 21.55.430**
AS 21.55.040 AS 21.55.400

3 AAC 31 is amended by adding a new section to read:

3 AAC 31.515. Health care insurer eligibility for reinsurance payments. (a) A health care insurer is eligible for reinsurance payments to reimburse the insurer for the claims of a high risk resident for a benefit year if the health care insurer

(1) provides evidence to the association that the health care insurer has paid a claim of a high risk resident for the applicable benefit year that is for a covered condition listed under 3 AAC 31.540;

(2) continues to pay the claims of a high risk resident for the applicable benefit year;

(3) pays to the association, under (b) of this section, the premium amount the health care insurer receives under the insurance policy for the applicable benefit year covering the eligible high risk resident;

(4) pays to the association, under (c) of this section, pharmacy rebates the health care insurer receives for the applicable benefit year for health care services provided to the applicable high risk resident; and

(5) reports to the association payments, applicable to the high risk resident, the health care insurer collects for

(A) third party liabilities;

(B) payments the health care insurer recovers for overpayments;

(C) payments for commercial reinsurance recoveries; and

(D) estimated federal cost-sharing reduction payments made under 42 U.S.C. 18071.

(b) The health care insurer shall pay to the association the separately identifiable premium amount the health care insurer received under the insurance policy for the applicable benefit year covering the eligible high risk resident not later than 30 calendar days after the association accepts a risk ceded to it with respect to a high risk resident. If the high risk resident is covered under a family policy and the high risk resident has a separately identifiable premium equal to $0, the health care insurer shall pay to the association the highest separately identifiable premium under the family policy. For each additional high risk resident covered under a family policy who has a separately identifiable premium equal to $0, the health care insurer shall pay to the association the next highest separately identifiable premium under the family policy.

(c) A health care insurer shall pay to the association a pharmacy rebate required to be paid to the association under (a)(4) of this section not later than 30 calendar days after receipt of the pharmacy rebate. (Eff. ____/____/____, Register ____)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.400

3 AAC 31.520 is repealed and readopted to read:

3 AAC 31.520. Health care insurer duties and rules. (a) A health care insurer shall comply with the requirements established by the association in order to cede a risk to the association.

(b) A health care insurer shall continue to administer and manage the policy for risk ceded to the association in accordance with the terms of the insurance policy and with the insurance law of this state.

(c) A health care insurer shall offer individuals that may be ceded to the association the same plans offered to other individuals.

(d) A health care insurer may not vary premium rates based on whether a risk is ceded to the association.

(e) A health care insurer may cede a risk to the association with respect to a high risk resident at any time during the period beginning on the date the high risk resident's coverage becomes effective with the health care insurer and ending on March 1 of the year following the calendar year in which the high risk resident's coverage becomes effective with the health care insurer. A health care insurer that wishes to cede risk with respect to a high risk resident to the association in a subsequent calendar year shall re-cede that risk for that calendar year.

(f) A health care insurer shall submit to the program claims incurred during a calendar year for a ceded risk not later than 18 months after that calendar year for the claim to be eligible for reimbursement from the program. (Eff. 2/2/2013, Register 205; am ___/___/___, Register___)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.400

3 AAC 31 is amended by adding a new section to read:

3 AAC 31.525. Premiums and other financial matters. (a) A health care insurer shall forward all premiums to the association for each risk ceded to the program and may not retain any portion of the premium.

(b) A health care insurer shall report to the association amounts collected by a health care insurer for

(1) third party liabilities;

(2) overpayment recoveries;

(3) estimated federal cost-sharing reduction payments made under 42 U.S.C. 18071;

(4) commercial reinsurance recoveries;

(5) pharmacy rebates; and

(6) any other similar amounts with respect to risk ceded to the program.

(c) The association shall retain all premiums it receives in excess of administrative and operational expenses and claims paid for ceded risks in a calendar year and shall apply any

excess premiums toward payment of future administrative and operational expenses and claims incurred by ceded risks in subsequent years of the program.

