STATE OF ALASKA
DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE

GROUP HEALTH POLICY FORM CHECKLIST

General Requirements --- Group Health insurance Forms			
REVIEW REQUIREMENTS	**REFERENCE**	**COMMENTS**	**FORM & Page #'s**
Disapproval of Forms	AS 21.42.130		
Required Provisions	AS 21.42.140 AS 21.54.010		
Entire Contract	AS 21.42.150		
Contents	AS 21.42.160		
Additional Contents	AS 21.42.170		
Definition of Group Insurance/Allowable Groups	AS 21.54.060		
Misrepresentation	AS 21.36.030		
Charter, By-Laws	AS 21.42.180		
Execution	AS 21.42.190		
Non-complying	AS 21.42.220		
Construction	AS 21.42.230		
Insurable Interest	AS 21.42.020		
Unfair Discrimination	AS 21.36.090 AS 21.54.100		
Domestic Violence	AS 21.36.430		
Non-English Translations	AS 21.42.175		
Genetic Information	AS 21.36.480 42 USC 300gg-1(b)(3) 42 USC 300gg-1(c-f) 42 USC 300gg-91	Consistent with Federal requirements	
Discretionary Language	AS 21.36, AS 21.42.130	A contract may not assert exclusive or discretionary authority to interpret contractual provisions.	
Domestic Partnership Benefits	AS 21.36.090(b), AS 21.42.130	Domestic partnership benefits, if offered, must be available to both same and opposite sex partners.	
Arbitration	AS 21.42.130, AS 21.42.392(e)	Venue must be in place of insured's residence and method of arbitration and source of information on the arbitration process must be provided to the insured.	
Terrorism Exclusions	AS 21.36, AS 21.45.250(2)	Terrorism and terrorism-related exclusions are prohibited.	
Applications	AS 21.42.110	Applications must state that information provided by the applicant are representations and not warranties.	

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Coordination of Benefits	AS 21.42.205 3 AAC 26.110(c)		
Alaska Mandates --- Health Care Insurance Forms			
HIPAA Pre-existing Condition, Credible Coverage, Definitions	AS 21.54.110-.120, .160-.500	Alaska allows a 90-day break in coverage.	
Renewability, Termination and Modification of Coverage	AS 21.54.130-.140		
Coverage of Dependents and Children	AS 21.42.345 AS 21.36.485	Children must be covered if dependent coverage is available. Newly born children of dependent children must be made an offer of coverage.	
Coverage of Dependent Students on leave of absence	AS 21.42.410 42 USC 300gg-54	Consistent with Federal requirements	
Acupuncture*	AS 21.42.353		
Services Provided by Nurse Midwives	AS 21.42.355		
Alcoholism or Drug Abuse*	AS 21.42.365; AS 21.54.151 42 USC 300gg-5	Applies to coverage for groups of five or more employees. Small groups with EHBs and large groups consistent with Federal requirements.	
Diabetes	AS 21.42.390	When pharmacy services are covered, diabetes treatment must also be covered, including outpatient self-management training or education.	
Prostate and Cervical Cancer Detection*	AS 21.42.395	Annual screening/tests covered.	
Reconstructive Surgery Following Mastectomy	AS 21.42.400 42 USC 300gg-6 42 USC 300gg-52	Consistent with Federal requirements	
Costs of Birth	AS 21.42.347	Time frames consistent with Federal requirements. Requirement does not affect a payment arrangement between the provider/hospital and the insurer See “Maternity Coverage” below for ACA requirements.	
Newborn and Infant Hearing Screening	AS 21.42.349		
Well-baby Exams	AS 21.42.351		
Mammograms*	AS 21.42.375		
Colorectal Cancer Screening	AS 21.42.377	American Cancer Society recommendations	
Phenylketonuria*	AS 21.42.380		

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Autism Spectrum Disorders	AS 21.42.397	Under AS 21.42.397(b)(3) minimum autism coverage is subject to "copayment, deductible, and coinsurance provisions, and other general exclusions or limitations included in a health insurance policy to the same extent as other health care services covered by the policy". This means that a policy may apply the same cost-sharing requirements to autism coverage as are applied to other coverage. Note that beginning on 1/1/2014 treatment for mental health and behavioral health conditions are mandated benefits under the ACA and therefore small group plans will not be able to exclude coverage for autism, despite the "general exclusions or limitations" provision of this mandate.	
Clinical Trials related to Cancer	AS 21.42.415	Includes palliative care, complications and transportation See "Approved Clinical Trials" below for ACA requirements.	
Coverage for prescription drugs; specialty drug tiers	AS 21.42.420	90 day notice	
Coverage for topical eye medication	AS 21.42.425	Allows for the early refill of topical eye medication for treatment of a chronic condition	
Dental, Vision, and Hearing*	AS 21.42.385	Minimum coverage must be offered as rider or separate policy, unless insurer has written less than $300,000 premiums in previous calendar year.	
Mental Health Parity	AS 21.54.151 42 USC 300gg-5	Consistent with Federal requirements.	
ACA Requirements -- Grandfathered and Non-Grandfathered Health Care Insurance Plans			
Rescissions	PHSA§2712 (75 Fed Reg 37188, 45 CFR §147.128)	No rescissions except in cases of fraud or intentional misrepresentation of material fact. Coverage may not be cancelled except with 30 days prior notice to each enrolled person who would be affected.	
Annual or lifetime limits	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126)	• No annual or lifetime limits are allowed on the dollar value of Essential Health Benefits (EHB) • Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB; issuers are not prohibited from excluding all benefits for a non-covered condition for all covered people, but if any benefits are provided for a condition, then no lifetime limit requirements apply.	

