H.524

An act relating to health insurance and the individual mandate

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

* * * Individual Mandate * * *

Sec. 1. 32 V.S.A. chapter 244 is amended to read:

CHAPTER 244. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE

§ 10451. DEFINITIONS

As used in this chapter:

(1) "Applicable individual" means, with respect to any month, an individual other than the following:

(A) an individual ~~with a religious conscience exemption~~ who is:

(i) a member of a recognized religious sect or division thereof that is described in 26 U.S.C. § 1402(g)(1) and is an adherent of established tenets or teachings of that sect or division; or

(ii) a member of a religious sect or division thereof that is not described in 26 U.S.C. § 1402(g)(1), who relies solely on a religious method of healing, and for whom the acceptance of medical health services would be inconsistent with the individual's religious beliefs;

(B) an individual not lawfully present in the United States; or

(C) an individual for any month if for the month the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) ~~"Eligible employer-sponsored plan" shall have the same meaning as in 26 U.S.C. § 5000A, as amended, and as in effect on December 31, 2017, and any related regulations.~~

~~(3)~~ "Minimum essential coverage" ~~shall have~~ has the same meaning as in 26 U.S.C. § 5000A~~, as amended,~~ and any related regulations and federal guidance, as in effect on December 31, 2017~~, and any related regulations~~. The term also includes any other coverage or health insurance product deemed by the Department of Financial Regulation to constitute minimum essential coverage based on the criteria established in federal law and guidance in effect on December 31, 2017.

§ 10452. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE

An applicable individual shall ensure that the individual and any dependent of the individual who is also an applicable individual is covered at all times under minimum essential coverage.

§ 10453. REPORTING AND DOCUMENTATION OF COVERAGE

(a) Each applicable individual who files or is required to file an individual income tax return as a resident of Vermont, either separately or jointly with a spouse, shall indicate on the return, in a manner prescribed by the

Commissioner of Taxes, whether the individual had minimum essential coverage in effect for each of the 12 months of the taxable year for which the return is filed as required by section 10452 of this chapter, whether covered as an individual or as a named beneficiary of a policy covering multiple individuals.

(b) An applicable individual who indicates on a Vermont income tax return that the individual had minimum essential coverage shall provide to the Department of Taxes, upon the Department's request, a copy of the statement of coverage furnished to the individual pursuant to 26 U.S.C. § 6055 by the provider of the individual's minimum essential coverage.

(c) In the event that the requirement for providers of minimum essential coverage to furnish a statement of coverage to individuals pursuant to 26 U.S.C. § 6055 is suspended or eliminated for any taxable year, the Department of Vermont Health Access and each employer, health insurance carrier, and other entity providing minimum essential coverage to residents of this State shall submit a return to the Department of Taxes including the same information as had been provided to the Internal Revenue Service pursuant to 26 U.S.C. § 6055 at such time and in such form as the Commissioner of Taxes shall require.

§ 10454. OUTREACH TO UNINSURED VERMONTERS

The Department of Vermont Health Access, in consultation with the Office of the Health Care Advocate and other interested stakeholders, shall use information obtained from the Department of Taxes regarding Vermont residents without minimum essential coverage to provide targeted outreach to assist those residents in identifying and enrolling in appropriate and affordable health insurance or other health coverage.

Sec. 2. 32 V.S.A. § 3102(e) is amended to read:

(e) The Commissioner may, in his or her discretion and subject to such conditions and requirements as he or she may provide, including any confidentiality requirements of the Internal Revenue Service, disclose a return or return information:

* * *

(20) To the Department of Vermont Health Access for purposes of providing outreach to Vermont residents without minimum essential coverage pursuant to section 10459 of this title.

Sec. 3. [Deleted.]

* * * Health Insurance Consumer Protections; Association Health Plans; Look-Through Doctrine * * *

Sec. 4. 8 V.S.A. § 4080 is amended to read:

§ 4080. REQUIRED POLICY PROVISIONS

(a) No ~~such~~ group insurance policy shall contain any provision relative to notice of claim, proofs of loss, time of payment of claims, or time within which legal action must be brought upon the policy ~~which~~ that, in the opinion of the Commissioner, is less favorable to the persons insured than would be permitted by the provisions set forth in section 4065 of this title. In addition, each such policy shall contain in substance the following provisions:

* * *

(b)(1) Preexisting condition exclusions.

(A) A group insurance policy shall not contain any provision that excludes, restricts, or otherwise limits coverage under the policy for one or more preexisting health conditions.

(B) As used in this subdivision (1), "group insurance policy" shall not include a policy providing coverage for a specified disease or other limited benefit coverage.

(2) Annual limitations on cost sharing.

(A)(i) The annual limitation on cost sharing for self-only coverage for any year shall be the same as the dollar limit established by the federal government for self-only coverage for that year in accordance with 45 C.F.R. § 156.130.

