H.78

Introduced by Representatives Higley of Lowell, Gage of Rutland City, Browning of Arlington, Burditt of West Rutland, Condon of Colchester, Devereux of Mount Holly, Dickinson of St. Albans Town, Hubert of Milton, LaClair of Barre Town, Lewis of Berlin, Morrissey of Bennington, Smith of New Haven, Strong of Albany, and Terenzini of Rutland Town

Referred to Committee on

Date:

Subject: Health; health insurance; Vermont Health Benefit Exchange

Statement of purpose of bill as introduced: This bill proposes to allow insurers to sell individual and small group health benefit plans outside the Vermont Health Benefit Exchange and to allow Vermont residents to purchase health insurance plans that are offered in any other state.

An act relating to making health insurance plans available outside the Exchange and to purchasing health insurance across state lines

It is hereby enacted by the General Assembly of the State of Vermont:

* * * Establishing a Market Outside the Exchange * * *

Sec. 1. 8 V.S.A. § 4080g(a) is amended to read:

(a) Application. Notwithstanding the provisions of section 4080h of this title and of 33 V.S.A. § 1811, on and after January 1, 2014, the provisions of this section shall apply to an individual, small group, or association plan that qualifies as a grandfathered health plan under Section 1251 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152)(Affordable Care Act). In the event that a plan no longer qualifies as a grandfathered health plan under the Affordable Care Act, the provisions of this section shall not apply and the provisions of section 4080h of this title shall apply if the plan is offered outside the Vermont Health Benefit Exchange and the provisions of 33 V.S.A. § 1811 shall govern if the plan is offered through the Vermont Health Benefit Exchange.

Sec. 2. 8 V.S.A. § 4080h is added to read:

§ 4080h. INDIVIDUAL AND SMALL GROUP PLANS

(a) As used in this section:

(1) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as may be further amended.

(2) "Health benefit plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization health benefit plan offered outside the Vermont Health Benefit Exchange and issued to an individual or to an employee of a small employer. The term does not include coverage only for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage in which benefits for health services are secondary or incidental to other insurance benefits as provided under the Affordable Care Act. The term also does not include stand-alone dental or vision benefits, long-term care insurance, specific disease or other limited benefit coverage, Medicare supplemental health benefits, Medicare Advantage plans, and other similar benefits excluded under the Affordable Care Act.

(3) "Registered carrier" means any person, except an insurance agent, broker, appraiser, or adjuster, that issues a health benefit plan and that has a registration in effect with the Commissioner of Financial Regulation as required by this section.

(4) "Small employer" means an entity that employed an average of not more than 100 employees on working days during the preceding calendar year.

The term includes self-employed persons to the extent permitted under the Affordable Care Act.

(b) A health benefit plan shall comply with the requirements of the Affordable Care Act, including providing the essential health benefits package, offering only plans with at least a 60 percent actuarial value, adhering to limitations on deductibles and out-of-pocket expenses, and offering plans with a bronze-, silver-, gold-, or platinum-level actuarial value.

(c) No person may provide a health benefit plan to an individual or small employer unless such person is a registered carrier. The Commissioner of Financial Regulation shall establish, by rule, the minimum financial, marketing, service, and other requirements for registration. Such registration shall be effective upon approval by the Commissioner and shall remain in effect until revoked or suspended by the Commissioner for cause or until withdrawn by the carrier. A carrier may withdraw its registration upon at least six months' prior written notice to the Commissioner. A registration filed with the Commissioner shall be deemed to be approved unless it is disapproved by the Commissioner within 30 days of filing.

(d) A registered carrier shall guarantee acceptance of all individuals, small employers, and employees of small employers, and each dependent of such individuals and employees, for any health benefit plan offered by the carrier.

(e) A registered carrier shall offer a health benefit plan rate structure that at least differentiates between single person, two person, and family rates.

(f)(1) A registered carrier shall use a community rating method acceptable to the Commissioner of Financial Regulation for determining premiums for health benefit plans. Except as provided in subdivision (2) of this subsection, the following risk classification factors are prohibited from use in rating individuals, small employers, or employees of small employers, or the dependents of such individuals or employees:

(A) demographic rating, including age and gender rating;

(B) geographic area rating;

(C) industry rating;

(D) medical underwriting and screening;

(E) experience rating;

(F) tier rating; or

(G) durational rating.

