Market outside the Exchange, Consumer health information, Claims Edit Standards

* * * 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.~~

* * * Health Care Price Transparency * * *

Sec. 6. 18 V.S.A. § 9410a is added to read:

§ 9410a. HEALTH CARE QUALITY AND PRICE COMPARISON

(a)(1) The Green Mountain Care Board shall establish a website allowing health care consumers to compare the price of medical care in Vermont by insurance plan and by service or procedure, including office visits, emergency care, radiologic services, and preventive care such as mammography and colonoscopy, as well as comparing the cost of prescription drugs. The website shall also enable consumers to compare quality across providers. The Board may develop and administer the comparison website itself or through a contract with a third party.

(2) The website shall allow a consumer to compare price by selecting a specific service or procedure, insurance plan, and geographic region of the State. Based on the criteria specified, the website shall provide the consumer with an estimate for each provider of the amount the consumer would pay for the service or procedure, an estimate of the amount the insurance would pay, and an estimate of the combined payments.

(3) For consumers without health insurance or who choose to compare costs without selecting an insurance plan, the website shall provide the average cost for the service or procedure in the specified geographic region.

(b) Cost data for the comparison website shall be derived from the unified health care database established in section 9410 of this title.

(c) The Department of Vermont Health Access shall ensure that the website for the Vermont Health Benefit Exchange includes a prominently placed link to the comparison website established by this section to allow health care consumers to make informed decisions about the health care services they receive.

Sec. 7. 18 V.S.A. § 4634 is amended to read:

§ 4634. PRESCRIPTION DRUG PRICE DISCLOSURE

(a) Upon request, a pharmacy shall disclose to any consumer or health care provider the usual and customary retail price of a prescription drug.

(b) With each prescription dispensed, a pharmacy shall disclose to the consumer, in writing, the price of the prescription and any payment toward the price required of the consumer.

(c) Each pharmacy shall display on or near the pharmacy counter and on the pharmacy website, if any, the usual and customary retail price of the 20 most commonly

prescribed prescription medications dispensed at that pharmacy, as well as the average price for each of those prescription medications.

(d) ~~For purposes of~~ As used in this section:

(1) "Price of the prescription" means the amount charged by the pharmacy to the consumer or, if applicable, to the consumer's health benefit plan.

(2) "Usual and customary retail price" means the total price charged to a consumer who does not have prescription drug coverage under a health benefit plan.

~~(d)~~(e) In addition to any other remedy provided by law, the ~~attorney general~~ Attorney General may file an action in ~~superior court~~ Superior Court for a violation of this section. In any such action, the ~~attorney general~~ Attorney General shall have the same authority to investigate and to obtain remedies as if the action were brought under the Consumer Protection Act, 9 V.S.A. chapter 63. Each violation of this section constitutes a separate civil violation for which the ~~attorney general~~ Attorney General may obtain relief.

* * * Claims Edit Standards * * *

Sec. 8. 2013 Acts and Resolves No. 79, Sec. 5b, as amended by 2014 Acts and Resolves No. 144, Sec. 10, is further amended to read:

Sec. 5b. STANDARDIZED HEALTH INSURANCE CLAIMS AND EDITS

(a)(1) As part of moving away from fee-for-service and toward other models of payment for health care services in Vermont, the Green Mountain Care Board, in consultation with the Department of Vermont Health Access, health care providers, health insurers, and other interested stakeholders, shall develop a complete set of standardized edits and payment rules based on ~~Medicare or on another set of standardized edits and payment rules appropriate for~~

~~use in Vermont~~ Medicaid. The Board and the Department shall adopt by rule the standards and payment rules that health care providers, health insurers, and other payers shall use beginning on January 1, 2016 ~~and that Medicaid shall use beginning on January 1, 2017~~.

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* * * Effective Dates * * *

Sec. 9. EFFECTIVE DATES

(a) Secs. 1-5 shall take effect on July 1, 2015 for coverage beginning on January 1, 2016.

(b) Secs. 6–8, and this section shall take effect on passage. The Green Mountain Care Board shall ensure the website required by Sec. 6 is operational on or before October 1, 2015, and pharmacies shall display the information required by Sec. 7 on or before July 1, 2015.