(ii) The annual limitation on cost sharing for other than self-only coverage for any year shall be twice the dollar limit for self-only coverage described in subdivision (i) of this subdivision (A).

(B)(i) In the event that the federal government does not establish an annual limitation on cost sharing for any plan year, the annual limitation on cost sharing for self-only coverage for that year shall be the dollar limit for self-only coverage in the preceding calendar year, increased by any percentage by which the average per capita premium for health insurance coverage in Vermont for the preceding calendar year exceeds the average per capita premium for the year before that.

(ii) The annual limitation on cost-sharing for other than self-only coverage for any year in which the federal government does not establish an annual limitation on cost sharing shall be twice the dollar limit for self-only coverage described in subdivision (i) of this subdivision (B).

(3) Ban on annual and lifetime limits. A group insurance policy shall not establish any annual or lifetime limit on the dollar amount of essential health benefits, as defined in Section 1302(b) of the Patient Protection and

Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and applicable regulations and federal guidance, for any individual insured under the policy, regardless of whether the services are provided in-network or out-of-network.

(4)(A) No cost sharing for preventive services. A group insurance policy shall not impose any co-payment, coinsurance, or deductible requirements for:

(i) preventive services that have an "A" or "B" rating in the current recommendations of the U.S. Preventive Services Task Force;

(ii) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(iii) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings as set forth in comprehensive guidelines supported by the federal Health Resources and Services Administration; and

(iv) with respect to women, to the extent not included in subdivision (i) of this subdivision (4)(A), evidence-informed preventive care and screenings set forth in binding comprehensive health plan coverage

guidelines supported by the federal Health Resources and Services Administration.

(B) Subdivision (A) of this subdivision (4) shall apply to a high-deductible health plan only to the extent that it would not disqualify the plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

Sec. 5. 8 V.S.A. § 4089d is amended to read:

§ 4089d. COVERAGE; DEPENDENT CHILDREN

(a) As used in this section, "health insurance plan" ~~shall mean~~ means any group or individual policy~~,~~; nonprofit hospital or medical service corporation subscriber contract~~,~~; health maintenance organization contract~~,~~; self-insured group plan, to the extent permitted under federal law; and prepaid health insurance plans delivered, issued for delivery, renewed, replaced, or assumed by another insurer, or in any other way continued in force in this State.

(b) A health insurance plan that provides dependent coverage of children shall continue to make that coverage available for an adult child until the child attains 26 years of age, provided that this subsection shall not apply to a plan providing coverage for a specified disease or other limited benefit coverage, and further provided that nothing in this subsection shall require a plan to make coverage available for the child of a child receiving dependent coverage.

(c)(1) A health insurance plan that provides for terminating the coverage of a dependent child upon attainment of the limiting age for dependent children

specified in the policy shall not limit or restrict coverage with respect to an unmarried child who:

~~(1)~~(A) is incapable of self-sustaining employment by reason of a mental or physical disability that has been found to be a disability that qualifies or would qualify the child for benefits using the definitions, standards, and methodology in 20 C.F.R. Part 404, Subpart P;

~~(2)~~(B) became so incapable prior to attainment of the limiting age; and

~~(3)~~(C) is chiefly dependent upon the employee, member, subscriber, or policyholder for support and maintenance.

~~(c)~~(2) Coverage under ~~subsection (b) of this section~~ subdivision (1) of this subsection shall not be denied any person based upon the existence of such a condition; however a health insurance plan may require reasonable periodic proof of a continuing condition no more frequently than once every year.

(d) A health insurance plan that covers dependent children who are full-time college students beyond ~~the age of~~ 18 years of age shall include coverage for a dependent's medically necessary leave of absence from school for a period not to exceed 24 months or the date on which coverage would otherwise end pursuant to the terms and conditions of the policy or coverage, whichever comes first, except that coverage may continue under subsection (b) of this section as appropriate. To establish entitlement to coverage under this subsection, documentation and certification by the student's treating physician

of the medical necessity of a leave of absence shall be submitted to the insurer or, for self-insured plans, the health plan administrator. The health insurance plan may require reasonable periodic proof from the student's treating physician that the leave of absence continues to be medically necessary.

Sec. 6. 33 V.S.A. § 1811 is amended to read:

§ 1811. HEALTH BENEFIT PLANS FOR INDIVIDUALS AND SMALL EMPLOYERS

(a) As used in this section:

(1) "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 through the Vermont Health Benefit Exchange or a reflective silver plan offered in accordance with section 1813 of this title that is issued to an individual or to an employee of a small employer~~ policy, contract, certificate, or agreement offered or issued to an individual or to an employee of a small employer by a registered carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services. The term includes plans offered through the Vermont Health Benefit Exchange and reflective silver plans offered in accordance with section 1813 of this title, but it 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; short-term, limited-duration health 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.

