Division of Insurance Responses to Questions Relevant to Proposed Regulations

Relating to

Health Discount Plans, Filings, Recordkeeping, Licensee Renewal Dates, Delivery of Evidence of Insurance, Insurance Claims, Annuity Disclosures, Fees, and Definitions.

Question No. 1

Does the proposed new section 3 AAC 26.075 relating to arbitration apply to all lines of insurance?

Division Response:

The proposed new section applies to all lines of insurance.

Question No. 2

Can you clarify what is the intent of the proposed new subsection 3 AAC 26.110(g) and when the exception of the drug not being available would apply? Also please clarify the meaning of the phrase "when needed" in this provision and in 3 AAC 26.110(h).

Division Response:

The proposed 3 AAC 26.110(g) provides "An insurer may require a covered individual to purchase specialty drugs from a specific in-network health care provider in order to receive benefits under a health insurance policy, unless the specialty drug is not available from the health care provider when needed."

The proposed 3 AAC 26.110(h) provides "an insurer may require a covered individual to receive transplant services from an in-network health care provider in order to receive benefits under a health insurance policy, unless transplant services are not available from a network health care provider when needed."

Under AS 21.07.030 insurance companies may have a network product but must provide non-network benefits. Network only plans are not permitted. In addition, AS 21.51.120 and AS 21.54.020 state that services must not be required to be provided by a particular provider or hospital. The intent of 3 AAC 26.110(g) is to clarify that benefits for specialty drugs may be limited to specialty pharmacies.

The exception is intended to include circumstances such as when the consumer needs a drug immediately and can obtain the drug at a non-specified pharmacy locally rather than waiting for mail order or when the specialty drug(s) is not in stock at the specified network pharmacy/vender.

Please note under Alaska's reasonable access requirements, the company must cover (pay for) the specialty drug at the same cost sharing as though it was obtained from the specified network pharmacy/vender, if the covered person cannot obtain the drug at the specified pharmacy. Balance billing is permitted.

The exception relating to transplant services is intended to include circumstances such as when the consumer needs the services immediately and can obtain the services at a non-network provider.

Question No. 3

Please clarify 3 AAC 26.110(i) and provide an example of the type of situation that would be prohibited by this new requirement?

Division Response:

The proposed 3 AAC 26.110(i) provides "an insurer may not process claims based on a procedure code that differs from the procedure code specified in the claim unless agreed upon by the health care provider that provided the service or supply."

The purpose of this provision is to formalize the requirements under Bulletin B 05-10. Insurance companies were receiving claims, then changing the procedure codes and making payment without notifying the provider. The provision would prevent insurers from unilaterally changing procedure codes. An example would be where a provider submits a discontinued CPT code and the insurer changes the code without consulting with, and the concurrence of, the provider.

Question No. 4

The term "health insurer" is used in some places of the proposed regulations while the term "insurer" is used in other places of the regulations. Does the use of the term "insurer" mean all lines?

Division Response:

The use of the term "insurer" refers to all insurers, however, the term must be read in context as the context may limit the types of insurers to which the provision applies. The division will review the proposed regulations in light of this question to determine if further clarification is needed.

Question No. 5

What is the specific regulatory authority for adding the arbitration provision to the regulations?

Division Response:

The division has cited Alaska Statute (AS) 21.06.090, 21.36.125, and 21.42.120 as authority to adopt this proposed regulation.

Question No. 6

Will the division under the proposed 3 AAC 31.210(m) require an insurer to file to obtain approval for out-of-state associations that may issue group health insurance?

Division Response:

The proposed 3 AAC 31.210(m) provides "An insurer may not issue insurance to a resident of this state under a group including an out-of-state group that does not meet the requirements of AS 21.54.060 for health insurance, AS 21.54.070 for blanket insurance and AS 21.48.010 for life insurance. Prior to issuing coverage to a resident of this state through a policy issued to an association or trust including a union trust an insurer must file and obtain approval of each association or trust through which a resident of this state will be issued coverage subject to the following: (1) if the constitution or by-laws of the association or trust are modified, the insurer must refile and obtain approval of the association or trust; (2) the filing for approval of the association or trust must be submitted separately from the forms that will be issued to the association or trust unless the form will be issued exclusively to the association or trust."

If the proposed change noted is adopted the division under this provision will require an insurer to file to obtain approval for out-of-state associations that may issue group health insurance.

Question No. 7

Was the definition of "large employer" in proposed 3 AAC 31.235(b) meant to be 101employees or 51 employees? Does this conflict with the division's recently issued Bulletin B 15-09? If there is a difference, why is there a difference?

Division Response:

The proposed definition of "large employer" in proposed 3 AAC 31.235 provides "In this subsection, "large employer" means an employer that employs an average of at least 101 employees on the business days during the preceding calendar year and that employs at least two employees on the first day of a health benefit plan year."

The proposed regulations were approved to notice before the "Protecting Affordable Coverage for Employees Act" (PACE) was signed into law and before Bulletin B 15-09 was issued which is why the 101 employees figure was noticed rather than the 51 employees figure. The division will evaluate whether the proposed regulation requires reconciliation with PACE and B 15-09 prior to final adoption.

Question No. 8

The notice and proposed regulations appear to be focused on health discount plans and health insurers. Do any of the proposed regulations apply to property and casualty insurers and specifically does the arbitration provision apply to property and casualty insurers?

Division Response:

The notice and proposed regulations include provisions that, if adopted would apply to other insurers including property and casualty insurers. The proposed arbitration provision, 3 AAC 26.075, if adopted, would apply to all insurers including property and casualty insurers.

Question No. 9

The notice provides that questions on the proposed action must be received by the division at least 10 days before the end of the public comment period. Is that 10 calendar days?

Division Response:

The division will compute the time period under AS 01.10.080 which provides "The time in which an act provided by law is required to be done is computed by excluding the first day and including the last, unless the last day is a holiday, and then it is also excluded." The notice provides that the public comment period ends at 5:00 p.m. on December 7, 2015, therefore, to be assured of receiving a response to any question, the question must be received no later than November 27, 2015.