PY2025 Alaska ACA Form and Rate Guidance

Filing Timelines

- Rate filings must be submitted separately from form filings.
- Under AS 21.42.120 form filings must be submitted no later than 30 days before the expected effective date. However, due to federal regulations, forms for products (offered either on or off the FFM) that become effective 1/1/2025 and will be offered only during the open enrollment period for calendar 2025, must be submitted no later than CMS filing deadline of 06/12/2024. Please be sure to submit templates with sufficient time in advance of the CMS filing deadline. Keep in mind that QHP forms not approved by the Division by 11:00 a.m. AKDT 08/14/2024 for products offered on the FFM, may not be issued or renewed in Alaska in 2025. Non-QHP form filings must be finalized by 11:00 am AKDT 10/15/2024.
- Under AS 21.51.405 and AS 21.54.015 rate filings must be submitted no later than 45 days prior to the expected effective date. However, due to federal regulations, rates for products (offered either on or off the FFM) that become effective 1/1/2025 and will be offered only during the open enrollment period for calendar year 2025 must be submitted no later than 06/17/2024. Companies must file with adequate time for QHP rate filings to be reviewed and approved by 11:00 a.m. AKDT 08/14/2024 in order to have 2025 rates for individual plans and 1/1/2025 rates for group plans. Non-QHP rate filings must be finalized by 11:00 a.m. AKDT 10/15/2024.
- Keep in mind that rate changes must be disclosed to consumers at least 45 days prior to the implementation of the rate change. Small group quarterly (2nd, 3rd, and 4th) rate filings must be submitted 105 days prior to the effective date in accordance with page 6 of the URRT instructions.

Form Filing Guidance

- The Alaska Division of Insurance requests that all plans associated with a product be submitted in a single product form filing.
- The SERFF/CMS plan management templates have not been enabled in Alaska and therefore insurers are not expected to complete and submit the templates in SERFF and insurers should file forms using the Division's current filing requirements and guidelines (templates should be submitted directly to HHS through HIOS; SERFF URRT Webservice should be used).
- Each form filing submission should address all applicable items identified on the form filing checklists which are available on the Division's website under Companies, Rates, and Policy Forms and:
    - The division will review the forms for compliance with ACA requirements with the exception of those requirements reserved to the FFM including essential community providers, formulary review, meaningful difference, or non-discriminatory cost sharing.
    - For each ACA product submission "PPACA-Related" should be selected in the General Information tab

- Either the filing number of the associated rate filing, or anticipated filing date of the rate filing should be identified.
- Statement of variability – as permitted by 3 AAC 31.250, variable language is allowed as long as the full range of text and numbers is specified and any relationship between such variables is fully explained. Deductibles, out-of-pocket maximums, and other cost sharing amounts should be bracketed as variable, and range of values explained. A Plan Summary or Schedule of Benefits may be submitted for each plan in lieu of an explanation of the relationship of variables.
- A summary listing all plans in the submitted product filing should be provided as supporting documentation and should include (1) plan name, (2) plan identification number, (3) metal level and actuarial value of plan, (4) indication of the extent to which the health plan benefits are not compatible with the actuarial value calculator, (5) description of benefit substitutions, if any, (6) an indication of whether the plan will be sold inside the FFM only, both inside and outside the FFM, or outside the FFM only. The Plan and Benefits template may be submitted as supporting documentation to supplement the summary listing of plans.
- Under 3 AAC 26.110(a), the basis of payment for out-of-network claims must be included in the contract form in sufficient detail for the consumer to understand the benefits.

- As set forth in the federal rule, plans offered inside the FFM do not need to include pediatric dental. However,
  - The Division requests that forms for any plan that will be offered outside the FFM include and bracket the pediatric dental provisions as variable so that pediatric dental provisions are reviewed and approved for inclusion in plans, as needed.
  - Forms for plans offered only inside the FFM that do not include pediatric dental provisions, should disclose 1) that pediatric dental benefit are a required essential health benefit under the ACA; 2) that the plan does not include pediatric dental benefits; and 3) to contact the FFM to purchase dental coverage.
- Certifications required:
  - Each filing must include a certification of compliance with the actuarial value calculator for each plan.
  - If health plan benefits are not compatible with the actuarial value calculator, the filing must include the actuarial certification required under 45 CFR 156.135 in the supporting documentation tab.
  - If a plan contains benefit substitutions, provide the required actuarial equivalence justification and certification in the supporting documentation tab.
- Attestation: Mental Health and Substance Use Disorder (MH/SUD) compliance,
  Companies shall attest to the following as a 1 page supporting document in the form filing:
  - Contract definitions have identified MH/SUD benefits to mean items or services for the treatment of a MH/SUD using independent standards of current medical practice.
  - The same standards were applied to medical/surgical as MH/SUD in determining the classification of benefits.