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

(3)~~(A) Until January 1, 2016, "small employer" means an entity which employed an average of not more than 50 employees on working days during the preceding calendar year. The term includes self-employed persons to the extent permitted under the Affordable Care Act. Calculation of the number of employees of a small employer shall not include a part-time employee who works fewer than 30 hours per week or a seasonal worker as defined in 26 U.S.C. § 4980H(c)(2)(B). An employer may continue to participate in the Exchange even if the employer's size grows beyond 50 employees as long as~~

~~the employer continuously makes qualified health benefit plans in the Vermont Health Benefit Exchange available to its employees.~~

~~(B) Beginning on January 1, 2016, "small~~

"Small employer" means an entity ~~which~~ 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. The number of employees shall be calculated using the method set forth in 26 U.S.C. § 4980H(c)(2). An employer may continue to participate in the Exchange even if the employer's size grows beyond 100 employees as long as the employer continuously makes qualified health benefit plans in the Vermont Health Benefit Exchange available to its employees.

(b)(1) To the extent permitted by the U.S. Department of Health and Human Services, an individual may purchase a health benefit plan through the Exchange website, through navigators, by telephone, or directly from a registered carrier under contract with the Vermont Health Benefit Exchange, if the carrier elects to make direct enrollment available. A registered carrier enrolling individuals in health benefit plans directly shall comply with all open enrollment and special enrollment periods applicable to 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 registered carrier under contract with the Vermont Health Benefit Exchange.

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

(c) No person ~~may~~ shall 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 of Financial Regulation and shall remain in effect until revoked or suspended by the Commissioner of Financial Regulation 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 of Financial Regulation. A registration filed with the Commissioner of Financial Regulation shall be deemed to be approved unless it is disapproved by the Commissioner of Financial Regulation within 30 days of filing.

(d)(1) Guaranteed issue. 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, regardless of any outstanding premium amount a

subscriber may owe to the carrier for coverage provided during the previous plan year.

(2) Preexisting condition exclusions. A registered carrier shall not exclude, restrict, or otherwise limit coverage under a health benefit plan for any preexisting health condition.

(3) Annual limitations on cost sharing.

(A)(i) The annual limitation on cost sharing for self-only coverage for any year shall be the same as the dollar limit established by the federal government for self-only coverage for that year in accordance with 45 C.F.R. § 156.130.

(ii) The annual limitation on cost sharing for other than self-only coverage for any year shall be twice the dollar limit for self-only coverage described in subdivision (i) of this subdivision (A).

(B)(i) In the event that the federal government does not establish an annual limitation on cost sharing for any plan year, the annual limitation on cost sharing for self-only coverage for that year shall be the dollar limit for self-only coverage in the preceding calendar year, increased by any percentage by which the average per capita premium for health insurance coverage in Vermont for the preceding calendar year exceeds the average per capita premium for the year before that.

(ii) The annual limitation on cost-sharing for other than self-only coverage for any year in which the federal government does not establish an annual limitation on cost sharing shall be twice the dollar limit for self-only coverage described in subdivision (i) of this subdivision (B).

(4) Ban on annual and lifetime limits. A health benefit plan shall not establish any annual or lifetime limit on the dollar amount of essential health benefits, as defined in Section 1302(b) of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and applicable regulations and federal guidance, for any individual insured under the plan, regardless of whether the services are provided in-network or out-of-network.

(5)(A) No cost sharing for preventive services. A health benefit plan shall not impose any co-payment, coinsurance, or deductible requirements for:

(i) preventive services that have an "A" or "B" rating in the current recommendations of the U.S. Preventive Services Task Force;

(ii) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(iii) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings as set forth in comprehensive

guidelines supported by the federal Health Resources and Services Administration; and

(iv) with respect to women, to the extent not included in subdivision (i) of this subdivision (5)(A), evidence-informed preventive care and screenings set forth in binding comprehensive health plan coverage guidelines supported by the federal Health Resources and Services Administration.

(B) Subdivision (A) of this subdivision (5) shall apply to a high-deductible health plan only to the extent that it would not disqualify the plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

* * *

Sec. 7. 8 V.S.A. § 4079a is amended to read:

§ 4079a. ASSOCIATION HEALTH PLANS

(a) As used in this section, "association health plan" means a policy issued to an association; to a trust; or to one or more trustees of a fund established, created, or maintained for the benefit of the members of one or more associations or a contract or plan issued by an association or trust or by a multiple employer welfare arrangement as defined in the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.

(b) The Commissioner of Financial Regulation shall adopt rules pursuant to 3 V.S.A. chapter 25 regulating association health plans in order to protect

Vermont consumers and promote the stability of Vermont's health insurance markets, to the extent permitted under federal law, including rules regarding licensure, solvency and reserve requirements, and rating requirements. The Department's rules shall ensure that coverage issued to an association is rated based on the size of its underlying member employers and not on the size of the association group, such that individual members are issued individual coverage, employers with 100 or fewer employees are issued small group coverage, and employers with more than 100 employees are issued large group coverage.