Coverage for dependents to age 26	PHSA §2714 (75 Fed Reg 27122, 45 CFR §147.120)	Available if dependent coverage offered.	
Use of Uniform Summary of Benefits and Coverage with Examples and Uniform Definitions			
Waiting Period	PHSA §2708	Waiting periods may be no longer than 90 days.	
ACA Requirements-Non-Grandfathered Health Care Insurance Plans **(Issued on or after 1/1/2014, applies large group only when noted)** **Note: In addition to the listed items, health care plans must also include EHB benefits consistent with the Alaska Benchmark plan**			
No pre-existing condition exclusions [L]	PHSA §2704 PHSA §1255 (75 Fed Reg 37188, 45 CFR §147.108)	No pre-existing condition exclusions for individuals 19 and under. For plan years beginning on or after 01/01/2014, no pre-existing condition exclusions for all individuals.	
Provide Essential Health Benefits • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance use disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care	PHSA §2707	Mental health and substance use disorder services must comply with federal parity law and final rules for plans renewing on or after 1/1/2015.	
Preventive Services [L]	PHSA §2713 (75 Fed Reg 41726, 45 CFR §147.130)	Covers preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Companies may refer to USPSTF and other required organization recommendations. Contract language should emphasize that first dollar preventive benefits are limited and give examples of services that are limited to primary care settings in order to prevent consumer confusion.	

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60 day advance notice to enrollees	PHSA 2715 (75 Fed Reg 41760)	Notice before the effective date of any material modification including changes in preventive benefits.	
Coverage for emergency services	PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138) SSA §1395dd	Must be covered at in-network cost-sharing level (patient is not penalized for emergency care at out-of-network provider)	
Designated primary care provider	PHSA §2719A (75 Fed Reg 37188, 45 CFR §147.138)		
Maternity coverage, hospital stays related to childbirth	PHSA §2725 (45 CFR §148.170)	Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. No prior authorization required for 48/96 hour hospital stay. Length of stay begins at the time of delivery if in hospital, admission to hospital if delivery occurred outside the hospital Insurer may not require the mother to give birth in a hospital. May not provide inducements to provider or mother to accept less than the minimum requirements.	
Mental Health and Substance Use Disorder Benefits Parity	PHSA §2726	Mental Health and Substance Use must be on par with other benefits. As an EHB, these services must not have a lifetime or annual limit.	
Coverage for reconstructive surgery after mastectomy	PHSA §2727	If plan covers mastectomy, then must cover reconstructive surgery for mastectomy. Coverage includes, breast on which mastectomy performed, other breast to produce symmetrical appearance, prostheses; and treatment of complications. Notice of benefit given at issue and annually.	
Dependent student on medically necessary leave of absence	PHSA §2728 (45 CFR §147.145)	If plan covers dependent students beyond age 26	
Coverage is guaranteed renewable	PHSA §2702 (45 CFR §148.122)	May only non-renew or cancel coverage for nonpayment of premiums, fraud, market exit, movement outside of service area, or cessation of bona-fide association membership.	
Coverage not based on genetic information (GINA)	PHSA §2753 (74 Fed Reg 51664, 45 CFR §148.180)	The incidental collection of genetic information is permitted, as long as it is not used for underwriting purposes.	

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Non-discrimination of providers	PHSA§2706	Issuers may not discriminate against any provider operating within their scope of practice.	
Approved Clinical Trials [L]	PHSA §2709	Approved clinical trial means phase I, II, III, or IV clinical trial, conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Federal requirements would allow requiring services to be provided by a network provider. Alaska law prohibits a requirement for a covered person to receive services from a particular provider.	
Claims procedures	45 CFR §147.136, 29 CFR §2560.503-1	required to include a description of: o claims procedures; o procedures for obtaining prior approval; o preauthorization procedures; o utilization review procedures; and o applicable time frames. Under Alaska law, urgent utilization review determination must be made within 24 hours. For all other utilization review decisions must be made within 72 hours.	
Internal appeals of adverse benefit determinations - processes, rights and required notices	PHSA §2719 (75 Fed Reg 43330, 76 Fed Reg 37208, 45 CFR §147.136)	Alaska law requires allowance for situations in which a covered person cannot meet an appeal deadline. Appeal determinations must be made within 18 working days, for utilization review appeals. Appeal must be reviewed by one holding the same professional license as the treating provider.	
External review processes rights	PHSA §2719 (75 Fed Reg 43330, 76 Fed Reg 37208, 45 CFR §147.136)	Exhaustion of internal appeal not required if insurer did not meet internal appeal process timelines or for urgent care. Cost must be borne by the insurer. $25 filing fee permitted. Minimum dollar amount to qualify for external appeal not allowed Appeal must be filed within 4 months, decision must be made within 45 days, 72 hours for urgent appeals. The decision of the IRO is binding. HHS Administered external review process offers options: • HHS administered • Insurer contract with multiple IROs	

