Introduced by Committee on Health Care

Date:

Subject: Health; health insurance; individual mandate; preexisting conditions; association health plans

Statement of purpose of bill as introduced: This bill proposes to <Purpose>

An act relating to <Title>

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:

§ 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 pursuant to section 10456 of this chapter;

(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 any related regulations and federal guidance, as in effect on December 31, 2017~~, and any related regulations~~.

(3) "Family size" with respect to any taxpayer means the number of individuals for whom the taxpayer is allowed a deduction under federal/State law for the taxable year.

(4) "Household income" means, with respect to any taxpayer for any taxable year, an amount equal to the sum of:

(A) the taxpayer's modified adjusted gross income; plus

(B) the aggregated modified adjusted gross incomes of all other individuals who:

(i) were taken into account in determining the taxpayer's family size; and

(ii) were required to file a federal/State tax return for the taxable year.

(5) "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.

(6) "Modified adjusted gross income" means adjusted gross income modified by:

(A) any amount excluded from gross income under 26 U.S.C. § 911; and

(B) any amount of interest received or accrued by the taxpayer during the taxable year that is exempt from taxation.

§ 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. SHARED RESPONSIBILITY REQUIREMENT; PENALTY

(a) If a taxpayer who is an applicable individual, or any applicable individual for whom the taxpayer is liable, fails to meet the requirement to maintain minimum essential coverage set forth in section 10452 of this chapter for one or more months of the taxable year, then, unless the taxpayer qualifies for an exemption under section 10455 or 10456 of this chapter, there shall be imposed on the taxpayer a penalty in an amount determined under section 10454 of this chapter.

(b) Any penalty imposed pursuant to this section for any month shall be included with the taxpayer's return under chapter 151 of this title for the taxable year that includes that month.

(c) If an individual with respect to whom a penalty is imposed by this section for any month:

(1) is a dependent, as defined in 26 U.S.C. § 152, of another taxpayer for the taxable year including that month, the other taxpayer shall be liable for the penalty; or

(2) files a joint return for the taxable year including that month, the individual and his or her spouse shall be jointly liable for the penalty.

(d) In the event that the federal government reinstates a financial penalty for failure to maintain minimum essential coverage under 26 U.S.C. § 5000A, the monthly penalty established by this section shall be suspended for each month for which a federal financial penalty is in effect.

§ 10454. AMOUNT OF PENALTY

(a) In general. The amount of the penalty imposed by this section on any taxpayer for any taxable year for failure to maintain minimum essential coverage during one or more months of that year shall be equal to the lesser of:

(1) the sum of the monthly penalty amounts determined in subsection (b) of this section for the month or months during the taxable year in which one or more such failures occurred; or

(2) an amount equal to the average premium for the applicable family size involved for a bronze-level plan offered through the Vermont Health Benefit Exchange in the calendar year with or within which the taxable year ends.

(b) Monthly payment amounts. For purposes of subdivision (a)(1) of this section, the monthly penalty amount with respect to any taxpayer for any month during which a failure to maintain minimum essential coverage occurred is an amount equal to one-twelfth of the greater of the amounts determined pursuant to subdivisions (1) and (2) of this subsection:

(1) Flat dollar amounts. An amount equal to the lesser of:

(A) the sum of the applicable dollar amounts set forth in subsection (c) of this section for all individuals with respect to whom the failure occurred during that month; or

(B) 300 percent of the applicable dollar amount, determined without regard to subdivision (c)(2) of this section, for the calendar year with or within which the taxable year ends.

(2) Percentage of income. An amount equal to 2.5 percent of the excess of the taxpayer's household income for the taxable year over the amount of gross income specified in 26 U.S.C. § 6012(a)(1) with respect to the taxpayer for the taxable year.

(c) Applicable dollar amount.

(1) The applicable dollar amount shall be $695.00. For each calendar year after 2020, the applicable dollar amount shall be adjusted by a percentage equal to any percentage change in the premium for the second lowest-cost bronze-level plan in the Vermont Health Benefit Exchange.

(2) Notwithstanding the provisions of subdivision (1) of this subsection, if an applicable individual has not attained 18 years of age as of the beginning of a month, the applicable dollar amount with respect to that individual shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

§ 10455. EXEMPTIONS

No penalty shall be imposed pursuant to section 10453 of this chapter with respect to any of the following:

(1) Individuals who cannot afford coverage.

