

1 **Color Key for Draft 2.3:**

2 **Yellow** – new language since Draft 1.4

3 **Pink** – waiting for Tax Department input

4 **Green** – potential change based on stakeholder input

5 **Blue** – question for Committee

6 Introduced by Committee on Health Care

7 Date:

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

10 Statement of purpose of bill as introduced: This bill proposes to implement
11 Vermont’s individual mandate to maintain health insurance coverage. It would
12 also implement certain health insurance consumer protections, including
13 banning preexisting condition exclusions and requiring coverage for
14 dependents up to 26 years of age. The bill would require looking through the
15 structure of an association to provide health insurance plans based on the size
16 of each underlying employer. It would prohibit paying brokers to enroll
17 Vermont residents in certain health expense-sharing arrangements and would
18 require the Green Mountain Care Board to quantify the impact of the Medicaid
19 cost shift on health insurance premiums. It would also direct the Agency of
20 Human Services to develop strategies for increasing the affordability of health

1 insurance and evaluate options for the future of Vermont’s health insurance
2 markets.

3 An act relating to health insurance and the individual mandate

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

5 * * * Individual Mandate * * *

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

7 CHAPTER 244. REQUIREMENT TO MAINTAIN MINIMUM
8 ESSENTIAL COVERAGE

9 § 10451. DEFINITIONS

10 As used in this chapter:

11 (1) “Applicable individual” means, with respect to any month, an
12 individual other than the following:

13 (A) an individual with a religious ~~conscience~~ exemption pursuant to
14 section 10456 of this chapter;

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

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

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

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

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

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

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

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

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

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

19 (6) “Modified adjusted gross income” means adjusted gross income
20 modified by:

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

2 and

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

5 § 10452. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL
6 COVERAGE

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

10 § 10453. SHARED RESPONSIBILITY REQUIREMENT; PENALTY

11 (a) If a taxpayer who is an applicable individual, or any applicable
12 individual for whom the taxpayer is liable, fails to meet the requirement to
13 maintain minimum essential coverage set forth in section 10452 of this chapter
14 for one or more months of the taxable year, then, unless the taxpayer qualifies
15 for an exemption under section 10455 or 10456 of this chapter, there shall be
16 imposed on the taxpayer a penalty in an amount determined under section
17 10454 of this chapter.

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

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

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

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

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

12 § 10454. AMOUNT OF PENALTY (revised for readability)

13 (a) Generally. The amount of the penalty to be imposed on any taxpayer
14 for any taxable year for failure to maintain minimum essential coverage during
15 one or more months of that year shall be equal to the lesser of:

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

19 (2) an amount equal to the average monthly/annual premium for the
20 applicable family size involved for a bronze-level plan offered through the
21 Vermont Health Benefit Exchange in the calendar year with or within which

1 the taxable year ends, **provided that the applicable family size for any**
2 **month shall not include any family member who maintained minimum**
3 **essential coverage for that month.**

4 (b) Monthly payment amounts. For purposes of subdivision (a)(1) of this
5 section, the monthly penalty amount with respect to any taxpayer for any
6 month during which a failure to maintain minimum essential coverage
7 occurred is an amount equal to one-twelfth of the greater of the flat dollar
8 amounts determined pursuant to subdivision (1) of this section or the
9 percentage of income determined pursuant to subdivision (2) of this
10 subsection.

11 (1) Flat dollar amounts.

12 (A) The flat dollar amount for each month is the sum of the
13 applicable dollar amounts for each individual who failed to maintain minimum
14 essential coverage for that month, up to a maximum per household of three
15 times the applicable dollar amount established in subdivision (B)(i) of this
16 subdivision (1). The reduced dollar amount specified in subdivision (B)(ii) of
17 this subdivision (1) with respect to individuals under 18 years of age shall not
18 be used in calculating the household maximum.