- Financial requirements and quantitative treatment limitation are applied on an equal basis between medical/surgical and MH/SUD benefits within the same classification.
- Non-quantitative treatment limitations are applied uniformly between medical/surgical and MH/SUD for the following:
    - Medical management
    - Experimental and investigational determinations
    - Provider credentialing
    - Network adequacy
    - Provider reimbursement rates
    - Prescription drugs
- The insurer has developed adequate oversight standards for vendors who are utilized to process MH/SUD claims to ensure compliance with MHPAEA.

Acceptance by the Division does not absolve the insurer from future findings of non-compliance.

- An approved dental form, to which no changes are proposed, is not required to be re-filed with the Division. Any changes to supporting documentation such as new HIOS plan identification numbers would necessitate a new form filing. Additionally, if continued certification is not desired for a previously certified stand-alone dental plan, any references to the Affordable Care Act or "Certified Stand Alone Dental" must be removed from the form before it may be offered without certification by CMS.
- Insurers are required to provide an annual program description of the segregation of funds for termination of pregnancy coverage in their plans as outlined in section 1303 of the ACA and 45 CFR 156.280. The program description may be either filed in SERFF or submitted via email to sarah.bailey@alaska.gov.

Rate Filing Guidance

- Alaska has an effective rate review program, and it is expected that CMS will certify a qualified health plan, if Alaska confirms the rates are justified.
- Because of the single risk pool requirement, the Division requests that insurers submit a single rate filing for all individual ACA-compliant plans and a single rate filing for all small employer ACA-compliant plans.
- Each rate filing submission must continue to comply with Alaska's health rate filing regulation 3 AAC 31.235 as revised October 2016. Note that the rate filing must include development of the index rate and must describe and provide detailed justification for all assumptions used in the development of the index rate, adjustments to the index rate including risk adjustment, and development of proposed premium rates.
- On the Rate/Rule Schedule tab in SERFF, submit a rate sheet showing consumer adjusted premium rate for each plan and complete the historical summary section at the top of the Rate/Rule Schedule Tab.
- Individual market insurers shall provide their projected CSR variant distribution as support for the silver loading calculation. Off exchange only plans shall not include any CSR loading.

- Provide an exhibit showing the calculation of the overall rate change derived from the enrollment-weighted rate changes for each plan.
- The required federal unified rate review templates and supporting memoranda shall be submitted on the URRT tab in SERFF.
- Alaska has three specified geographical rating areas defined by 3-digit zip codes as follows:
  - Rating Area 1: 995
  - Rating Area 2: 996/997
  - Rating Area 3: 998/999
- Tobacco rates shall not be applied to consumers under age 21.
- Small group wellness program details must be submitted in support of any tobacco rating factor.
- Please provide the actuarial value calculator screen shots for each plan to assess metal level and confirm actuarial value.
- The cost for pediatric dental benefits should be calculated separately and rates for a plan with and without pediatric dental benefits should be included in the rate filing.

- Each rate filing must include in the actuarial memorandum a certification that the methodology used to calculate the actuarial value for each plan complies with federal regulations.

- Premium rates may be rounded to the nearest dollar.
- <u>Composite Rating in Small Group Market</u>
  Insurers are required to determine the total premium for a group at issue using the required per-member federal methodology with a limit of 3 children under 21. However, Alaska will allow insurers off the FFM to offer small employers 4-tier premium rates. Note that due to system constraints the FFM is unable to accept composite rates and therefore premiums for small employers that purchase coverage through the FFM must be per-member premiums. Insurers that elect to offer 4-tier premium rates to employers must determine the tier premiums in a manner that allocates the total group premium to employees based on applicable family tier and using the following specified tier factors and tiered employee premium formula:

  - 4-tier factors

    - Employee only = 1.00
    - Employee + spouse = 2.00
    - Employee + children = 1.85
    - Employee + family = 2.85

  - 4-tier employee premium

    4-tier employee premium = (Total premium for group) ÷ (Employee count weighted by tier factor) * (Applicable employee tier factor)

The 4-tier employee premium rates must be determined at issue and may not be adjusted during the policy year.

Note that insurers must also comply with other federal requirements including 1) the 4-tier employee premium rates must be determined at issue and may not be adjusted during the policy year; 2) if an insurer elects to offer 4-tier premium rates in compliance with the above factors and formula with respect to a particular product, the insurer must make 4-tier premium rates available to any small employer that enrolls in that product; and 3) tobacco rating must be determined based on the premium rate that would be applied on per-member basis and included in the premium charged to an individual. Explain how out of state employees are treated by this calculation.