(d) Premiums received by the association for the program will be used first to pay, or to establish reasonable reserves for payment of, administrative and operational expenses of the program and second to pay claims for risks ceded to the program. Claims for risks ceded to the program will be paid first from premiums remaining available after payment of, or establishment of reasonable reserves for payment of, administration and operational expenses of the program and second from other available program funds. (Eff. ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.430
AS 21.55.040 AS 21.55.400

3 AAC 31.530 is repealed and readopted to read:

3 AAC 31.530. Accounting, reporting, and auditing. (a) A health care insurer that cedes a risk to the program shall submit to the program all data and information when required by the association and in the manner and format required by the association. The data and information must include

(1) eligibility information;

(2) claims information; and

(3) premium information.

(b) The association shall maintain its books, records, accounts, and operations on a calendar-year basis.

(c) The association shall conduct a final accounting with respect to each calendar year after April 15 of the following calendar year.

(d) Claims with respect to ceded risk that are incurred during a calendar year and are submitted for reimbursement not later than April 15 of the following calendar year will be allocated to the calendar year in which they are incurred. Claims submitted after April 15 following the calendar year in which they are incurred will be allocated to a later calendar year in accordance with the operating rules, policies, and procedures of the program.

(e) If the total receipts of the fund with respect to a calendar year are expected to be insufficient to pay all program expenses, claims for reimbursement, and other disbursements allocable to that calendar year, all claims for reimbursement allocable to that calendar year will be reduced proportionately to the extent necessary to prevent a deficit in the fund for that calendar year. Any reduction in claims for reimbursement with respect to a calendar year will apply to all claims allocable to that calendar year without regard to when those claims are submitted for reimbursement, and any reduction will be applied to each claim in the same proportion.

(f) The association shall establish a process for auditing each health care insurer ceding risk to the program. Audits may include both a baseline audit conducted in connection with commencement of an insurer's participation in the program and periodic audits up to four times a year throughout the insurer's participation in the program.

(g) The association shall engage an independent qualified auditing entity to perform a financial and programmatic audit for each benefit year in accordance with generally accepted auditing standards. The association shall provide a copy of the audit to the director at the time the association receives the audit. The association shall make a public summary of the results of the

audit. The public summary must be made available within a time period and in a manner that a prudent person would consider to be timely and informative.

(h) The director or the director's designee may conduct financial and programmatic audits of the reinsurance program and the association to assess compliance with

(1) 3 AAC 31.500 – 3 AAC 31.549;

(2) the contract between the director and the association; and

(3) the plan of operation established for the administration and operation of the program. (Eff. 2/2/2013, Register 205; am ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 **AS 21.55.430**

AS 21.55.040 AS 21.55.400

3 AAC 31 is amended by adding new sections to read:

3 AAC 31.535. Annual true-up. (a) The association shall establish a true-up process with respect to a calendar year to reflect adjustments made in establishing the final accounting for that calendar year, including crediting of premiums received with respect to risk ceded after the end of the calendar year and retroactive reductions or other adjustments in reimbursements necessary to prevent a deficit in the fund for that calendar year and to prevent a windfall to an insurer as a result of third party recoveries, recovery of overpayments, commercial reinsurance recoveries, or risk adjustments made under 42 U.S.C. 18063 (sec. 1343 of the Patient Protection and Affordable Care Act, P.L. 111-148). The true-up must occur after April 15 following the calendar year to which it relates.

(b) With respect to the risk adjustment transfers as determined by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight (CCIIO),

(1) the director or the director's designee will review the risk adjustment transfers to determine the impact of the ceding of risk to the program;

(2) the review will occur not later than 60 days after publication of the notice of final risk adjustment transfers by the Center for Consumer Information and Insurance Oversight;

(3) the director or director's designee will notify a health care insurer of the amount of any risk adjustment transfer it received that does not accurately reflect benefits provided under the program and

(A) the health care insurer shall pay that amount to the program not later than 30 days after receipt of the notice from the director or the director's designee; and

(B) as appropriate, the director or the director's designee will refund that amount to the health care insurer or insurers that made the federal risk adjustment payment; and