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Meets Annual limits on Deductibles/cost sharing [L]			
Open Enrollment		Applicable if a small group does not meet contribution or participation requirements	
60%,70%, 80%, or 90% (+/- 2%) minimum AV	ACA §1302	A Catastrophic plan may have a lower AV, certification of AV level must be included in filing.	
Health management	Alaska benchmark plan	Including but not limited to: health education, nicotine dependency programs.	
Neurodevelopmental therapy	Alaska benchmark plan	Up to age 7	
Nutritional therapy	Alaska benchmark plan		
Electronic Visits	Alaska benchmark plan		
Sales tax for medical equipment and supplies	Alaska benchmark plan		
[L] *Applies to large group*			
Additional Requirements for Health Care Insurance Plans Offered on the FFM			
Offer at least a Silver and a Gold plan			
Offer Child-Only Option			
Provides access to directory of providers			
Grace Period	45 CFR 156.270(d)	Three month grace period for enrollees receiving tax credits	
Claim Provisions			
Discharge	AS 21.42.280		
Unfair Claim Practices	AS 21.36.125		

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Claim Payments–UCR	3 AAC 26.110(a)	Must reimburse at 80th percentile or higher. Must provide explanation of the basis of payments in the policy, including any payments for which a covered individual may be responsible and must be included on any schedule or summary of benefits page accompanying the policy.	
Prompt Payment of Claims	AS21.36.495 Bulletin B07-06	Clean claims must be paid within 30 calendar days after receipt by insurer or TPA. Claims other than clean claims must be paid within 15 days of receipt of needed information. Delaying payment to negotiate discounts with provider not valid reason for considering the claim not to be clean	
Recovery of Overpayments	AS 21.36.125(a)(3) Bulletin B07-06	Recovering or correcting payments after the time period allowed for an insured to appeal or submit a claim is a violation of AS 21.36.	
Reducing Payment due to overpayment on previous claim	AS 21.36.125(a)(6) AS21.36.495 Bulletin B07-06		
Provider, External Appeal, Utilization Review Provisions			
Provider Contract Provisions	AS 21.07.010		
Required Contract Provisions	AS 21.07.020		
Choice of Provider	AS 21.07.030 AS 21.54.020	Network only (closed networks) plans are not allowed in Alaska	
Non-Contracted Providers within a Contracted Facility	AS 21.42.130 Bulletin B07-06	Alaska requires insurers to disclose the responsibility of a covered person to pay for charges greater than UCR if the covered person is admitted to a contracted hospital and receives services from a non-contracted provider. Payment must be at in-network rates when non-contracted provider provides services in a contracted facility and the individual does not have a choice as to who performs the services.	
Reasonable Access to Providers	AS 21.36.125 AS 21.42.130	If there is not reasonable access to a network provider (i.e. 50 miles from individual's residence), coverage for a non-network provider must be at the same benefit level (i.e. deductibles, coinsurance and other cost sharing requirements) as a network provider for all covered services.	
Provider Discrimination	AS 21.36.090(d) AS 21.42.363	With respect to a covered service, an insurer may not unfairly discriminate against a listed provider, if the service is within the scope of the provider's occupational license.	

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Direct Payment to Provider	AS 21.54.020		
External Appeals	AS 21.07.050-.070	For plans subject to ACA, these external appeal provisions have been preempted by ACA. Insurers are required to comply with the ACA external appeal requirements.	
Dental Care Coverage	AS 21.42.392	A covered person may bring a civil action against a health care insurer to enforce the person's rights under this section if the covered person has exhausted the administrative appeal process.	

***Not applicable to Fraternal Benefit Societies**

REQUIREMENTS FOR SMALL EMPLOYER HEALTH PLANS

Applicability	AS 21.56.110		
Premium Rates	AS 21.56.120		
Required Offer of Coverage	AS 21.56.140		
Participation requirements	AS 21.56.140(c)	May not consider employees (or dependents) that have existing creditable coverage, including individual health plans, in determining whether the minimum participation level is met.	
	AS 21.56.160		

REQUIREMENTS FOR HOSPITAL OR MEDICAL SERVICE CORPORATIONS

Form Filings	AS 21.87.180	Forms and agreements must be filed for approval.	
Service Agreements	AS 21.87.140 AS 21.87.150	Medical and hospital service agreements must be filed for approval.	
Allowable Medical Services and Benefits	AS 21.87.120		
Allowable Hospital Services and Benefits	AS 21.87.130		
Minimum Service Benefits	AS 21.87.170		
Subscriber Contracts	AS 21.87.160		

REQUIREMENTS FOR FRATERNAL BENEFIT SOCIETIES

Allowable Benefits	AS 21.84.201		
Beneficiaries	AS 21.84.230		
Benefit Contract	AS 21.84.255	Contract must be filed for approval, 60-day review period.	