(c) The provisions of section 3661 of this title shall apply to association health plans.

Sec. 8. 8 V.S.A. § 4796 is amended to read:

§ 4796. COMMISSIONS; PAYMENT; ACCEPTANCE

* * *

(e) A person licensed under this chapter shall not accept a commission, service fee, brokerage, or other valuable consideration for selling, soliciting, negotiating, or otherwise orchestrating the sale, enrollment, membership, or other connection between a Vermont resident and any arrangement involving the sharing of health-related expenses that is not insurance as defined in section 3301a of this title.

* * * Health Insurance Affordability * * *

Sec. 9. HEALTH INSURANCE AFFORDABILITY; REPORT

(a) The Agency of Human Services, in consultation with interested stakeholders, shall:

(1) develop a strategy for making health insurance affordable for all Vermont residents, including younger Vermonters and Vermonters who are not eligible for financial assistance, which shall include consideration of:

(A) the maximum percentage of an individual's or family's income that the individual or family should be required to pay for health insurance premiums; and

(B) how to link the cost of health insurance to an individual's or family's income so that no individual or family pays more than the maximum percentage identified in subdivision (A) of this subdivision (1);

(2) explore requiring individuals enrolled in the Medicaid program with income between 100 and 138 percent of the federal poverty level to pay the maximum co-payment amounts for their health care services as are allowed under federal law and investing the State funds saved in assisting Vermonters who have lower incomes with obtaining access to affordable health insurance coverage; and

(3) explore the potential for establishing a regional, publicly financed, universal health care program in cooperation with other states, including

identifying the opportunities and challenges that would be presented by partnering with other states to create such a program.

(b) On or before December 1, 2019, the Agency of Human Services shall submit its findings, recommendations, strategies, and estimates to the House Committees on Health Care, on Appropriations, and on Ways and Means; the Senate Committees on Health and Welfare, on Appropriations, and on Finance; the Joint Fiscal Committee; and the Health Reform Oversight Committee. The Agency shall address any need for, and feasibility of, obtaining a federal waiver of certain provisions of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, as permitted under Section 1332 of that Act.

Sec. 10. 18 V.S.A. § 9375(d) is amended to read:

(d) Annually on or before January 15, the Board shall submit a report of its activities for the preceding calendar year to the House Committee on Health Care and the Senate Committee on Health and Welfare.

(1) The report shall include:

* * *

(F) the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premium rates and any recommendations on mechanisms to ensure that appropriations intended to

address the Medicaid cost shift will have the intended result of reducing the premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged;

* * *

Sec. 11. [Deleted.]

* * * Merged Insurance Markets * * *

Sec. 12. MERGED INSURANCE MARKETS; REPORT

(a) The Agency of Human Services, in consultation with interested stakeholders, shall evaluate Vermont's health insurance markets to determine the potential advantages and disadvantages to individuals, small businesses, and large businesses, including the impacts on health insurance premiums and access to health care services, of:

(1) maintaining the current health insurance market structure, in which the individual and small group markets are merged and the large group market is separate;

(2) moving to a fully merged market structure, in which individuals, small groups, and large groups are merged into a single market; and

(3) moving to a fully separated market structure, in which individuals, small groups, and large groups each purchase health insurance in a separate market.

(b) On or before December 1, 2019, the Agency of Human Services shall submit its findings and any recommendations for modifications to the current market structure to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance.

* * * Effective Dates * * *

Sec. 13. EFFECTIVE DATES

(a) Sec. 1 (32 V.S.A. chapter 244) shall take effect on January 1, 2020 and apply to taxable years 2020 and after.

(b) Sec. 2 (32 V.S.A. § 3102(e)) shall take effect on January 1, 2020.

(c) Secs. 4 (8 V.S.A. 4080), 5 (8 V.S.A. § 4089d), and 6 (33 V.S.A. § 1811(d)) shall take effect on January 1, 2020 and shall apply to all individual and group insurance policies and health benefit plans issued on and after January 1, 2020 on such date as a health insurer offers, issues, or renews the policy or plan, but in no event later than January 1, 2021.

(d) Secs. 6 (33 V.S.A. § 1811(a)–(c)) and 7 (8 V.S.A. § 4079a) shall take effect on passage and shall apply to all health benefit plans issued, offered, or renewed for coverage on and after that date, beginning with plans for the 2020 plan year.

(e) Secs. 8 (8 V.S.A. § 4796), 9 (health insurance affordability; report), 10 (18 V.S.A. § 9375(d)), 12 (merged markets; report), and this section shall take effect on passage.