(A) No penalty shall be imposed on any applicable individual for any month if the individual's household income is below 400 percent of the federal poverty level and individual's required contribution, determined on an annual basis, for coverage for the month exceeds 8.3 percent of the individual's household income for the taxable year. For purposes of this subdivision (A), the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

(B)(i) As used in this subdivision (1), "required contribution" means:

(I) in the case of an individual eligible to purchase minimum essential coverage through an eligible employer-sponsored plan, the portion of the annual premium that would be paid by the individual for self-only coverage; and

(II) in the case of an individual eligible only to purchase minimum essential coverage in the individual market, the annual premium for the lowest-cost bronze-level plan available through the Vermont Health Benefit Exchange, reduced by the amount of the federal premium tax credit for which the individual would be eligible under 26 U.S.C. § 36B and the amount of Vermont premium assistance available to the individual under 33 V.S.A. § 1812(a).

(ii) For purposes of subdivision (i)(I) of this subdivision (1)(B), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination under subdivision (A) of this subdivision (1) shall be made by reference to the required contribution of the employee.

(C) For each plan year after 2020, the percentage in subdivision (A) of this subdivision (1) shall be substituted with the percentage that the Commissioner of Financial Regulation, in consultation with the Commissioner of Vermont Health Access and the Chair of the Green Mountain Care Board,

determines reflects the excess of the rate of premium growth for health benefit plans between the preceding calendar year and 2018 over the rate of income growth in this State for the same period.

(2) Taxpayers with lower income. No penalty shall be imposed on any applicable individual for any month during a calendar year if the individual's household income for the most recent taxable year for which the Department of Taxes determines information is available is less than 200 percent of the federal poverty level.

(3) Members of Indian tribes. No penalty shall be imposed on any applicable individual for any month during which the individual is a member of an Indian tribe as defined in 26 U.S.C. § 45A(c)(6).

(4) Months during short coverage gaps.

(A) No penalty shall be imposed for any month the last day of which occurred during a period in which the applicable individual was not covered by minimum essential coverage for a continuous period of three months or less. For purposes of this subdivision (4), the length of a continuous period shall be determined without regard to the calendar years in which the months of the period occurred.

(B) If a continuous period is greater than three months, no exemption shall be provided for any month in the period.

(C) If an applicable individual was not covered by minimum essential coverage for more than one continuous period of three months or less during the same calendar year, the exemption provided by this subdivision (4) shall apply only to the months in the first of such periods.

(D) The Commissioner of Taxes, in consultation with the Commissioner of Financial Regulation, shall adopt rules pursuant to 3 V.S.A. chapter 25 for collecting the penalty imposed by section 10453 of this chapter in cases in which a continuous period includes months in more than one taxable year.

(5) Hardships.

(A) No penalty shall be imposed on any applicable individual who for any month is determined by the Commissioner of Vermont Health Access to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan, including if there is no affordable qualified health plan available through the Vermont Health Benefit Exchange or through the individual's employer to cover the individual, or if the individual meets the requirements for any other hardship exemption established by the Commissioner of Vermont Health Access by rule.

(B) The Commissioner of Vermont Health Access shall adopt rules pursuant to 3 V.S.A. chapter 25 defining the additional circumstances under which an applicable individual shall be deemed to have suffered a hardship

under this subdivision (5) and setting forth the process for obtaining an exemption from the penalty.

(6) Nonresidents. Exemption for Vermont income tax filers who are not Vermont residents?

§ 10456. RELIGIOUS EXEMPTIONS

An individual shall be exempt from the requirement to maintain minimum essential coverage and shall not be subject to a penalty under this chapter for any month if the individual has in effect an exemption from the Commissioner of Vermont Health Access certifying that the individual is:

(1)(A) 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

(B) 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.

(2) As used in this section, "medical health services" does not include routine dental, vision, and hearing services; midwifery services; vaccinations; necessary medical services provided to children; services required by law or by a third party; and such other services as the Commissioner of Vermont Health Access may provide in implementing this chapter.

§ 10457. ADMINISTRATION AND PROCEDURE

(a) Generally.

(1) The penalty provided in section 10453 of this chapter shall be paid upon notice and demand by the Department of Taxes and, except as provided in subdivision (2) of this subsection, shall be assessed and collected in the same manner as an assessable penalty under chapter 151 of this title.

(2) Notwithstanding any provision of law to the contrary:

(A) in the case of any failure by a taxpayer to pay timely any penalty imposed by this chapter, the taxpayer shall not be subject to any criminal prosecution or criminal penalty with respect to the failure; and

(B) the Commissioner of Taxes shall not:

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this chapter; or

(ii) levy on any such property with respect to such failure.