(2)(A) The Commissioner shall, by rule, adopt standards and a process for permitting registered carriers to use one or more risk classifications in their community rating method, provided that the premium charged shall not deviate above or below the community rate filed by the carrier by more than 20 percent and provided further that the Commissioner's rules may not permit

any medical underwriting and screening and shall give due consideration to the need for affordability and accessibility of health insurance.

(B) The Commissioner's rules shall permit a carrier, including a hospital or medical service corporation and a health maintenance organization, to establish rewards, premium discounts, split benefit designs, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by a member or subscriber to programs of health promotion and disease prevention. The Commissioner shall consult with the Commissioner of Health, the Director of the Blueprint for Health, and the Commissioner of Vermont Health Access in the development of health promotion and disease prevention rules that are consistent with the Blueprint for Health. Such rules shall:

(i) limit any reward, discount, rebate, or waiver or modification of cost-sharing amounts to not more than a total of 15 percent of the cost of the premium for the applicable coverage tier, provided that the sum of any rate deviations under subdivision (A) of this subdivision (2) does not exceed 30 percent;

(ii) be designed to promote good health or prevent disease for individuals in the program and not be used as a subterfuge for imposing higher costs on an individual based on a health factor;

(iii) provide that the reward under the program is available to all similarly situated individuals and shall comply with the nondiscrimination provisions of the federal Health Insurance Portability and Accountability Act of 1996; and

(iv) provide a reasonable alternative standard to obtain the reward to any individual for whom it is unreasonably difficult due to a medical condition or other reasonable mitigating circumstance to satisfy the otherwise applicable standard for the discount and disclose in all plan materials that describe the discount program the availability of a reasonable alternative standard.

(C) The Commissioner's rules shall include:

(i) standards and procedures for health promotion and disease prevention programs based on the best scientific, evidence-based medical practices as recommended by the Commissioner of Health;

(ii) standards and procedures for evaluating an individual's adherence to programs of health promotion and disease prevention; and

(iii) any other standards and procedures necessary or desirable to carry out the purposes of this subdivision (2).

(D) The Commissioner may require a registered carrier to identify that percentage of a requested premium increase which is attributed to the following categories: hospital inpatient costs, hospital outpatient costs,

pharmacy costs, primary care, other medical costs, administrative costs, and projected reserves or profit. Reporting of this information shall occur at the time a rate increase is sought and shall be in the manner and form directed by the Commissioner. Such information shall be made available to the public in a manner that is easy to understand.

(g) A registered carrier shall file with the Commissioner an annual certification by a member of the American Academy of Actuaries of the carrier's compliance with this section. The requirements for certification shall be as the Commissioner prescribes by rule.

(h) A registered carrier shall provide, on forms prescribed by the Commissioner, full disclosure to a small employer of all premium rates and any risk classification formulas or factors prior to acceptance of a plan by the small employer.

(i) A registered carrier shall notify an applicant for coverage as an individual of the income thresholds for eligibility for State and federal premium tax credits and cost-sharing subsidies in plans purchased through the Vermont Health Benefit Exchange pursuant to 33 V.S.A. chapter 18, subchapter 1, and the potential that the applicant may be eligible for the credit or subsidy, or both.

(j) A registered carrier shall guarantee the rates on a health benefit plan for a minimum of 12 months.

(k) The Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, shall disapprove any rates filed by any registered carrier, whether initial or revised, for insurance policies unless the anticipated medical loss ratios for the entire period for which rates are computed are at least 80 percent, as required by the Affordable Care Act.

(l) The guaranteed acceptance provision of subsection (d) of this section shall not be construed to limit an employer's discretion in contracting with his or her employees for insurance coverage.