- For ACA-compliant plans, the following data should be provided for each month for the previous four (4) complete calendar years in addition to the current year's partial data through the date of submission:
    1. Number of covered individuals
    2. Premiums earned
    3. Total billed charges
    4. Paid claims
    5. Incurred claims
    6. Allowed claims
    7. Rx Incurred Claims
    8. Rx Rebates
    9. Average age
    10. Number of claims greater than $100,000

- For ACA-compliant plans, the following data should be provided for each PLAN for the two (2) previous calendar years:
    1. Number of covered individuals
    2. Premiums earned
    3. Incurred claims
    4. Allowed claims
    5. Average age

- Number of and total incurred claims during the previous calendar year by HHS-Condition Categories (see HCC Excel spreadsheet)

- For each of the following, show in-network vs out of network for the previous calendar year.
    1. Total billed charges
    2. Incurred claims
    3. Allowed claims

The above data (1, 2, and 3) will be held confidential!

- Please provide the historical performance showing the two (2) calendar years previous to the current plan year using the same subcategories and format for cost and utilization for incurred claims shown in the Agnew Beck document exhibit on page 23 found at http://agnewbeck.com/wp-content/uploads/2016/05/MCDRE_Actuarial_Redesign_1-19-16.pdf. The company shall provide a comparison of actual to expected trend for the most recent experience period. Please provide a calculation of trend projections for the remainder of the current plan year and for the plan year for which these rates apply.

- Please provide a year and a half of monthly utilization starting from January 1st of the preceding calendar year until the date of the filing for Inpatient, Outpatient, and Professional Services. Please include specific information on telehealth and its utilization.

- Project the monthly utilization for the remainder of the current plan year and for the plan year to which these rates apply.

- Please provide insight to the company's scenario testing (best, worst, and expected) regarding enrollment and trend projections.

- Provide the basis of payment for out of network providers. For companies that have discontinued the 80th percentile as the basis of payment, the observed cost savings for YTD 2024 and the projected cost savings for 2025.

- For Individual Market rate filings, provide a separate URRT file showing the development of the rates WITHOUT the reinsurance program and provide a brief memorandum summarizing any change in assumptions in the without reinsurance rate development (i.e., enrollment changes, morbidity changes, admin changes). These files should be loaded as supporting documentation (not replacing the existing URRT file).

Associations

- ERISA employer association—see Association Guidance.
- Since an ERISA employer association is considered a large employer and pursuant to AS 21.54.100 small employers may not be charged premiums based on health status, employer rating tiers (rating small employer members by health status, claims experience) are prohibited.
- Benefit plans and rates offered to small employer or individual members of associations that are not ERISA employer associations must be the same as offered in the small employer and individual markets.
- Associations that qualify for health insurance under state law are allowed to be offered in Alaska. These groups must be a bona fide association consistent with AS 21.97.900(7).

Essential Health Benefits (EHB)/Benefit Mandates

The essential health benefit benchmark plan in Alaska is the Premera Heritage Select Envoy plan. See ACA Benchmark Plan Brochure | ACA Benchmark Plan.
The benchmark plan benefits are the essential health benefits in Alaska (with rehabilitative, habilitative and pediatric dental as described in the guidance) and the benchmark plan sets the minimum level of coverage within in each category of coverage (the 10 categories listed in the ACA and one category for all other coverage in the benchmark plan). A plan offered in Alaska must be substantially equal to the benchmark plan in the scope of benefits offered and limitations on the benefits. However, pursuant to federal regulations insurers may substitute a different benefit or benefit level for a benchmark plan benefit or benefit level within the same category as long as the insurer demonstrates that the coverage within the category is actuarially equivalent (see 45 CFR 156.115).

Clinical trial coverage

Alaska's clinical trial mandate in AS 21.42.415 applies only to cancer including leukemia, lymphoma and bone marrow stem cell disorder clinical trials. ACA applies to "life threatening disease" clinical trials in addition to cancer. ACA does not preempt state law that provides coverage in addition to the minimum coverage required under the clinical trial coverage mandate in Section 2709 of the ACA. Therefore, insurers must comply with the ACA mandate, as well as, the Alaska mandate to the extent that the Alaska mandate provides additional coverage for cancer, leukemia, lymphoma and bone marrow stem cell disorder clinical trials. One substantive additional benefit required under Alaska's mandate is "transportation for the patient that is primarily for and essential to the medical care". Alaska's mandate also requires coverage for palliative care and the diagnosis or treatment of complications. Insurers are allowed to apply deductible, coinsurance or copayment provision applicable to other benefits.