19 (B)(i) The applicable dollar amount for taxable year 2020 shall be
20 \$695.00. For each taxable year after 2020, the applicable dollar amount shall
21 be adjusted by a percentage equal to any percentage change in the premium for

1 the second-lowest cost **of all** bronze-level **health benefit** plans, **whether**
2 offered **through in or outside of** the Vermont Health Benefit Exchange,
3 **rounded to the nearest \$5.00 increment.**

4 (ii) Notwithstanding the provisions of subdivision (i) of this
5 subdivision (b)(1)(B), for an applicable individual who has not attained
6 18 years of age as of the beginning of a month, the applicable dollar amount
7 with respect to that individual for that month shall be equal to one-half of the
8 regular applicable dollar amount.

9 (2) Percentage of income. The percentage of income amount is
10 2.5 percent of the amount of a taxpayer's household income that exceeds the
11 federal income tax filing threshold specified in 26 U.S.C. § 6012(a)(1) for that
12 taxable year.

13 § 10455. EXEMPTIONS

14 No penalty shall be imposed pursuant to section 10453 **or 10454** of this
15 chapter with respect to any of the following:

16 (1) Individuals who cannot afford coverage.

17 (A) No penalty shall be imposed on any applicable individual for any
18 month if the individual's required contribution, determined on an annual basis,
19 for coverage for the month exceeds 8.3 percent of the individual's household
20 income for the taxable year. For purposes of this subdivision (A), the
21 taxpayer's household income shall be increased by any exclusion from gross

1 income for any portion of the required contribution made through a salary
2 reduction arrangement.

3 (B)(i) As used in this subdivision (1), “required contribution” means:

4 (I) in the case of an individual eligible to purchase minimum
5 essential coverage through an eligible employer-sponsored plan, the portion of
6 the annual premium that would be paid by the individual for self-only
7 coverage for the individual’s applicable family size, provided that the
8 applicable family size shall not include any family member who is eligible
9 a medical assistance program under Title XIX (Medicaid) or Title XXI
10 (SCHIP) of the Social Security Act; and

11 (II) in the case of an individual eligible only to purchase
12 minimum essential coverage in the individual market, the annual premium for
13 the lowest-cost bronze-level plan available through the Vermont Health
14 Benefit Exchange for the individual’s applicable family size , reduced by the
15 amount of the federal premium tax credit for which the individual or family
16 would be eligible under 26 U.S.C. § 36B and the amount of Vermont premium
17 assistance available to the individual or family under 33 V.S.A. § 1812(a),
18 provided that the applicable family size shall not include any family
19 member who is eligible for a medical assistance program under Title XIX
20 (Medicaid) or Title XXI (SCHIP) of the Social Security Act.

1 (ii) For purposes of subdivision (i)(I) of this subdivision (1)(B), if
2 an applicable individual is eligible for minimum essential coverage through an
3 employer by reason of a relationship to an employee, the determination under
4 subdivision (A) of this subdivision (1) shall be made by reference to the
5 required contribution of the employee **for coverage for the applicable family**
6 **size, provided that the applicable family size shall not include any family**
7 **member who is eligible for a medical assistance program under Title XIX**
8 **(Medicaid) or Title XXI (SCHIP) of the Social Security Act.**

9 (C) For each plan year after 2020, the percentage in subdivision (A)
10 of this subdivision (1) shall be ~~substituted with the percentage that the~~
11 ~~Commissioner of Financial Regulation, in consultation with the~~
12 ~~Commissioner of Vermont Health Access and the Chair of the Green~~
13 ~~Mountain Care Board, determines reflects the excess of the rate of~~
14 ~~premium growth for health benefit plans between the preceding calendar~~
15 ~~year and 2018 over the rate of income growth in this State for the same~~
16 ~~period~~ **adjusted by a percentage equal to any percentage change in the**
17 **premium for the second-lowest cost of all bronze-level health benefit**
18 **plans, whether offered through in or outside of the Vermont Health**
19 **Benefit Exchange.**

20 (2) Taxpayers with lower income. No penalty shall be imposed on any
21 applicable individual for any month during a calendar year if the individual's

1 household income for the most recent taxable year for which the Department
2 of Taxes determines information is available is less than 200 138 percent of the
3 federal poverty level.