Sec. 3. 8 V.S.A. § 4085 is amended to read:

§ 4085. REBATES AND COMMISSIONS PROHIBITED FOR NONGROUP AND SMALL GROUP POLICIES AND PLANS OFFERED THROUGH THE VERMONT HEALTH BENEFIT EXCHANGE

(a) No insurer doing business in this State and no insurance agent or broker shall offer, promise, allow, give, set off, or pay, directly or indirectly, any rebate of or part of the premium payable on a plan issued pursuant to section 4080g or 4080h of this title or 33 V.S.A. § 1811 or earnings, profits, dividends, or other benefits founded, arising, accruing or to accrue thereon or therefrom, or any special advantage in date of policy or age of issue, or any paid employment or contract for services of any kind or any other valuable consideration or inducement to or for insurance on any risk in this State, now or hereafter to be written, or for or upon any renewal of any such insurance,

which is not specified in the policy contract of insurance, or offer, promise, give, option, sell, purchase any stocks, bonds, securities, or property or any dividends or profits accruing or to accrue thereon, or other thing of value whatsoever as inducement to insurance or in connection therewith, or any renewal thereof, which is not specified in the plan.

(b) No person insured under a plan issued pursuant to section 4080g or 4080h of this title or 33 V.S.A. § 1811 or party or applicant for such plan shall directly or indirectly receive or accept or agree to receive or accept any rebate of premium or of any part thereof, or any favor or advantage, or share in any benefit to accrue under any plan issued pursuant to section 4080g or 4080h of this title or 33 V.S.A. § 1811, or any valuable consideration or inducement, other than such as is specified in the plan.

(c) Nothing in this section shall be construed as prohibiting any insurer from allowing or returning to its participating policyholders dividends, savings, or unused premium deposits; or as prohibiting any insurer from returning or otherwise abating, in full or in part, the premiums of its policyholders out of surplus accumulated from nonparticipating insurance~~,~~; or as prohibiting the taking of a bona fide obligation, with interest not exceeding six percent per annum, in payment of any premium.

(d)(1) No insurer shall pay any commission, fee, or other compensation, directly or indirectly, to a licensed or unlicensed agent, broker, or other

individual in connection with the sale of a health insurance plan issued pursuant to section 4080g or 4080h of this title or 33 V.S.A. § 1811, nor shall an insurer include in an insurance rate for a health insurance plan issued pursuant to section 4080g or 4080h of this title or 33 V.S.A. § 1811 any sums related to services provided by an agent, broker, or other individual. A health insurer may provide to its employees wages, salary, and other employment-related compensation in connection with the sale of health insurance plans, but may not structure any such compensation in a manner that promotes the sale of particular health insurance plans over other plans offered by that insurer.

(2) Nothing in this subsection shall be construed to prohibit the Vermont Health Benefit Exchange established in 33 V.S.A. chapter 18, subchapter 1 from structuring compensation for agents or brokers in the form of an additional commission, fee, or other compensation outside insurance rates or from compensating agents, brokers, or other individuals through the procedures and payment mechanisms established pursuant to 33 V.S.A. § 1805(17).

Sec. 4. 8 V.S.A. § 4085a(a) is amended to read:

(a) As used in this section, "group insurance" means any policy described in section 4079 of this title, except that it shall not include any small group

policy issued pursuant to section ~~4080a or~~ 4080g or 4080h of this title or to 33 V.S.A. § 1811.

Sec. 5. 33 V.S.A. § 1811(b) is amended to read:

(b)~~(1) No person may provide a health benefit plan to an individual unless the plan is offered through the Vermont Health Benefit Exchange.~~

~~(2)~~ To the extent permitted by the U.S. Department of Health and Human Services, a small employer or an employee of a small employer may purchase a health benefit plan through the Exchange website, through navigators, by telephone, or directly from a health insurer under contract with the Vermont Health Benefit Exchange.

~~(3) No person may provide a health benefit plan to an individual or small employer unless the plan complies with the provisions of this subchapter.~~

* * * Purchasing Health Insurance Across State Lines * * *

Sec. 6. 8 V.S.A. chapter 107, subchapter 4A is added to read:

Subchapter 4A. Health Insurance Market Expansion

§ 4094. PURPOSE

The General Assembly seeks to improve the health insurance coverage options available to Vermont residents and to increase competition among health benefit plans by permitting health insurers to issue individual health insurance policies in this State that are currently approved for issuance in any other state.