(b) Reporting coverage.

(1) 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:

(A) 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; or

(B) claims an exemption under section 10455 or 10456 of this chapter.

(2) Unless exempted from the penalty pursuant to section 10455 or 10456 of this chapter, a penalty shall be assessed on the return if:

(A) the applicable individual fails to indicate on the return as required by subdivision (1) of this subsection (b) or indicates that he or she did not have minimum essential coverage in effect; or

(B) the applicable individual indicates that he or she had minimum essential coverage in effect but the Commissioner of Financial Regulation, in consultation with the Commissioner of Vermont Health Access and the Chair of the Green Mountain Care Board, determines, based on the information available to him or her, that the requirement to maintain minimum essential coverage was not met.

(c) Collection of penalties. The Department of Taxes shall have all enforcement and collection procedures available under chapter 151 of this title to collect any penalties assessed pursuant to this chapter. All penalties assessed pursuant to this chapter shall be deposited into the State Health Care Resources Fund established by 33 V.S.A. § 1901d.

(1) If in any taxable year, in whole or in part, a taxpayer does not comply with the requirement to maintain minimum essential coverage, the Commissioner shall retain any amount overpaid by the taxpayer for purposes of making payments; provided, however, that the amount retained shall not exceed 50 percent of the premium for the lowest-cost bronze-level qualified health benefit plan offered through the Vermont Health Benefit Exchange during the previous year.

(2) If the amount retained pursuant to subdivision (1) of this subsection is insufficient to satisfy the penalty assessed, the Commissioner shall notify the taxpayer of the balance due on the penalty and any related interest.

(d) Appeals. Any applicable individual shall have the right to appeal a penalty collected pursuant to section 10453 of this chapter or the denial of an exemption pursuant to section 10455 or 10456 of this chapter.

(e) Rulemaking. The Commissioner of Taxes, in consultation with the Department of Financial Regulation, the Department of Vermont Health Access, and the Green Mountain Care Board, shall adopt rules pursuant to 3 V.S.A. chapter 25 as needed to carry out the purposes of this chapter.

§ 10458. 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.

* * * Health Insurance Consumer Protections * * *

Sec. 2. 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, 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; provided, however, that a group insurance policy may exclude, restrict, or otherwise limit coverage for one or more preexisting health conditions for any individual insured who failed to maintain minimum essential coverage as required by 32 V.S.A. chapter 244 for (the prior calendar year/X or more months during the prior calendar year?).

(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 42 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 for the preceding calendar 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 for essential health benefits – which benefits are these?

(4) No cost sharing for preventive services. A group insurance policy shall not impose any co-payment, coinsurance, or deductible requirements for preventive services that have an "A" or "B" rating in the current recommendations of the U.S. Preventive Services Task Force.

Sec. 3. 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 nothing in this section shall require the 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~~ attaining 26 years of age 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~~ attaining 26 years of 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 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.~~

[Repealed.]

Sec. 4. 33 V.S.A. § 1811(d) is amended to read: (combine with 33 V.S.A. § 1811 in Sec. 6?)

(d)(1) 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) A registered carrier shall not exclude, restrict, or otherwise limit coverage under a health benefit plan for any preexisting health condition; provided, however, that a group insurance policy may exclude, restrict, or otherwise limit coverage for one or more preexisting health conditions for any individual insured who failed to maintain minimum essential coverage as

required by 32 V.S.A. chapter 244 for (the prior calendar year/X or more months during the prior calendar year?).

(3)(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 42 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 for the preceding calendar 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 for essential health benefits – which benefits are these?

(5) No cost sharing for preventive services. A group insurance policy shall not impose any co-payment, coinsurance, or deductible requirements for preventive services that have an "A" or "B" rating in the current recommendations of the U.S. Preventive Services Task Force.

Sec. 5. 8 V.S.A. § 4085b is added to read:

§ 4085b. REBATES AND COMMISSIONS PROHIBITED FOR NON-REGULATED HEALTH EXPENSE-SHARING ARRANGEMENTS

No person 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, enrollment, membership, or other connection of a Vermont resident to any arrangement involving the sharing of health-related expenses that is not an insurance product regulated, in whole or in part, by the Department of Financial Regulation.

* * * Association Health Plans; Look-Through Doctrine * * *

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~~

(4) "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.

* * *

* * * Brokers' Fees in the Large Group Market * * *

Sec. 7. 8 V.S.A. § 4085a is amended to read:

§ 4085a. REBATES <u>AND COMMISSIONS</u> PROHIBITED FOR GROUP INSURANCE POLICIES

(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 of this title or to 33 V.S.A. § 1811.