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

7 (4) Months during short coverage gaps.

8 (A) No penalty shall be imposed for any month the last day of which
9 occurred during a period in which the applicable individual was not covered by
10 minimum essential coverage for a continuous period of three months or less.

11 For purposes of this subdivision (4), the length of a continuous period shall be
12 determined without regard to the calendar years in which the months of the
13 period occurred.

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

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

20 (D) The Commissioner of Taxes, in consultation with the
21 Commissioner of Financial Regulation, shall adopt rules pursuant to 3 V.S.A.

1 chapter 25 for collecting the penalty imposed by section 10453 of this chapter
2 in cases in which a continuous period includes months in more than one
3 taxable year.

4 (5) Hardships. ~~(A)~~ No penalty shall be imposed on any applicable
5 individual who for any month is determined by the Commissioner of Vermont
6 Health Access to have suffered a hardship with respect to the capability to
7 obtain **minimum essential** coverage **under a qualified health plan, including**
8 **if there is no affordable qualified health plan available through the**
9 **Vermont Health Benefit Exchange or through the individual's employer**
10 **to cover the individual, or if the individual meets the requirements for any**
11 **other hardship exemption established by the Commissioner of Vermont**
12 **Health Access by rule.** ~~(B)~~ The Commissioner of Vermont Health Access

13 shall adopt rules pursuant to 3 V.S.A. chapter 25 defining the **additional**
14 circumstances under which an applicable individual shall be deemed to have
15 suffered a hardship under this subdivision (5) and setting forth the process for
16 obtaining an exemption from the penalty.

17 **(6) Nonresidents. Exemption for Vermont income tax filers who are not**
18 **Vermont residents**

19 § 10456. RELIGIOUS EXEMPTIONS

20 An individual shall be exempt from the requirement to maintain minimum
21 essential coverage and shall not be subject to a penalty under this chapter for

1 any month if the individual has in effect an exemption from the Commissioner
2 of Vermont Health Access certifying that the individual is:

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

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

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

15 § 10457. ADMINISTRATION AND PROCEDURE

16 (a) Generally.

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

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

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

4 (B) the Commissioner of Taxes shall not:

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

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

8 (b) Reporting coverage.

9 (1) Each applicable individual who files or is required to file an
10 individual income tax return as a resident of Vermont, either separately or
11 jointly with a spouse, shall indicate on the return, in a manner prescribed by
12 the Commissioner of Taxes, whether the individual:

13 (A) had minimum essential coverage in effect for each of the
14 12 months of the taxable year for which the return is filed as required by
15 section 10452 of this chapter, whether covered as an individual or as a named
16 beneficiary of a policy covering multiple individuals; or

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

19 (2) Unless exempted from the penalty pursuant to section 10455 or
20 10456 of this chapter, a penalty shall be assessed on the return if:

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

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

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

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

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

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

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

13 § 10458. DOCUMENTATION OF HEALTH INSURANCE COVERAGE

14 (a) An employer or other sponsor of an employment-sponsored health
15 plan shall:

16 (1) provide, or contract with a service provider or insurance carrier
17 to provide, a written statement, annually on or before January 31, to each
18 subscriber or covered individual residing in this State to whom it provided
19 minimum essential coverage in the previous calendar year; and

20 (2) provide a separate report verifying the statement to the
21 Commissioner of Taxes.

1 **(b) If a Vermont resident is not covered under a Vermont-based**
2 **employment-sponsored health plan, the Department of Vermont Health**
3 **Access and health insurance carriers licensed or otherwise authorized to**
4 **offer health coverage under 8 V.S.A. chapter 101, 123, 125, or 139 shall:**

5 **(1) provide, or contract with a service provider or insurance carrier**
6 **to provide, a written statement, annually on or before January 31, to each**
7 **subscriber or covered individual residing in this State to whom it provided**
8 **minimum essential coverage in the previous calendar year; and**

9 **(2) provide a separate report verifying the statement to the**
10 **Commissioner of Taxes.**