§ 4094a. DEFINITIONS

As used in this subchapter:

(1) "Commissioner" means the Commissioner of Financial Regulation.

(2) "Foreign health insurer" means a health insurer holding a valid certificate of authority to transact individual health insurance in any other state.

(3) "Health insurer" means a health insurance company, nonprofit hospital or medical service corporation, or managed care organization.

§ 4094b. CERTIFICATION OF FOREIGN HEALTH INSURERS

(a) A foreign health insurer shall not issue a health insurance policy to an individual or otherwise transact business in this State by mail, Internet, or otherwise unless the Commissioner has issued a certification that the foreign health insurer has met the requirements of subsections (b) through (g) of this section. The Commissioner shall issue a certification or deny certification within 30 days of receipt of a request.

(b) A policy, contract, or certificate of individual health insurance offered for sale in this State by a foreign health insurer shall comply with the applicable individual health insurance laws in the state of domicile of the foreign health insurer and shall be actively marketed in that state.

(c) A foreign health insurer shall disclose to prospective enrollees in this State, in a format approved by the Commissioner, how the health plans it offers differ from individual health plans offered by domestic insurers. Health plans'

policies and applications for coverage shall contain a disclosure statement substantially similar to the following:

"This policy is issued by a health insurer doing business in (foreign health insurer's state of domicile) and is governed by the laws and rules of (foreign health insurer's state of domicile). This policy may not be subject to all of the insurance laws and rules of the State of Vermont, including coverage of certain health care services or benefits mandated by Vermont law. Before purchasing this policy, you should carefully review the terms and conditions of coverage under this policy, including any exclusions or limitations of coverage."

(d) A foreign health insurer shall include in all individual policies issued in this State the required standard policy provisions in section 4065 of this title.

(e) A foreign health insurer shall comply with the requirements of section 4089f of this title for the independent external review of health care service decisions.

(f) A foreign health insurer shall comply with the requirements for network adequacy established by the Commissioner by rule.

(g) A foreign health insurer shall comply with the requirements of section 4062 of this title regarding the filing and approval of premium rates and forms.

(h) A foreign health insurer shall designate an agent for receiving service of legal documents or process in accordance with the requirements of chapter 101 of this title.

(i) A foreign health insurer shall provide the Commissioner with access to the foreign health insurer's records in accordance with the requirements of chapter 101 of this title.

§ 4094c. UNFAIR TRADE PRACTICES

The provisions of chapter 129 of this title shall apply to a foreign health insurer permitted to transact individual health insurance pursuant to this subchapter.

§ 4094d. TAXES

A foreign health insurer transacting individual health insurance in this State under this subchapter is subject to the applicable taxes and assessments imposed on insurers transacting individual health insurance in this State pursuant to 32 V.S.A. chapter 211, subchapter 7 and 32 V.S.A. chapter 243.

§ 4094e. COMPLIANCE WITH COURT ORDERS

A foreign health insurer transacting individual health insurance in this State under this subchapter shall comply with lawful orders from courts of competent jurisdiction issued in a voluntary dissolution proceeding or in response to a petition for an injunction by the Commissioner asserting that the foreign health insurer is in a hazardous financial condition.

§ 4094f. EXEMPTION FROM OTHER REQUIREMENTS

Except as expressly provided in this subchapter, the requirements of this title do not apply to a foreign health insurer permitted to transact individual health insurance under this subchapter.

§ 4094g. AGREEMENT WITH INSURANCE REGULATORS IN OTHER STATES

The Commissioner shall enter into a memorandum of understanding or other agreement with the insurance department of the state of domicile of a foreign health insurer permitted to transact individual health insurance in this State under this subchapter with respect to enforcement of the provisions of this subchapter.

Sec. 7. EFFECTIVE DATES

(a) Secs. 1–5 (establishing a market outside the Exchange) shall take effect on July 1, 2015 for coverage beginning on January 1, 2016.

(b) Sec. 6 (purchasing health insurance plans across state lines) shall take effect on July 1, 2015 for coverage beginning on January 1, 2017.

(c) This section shall take effect on passage.