(b) 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 group insurance policy, ~~or on~~

~~any group insurance policy or agent's commission thereon~~ 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~~ that 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~~ that is not specified in the policy.

(c) No insured person under a group insurance policy or party or applicant for group insurance shall directly or indirectly receive or accept or agree to receive or accept any rebate of premium or of any part thereof ~~or all or any part of any agent's or broker's commission thereon~~, or any favor or advantage, or share in any benefit to accrue under any policy of insurance, or any valuable consideration or inducement, other than such as is specified in the policy.

(d) Nothing in this section shall be construed as prohibiting ~~the payment of commission or other compensation to any duly licensed agent or broker; or 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.

(e) ~~An insurer that pays a~~ No insurer shall pay any commission, fee, or other compensation, directly or indirectly, to a licensed or unlicensed agent, broker, or other individual ~~other than a bona fide employee of the insurer in connection with the sale of a group insurance policy shall clearly disclose to the purchaser of such group policy the amount of any such commission, fee, or compensation paid or to be paid~~, nor shall an insurer include in an insurance rate for a group insurance policy 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 shall not structure any such compensation in a manner that promotes the sale of any particular health insurance plan or plans over other plans offered by that insurer.

* * * Health Insurance Affordability * * *

Sec. 8. HEALTH INSURANCE AFFORDABILITY; REPORT

(a)(1) The Agency of Human Services, in consultation with interested stakeholders, shall develop a strategy to address the issue of premium

affordability for Vermonters who are not eligible for premium assistance, including younger Vermonters.

(2) The Agency's strategy shall prioritize market stability and use federal resources, if available. The strategy shall not disrupt coverage options for the rest of the population.

(3) The strategy shall be developed after consideration of the analyses and proposals described in subsections (b) and (c) of this section and shall be implemented not earlier than the 2021 plan year.

(b)(1) The Department of Financial Regulation, in consultation with the Agency of Human Services, shall develop a proposal to reduce premium costs for younger Vermonters, particularly those 26 to 34 years of age, who are most likely to be uninsured.

(2) In developing its proposal, the Department shall consider implementing age rating in qualified health benefit plans, as permitted under 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 (Affordable Care Act).

(3) The Department shall perform an actuarial analysis of 3:1 and 2:1 age curves and shall determine the impact of age rating on qualified health plan benefit premiums, subsidies, and enrollment.

(c)(1) The Agency of Human Services shall develop a proposal for making available to individuals and families in Vermont a lower-cost health insurance product that meets the coverage requirements of a qualified health benefit plan set forth in 33 V.S.A. chapter 18, subchapter 1, except that it may be offered outside the Vermont Health Benefit Exchange.

(2) The Agency shall consider implementing a fee schedule or reference price for provider reimbursement in the health insurance product designed pursuant to this subsection and shall use the Department of Financial Regulation's age analysis developed pursuant to subsection (b) of this section to model reimbursement rates and premium impacts.

(d) On or before November 1, 2019, the Agency of Human Services shall submit its proposed strategy for addressing premium affordability for unsubsidized and younger Vermonters, as informed by the analyses and proposals described in subsections (b) and (c) of this section, 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 proposed strategy shall address any need for, and feasibility of, obtaining a federal waiver of certain provisions of the Affordable Care Act, as permitted under Section 1332 of that Act.

Sec. 9. PREMIUM ASSISTANCE EXPANSION; LEGISLATIVE INTENT

It is the intent of the General Assembly to use the revenue generated from the penalty for failure to maintain minimum essential coverage, as established in Sec. 1 of this act, to expand the premium assistance available pursuant to 33 V.S.A. § 1812 to Vermont residents with income between 400 and 500 percent of the federal poverty level.

* * * Merged Insurance Markets * * *

Sec. 10. MERGED INSURANCE MARKETS; REPORT

(a) The Agency of Human Services, in collaboration with the Green Mountain Care Board and the Department of Financial Regulation, 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. 11. EFFECTIVE DATES

(a) Sec. 1 (32 V.S.A. chapter 244) shall take effect on January 1, 2020.

(b) Secs. 2 (8 V.S.A. 4080), 3 (8 V.S.A. § 4089d), and 4 (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.

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

(d) Secs. 5 (8 V.S.A. § 4085b), 7 (8 V.S.A. § 4085a), 8 (health insurance affordability; report), 9 (merged markets; report), 10 (premium assistance; intent), and this section shall take effect on passage.