(4) to facilitate the true-up process, a health care insurer shall submit to the director or the directors' designee, in a form and manner determined by the director or the director's designee, all data requested by the director in a data call in March of the year following the year to which the risk adjustment applies. (Eff. ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.430
AS 21.55.040 AS 21.55.400

3 AAC 31.540. Covered conditions. A resident of this state diagnosed with one or more of the following covered conditions under this section is a high risk resident under 3 AAC 31.500 – 3 AAC 31.549:

(1) human immunodeficiency virus or acquired immune deficiency syndrome (HIV/AIDS);

(2) septicemia sepsis, systemic inflammatory response syndrome/shock;

(3) metastatic cancer;

(4) lung, brain, and other severe cancers, including pediatric acute lymphoid leukemia;

(5) non-hodgkin's lymphomas and other cancers and tumors;

(6) mucopolysaccharidosis;

(7) lipidoses and glycogenosis;

(8) amyloidosis, porphyria, and other metabolic disorders;

(9) end-stage liver disease;

(10) chronic hepatitis;

(11) acute liver failure or disease, including neonatal hepatitis;

(12) intestinal obstruction;

(13) chronic pancreatitis;

(14) inflammatory bowel disease;

(15) rheumatoid arthritis and specified autoimmune disorders;

(16) hemophilia;

(17) acquired hemolytic anemia, including hemolytic disease of newborn;

(18) sickle cell anemia (hb-ss);

(19) thalassemia major;

(20) coagulation defects and other specified hematological disorders;

(21) anorexia/bulimia nervosa;

(22) paraplegia;

(23) amyotrophic lateral sclerosis and other anterior horn cell disease;

(24) quadriplegic cerebral palsy;

(25) cerebral palsy, except quadriplegic;

(26) myasthenia gravis/myoneural disorders and guillain-barre syndrome/inflammatory and toxic neuropathy;

(27) multiple sclerosis;

(28) parkinson's, huntington's and spinocerebellar disease, and other neurodegenerative disorders;

(29) cystic fibrosis;

(30) end stage renal disease;

(31) premature newborns, including birthweight 2000 – 2499 grams;

(32) stem cell, including bone marrow, transplant status/complications;

(33) amputation status, lower limb/amputation complications. (Eff.___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 AS 21.55.400

3 AAC 31.549 is repealed and readopted to read:

3 AAC 31.549. Definitions. In 3 AAC 31.500 – 3 AAC 31.549,

(1) "association" means the Comprehensive Health Insurance Association established under AS 21.55.010 – 21.55.060;

(2) "Comprehensive Health Insurance Association" means the nonprofit incorporated legal entity established under AS 21.55.010 – 21.55.060;

(3) “covered condition” means a high risk resident's health condition, injury, illness, or disease that is listed under 3 AAC 31.540;

(4) "diagnosis code" means a universal code that a health care provider uses to identify a person's diagnosis;

(5) “director” means the director of the division of insurance;

(6) “fund” means the segregated fund established within the association to hold all receipts and make all disbursements related to the program;

(7) "grandfathered health care coverage" means coverage provided by an individual health care insurance policy purchased before March 23, 2010;

(8) "health care exchange" has the meaning given in AS 21.51.500;

(9) "health care insurance plan" has the meaning given in AS 21.42.599;

(10) "health care insurer" has the meaning given in AS 21.54.500;

(11) "health care provider" has the meaning given in AS 21.07.250;

(12) “high risk resident” means a resident of this state who has been diagnosed with one or more of the covered conditions under 3 AAC 31.540;

(13) "individual market" has the meaning given in AS 21.51.500;

(14) “program” means the reinsurance program authorized under AS 21.55.400 and established under 3 AAC 31.500 – 3 AAC 31.549;

(15) "transitional health care coverage" means coverage provided by an individual health care insurance policy purchased after March 22, 2010 and before January 1, 2014. (Eff. 2/2/2013, Register 205; am ___/___/___, Register ___)

Authority: AS 21.06.090 AS 21.55.220 **AS 21.55.430**

[AS 21.42.345] AS 21.55.400