Rehabilitative and Habilitative Services

The following are definitions of rehabilitative and habilitative services for purposes of determining compliance with the ACA EHB coverage requirements:

- Rehabilitative services or devices are medical services or devices provided when medically necessary for restoration of bodily or cognitive functions lost due to a medical condition. Rehabilitative services include physical therapy, occupational therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope or his or her license. Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not a rehabilitative service. Rehabilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider.
- Habilitative services or devices are medical services or devices provided when medically necessary for development of bodily or cognitive functions to perform activities of daily living that never developed or did not develop appropriately based on the chronological age of the insured. Habilitative services include physical therapy, occupational therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope or his or her license. Therapy to retain skills necessary for activities of daily living and prevent regression to a previous level of function is a habilitative service, if medically necessary

and appropriate. Habilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider. Habilitative services do not include respite care, day habilitation services designed to provide training, structured activities and specialized assistance for adults, chore services to assist with basic needs, educational, vocational, recreational or custodial services.

Autism mandate (AS 21.42.397)

- The autism mandate requires coverage for medically necessary pharmacy, psychiatric care, psychological care, habilitative or rehabilitative care, and therapeutic care for the treatment of autism spectrum disorder; all of which are EHBs under the ACA. Therefore, Alaska considers the autism mandate an EHB.
- Although the autism mandate defines habilitative or rehabilitative care to include applied behavioral analysis, insurers may cover applied behavioral analysis as a type of mental health service as long as the plan provides the coverage for diagnosis and treatment of autism as specified in mandate.
- Note that under the autism mandate the number of visits to an autism service provider may not be limited and coverage must be provided to individuals at least up to age 21 for the treatment of autism. However, the age 21 limit may violate non-discrimination requirements and care should be taken to avoid discriminatory benefit designs.

Dental and Vision Coverage

Minimum pediatric dental and vision EHBs are those provided under the Federal Employee Dental and Vision Insurance Plans (FEDVIP).

- FEDVIP Dental: http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/MetLife.pdf

- FEDVIP Vision: http://cvw1.davisvision.com/forms/StaticFiles/English/FEP2014BenefitBooklet.pdf

Availability of dental (pediatric, adult or both) on the exchange is not sufficient to comply with the offer requirement. Each insurer must offer benefits at least as generous as required under AS 21.42.385. FEDVIP dental and vision coverage will be considered compliant with the minimum dental and vision coverage required under AS 21.42.385.

Health Reimbursement Accounts and Health Savings Accounts:

The amount of employer contributions to the HRA or HSA must be used for cost sharing and the federal actuarial value calculator treats these contributions as first dollar coverage. This effectively reduces the employee's cost sharing amount by the amount of the employer contribution. For example, a plan with a $2000 deductible and an employer contribution to an HRA of $1,500 results in a $500 deductible in the calculator.

Insurers may offer several contribution level options to employers, but each contribution level must result in a plan that is compliant with the actuarial value calculator. Each funding level or range of funding levels that the insurer will allow must be identified in the filing along with the corresponding actuarial values. An insurer is prohibited from issuing a plan to an employer that contributes an amount to an HRA or HSA that is not within the range of contribution levels filed and approved by the division. As a condition for issuance of an HRA or HSA plan insurers may require an employer to certify to the amount the employer will contribute to an HSA or HRA.

Network Adequacy:

In order to comply with Alaska's network adequacy requirements policy form filings must comply with the following provisions:

- Alaska law requires that insurers give insureds a choice of provider under AS 21.07.030. AS 21.51.120 (individual) and AS 21.54.020 (group) insurers are prohibited from restricting networks to particular hospitals or providers. This means that insurers are not allowed to restrict coverage to services provided by contracted hospitals or contracted providers; and issuers must provide benefits for services provided by non-contracted providers or hospitals.
- Under AS 21.51.120 (individual) and AS 21.54.020 (group) upon written request of an insured, insurers must pay providers directly.
- As set forth in 3 AAC 26.110(f) Alaska requires insurers to pay at in-network rates when a non-contracted provider performs services as part of a covered stay at a contracted facility and the individual does not have or is not given a choice as to who performs the services.
- Alaska requires insurers to pay at in-network levels level of cost-sharing if reasonable access to a network provider is not available as defined in the policy.

In addition, note that insurers must meet CMS's network adequacy requirements and that compliance with Essential Community Provider requirements will be determined by CMS.

Student health

- Student health forms must be submitted using H22 Student Health Insurance even if according to federal rule the coverage is considered individual.
- If the student health product is subject to ACA requirements and any filing content is related to compliance with the ACA then "PPACA-Related" should be selected in the General Information tab.
- Under AS 21.54.015, rates for health care insurance plans are subject to filing. A student health product that meets the definition of a health care insurance plan in AS 21.54.500(16) must be filed for approval. In general, this is any health insurance policy that provides benefits for medical care that is not an excepted benefits policy. A student health product that is subject to the ACA would be a health care insurance plan and rates must be filed.

- Please demonstrate that the plans' actuarial value is greater than 60%.

2025 Alaska Reinsurance Program Amount

The Alaska Reinsurance Program amount will be released in early June.