11 **(c)(1) The statements and reports required pursuant to subsections (a)**
12 **and (b) of this section shall identify the carrier or employer, the covered**
13 **individual and covered dependents, the insurance policy or similar**
14 **numbers, and the dates of coverage during the year, and shall provide**
15 **such additional information as the Commissioner of Taxes may require.**

16 **(2) The information provided in accordance with this section shall**
17 **be limited to the minimum amount of personal information necessary,**
18 **shall not include information about diagnoses or treatments, and, except**
19 **for information from the Department of Vermont Health Access, shall not**
20 **include Social Security numbers.**

1 **(3) The Commissioner of Taxes, in consultation with the**
2 **Commissioner of Financial Regulation, may specify the content and**
3 **formats of the statements and reports.**

4 **(4)(A) The information, statements, and reports provided in**
5 **accordance with this section are exempt from public inspection and**
6 **copying under the Public Records Act and shall be kept confidential,**
7 **except that the Commissioner of Taxes may disclose information in the**
8 **statements and reports to the Department of Financial Regulation and the**
9 **Department of Vermont Health Access.**

10 **(B) Notwithstanding 1 V.S.A. § 317(e), the Public Records Act**
11 **exemption created in subdivision (A) of this subdivision (4) shall continue**
12 **in effect and shall not be repealed through operation of 1 V.S.A. § 317(e).**

13 **(d) The rules or other written guidance adopted by the Commissioner**
14 **of Taxes to implement this section may include the allowance of reporting**
15 **alternatives for family or other joint coverage.**

16 **(e) The Commissioner of Taxes shall impose on any health insurance**
17 **carrier or employer or other sponsor of employment-sponsored health**
18 **coverage that fails to provide a written statement to a covered individual**
19 **or to report to the Commissioner in intentional violation of this section an**
20 **administrative penalty of \$50.00 per individual to which the failure**
21 **relates, not to exceed \$50,000.00 per violator per year. The penalties shall**

1 **be assessed and collected in the same manner as an assessable penalty**
2 **under chapter 151 of this title, provided that the Commissioner may, in**
3 **the Commissioner’s discretion, waive all or any portion of such penalties**
4 **for reasonable cause shown.**

5 **(f) Subsections (a)–(e) of this section shall apply only to the extent that**
6 **similar information is not otherwise provided pursuant to 26 U.S.C. §**
7 **6055.**

8 **§ 10459. OUTREACH TO UNINSURED VERMONTERS**

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

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

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21

* * *

(20) To the Department of Vermont Health Access for purposes of outreach to Vermont residents without minimum essential coverage pursuant to chapter 244 of this title.

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

Sec. 3. 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; **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**

1 ~~failed to maintain minimum essential coverage as required by 32 V.S.A.~~
2 ~~chapter 244 for (the prior calendar year/X or more months during the~~
3 ~~prior calendar year?).~~

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

7 (2) Annual limitations on cost sharing.

8 (A)(i) The annual limitation on cost sharing for self-only coverage
9 for any year shall be the same as the dollar limit established by the federal
10 government for self-only coverage for that year in accordance with 42 C.F.R.
11 § 156.130.

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

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

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

5 (3) Ban on annual and lifetime limits. A group insurance policy shall
6 not establish any annual or lifetime limit on the dollar amount of any
7 covered benefit under the policy for any individual insured under the
8 policy, regardless of whether the services are provided in-network or out-
9 of-network.

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

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

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

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

1 **comprehensive guidelines supported by the federal Health Resources and**
2 **Services Administration; and**

3 **(iv) with respect to women, to the extent not included in**
4 **subdivision (A) of this subdivision (4), evidence-informed preventive care**
5 **and screenings set forth in binding comprehensive health plan coverage**
6 **guidelines supported by the federal Health Resources and Services**
7 **Administration.**

8 **(B) Subdivision (A) of this subdivision (4) shall apply to a high-**
9 **deductible health plan only to the extent that it would not disqualify the**
10 **plan from eligibility for a health savings account pursuant to 26 U.S.C. §**
11 **223.**

12 Sec. 4. 8 V.S.A. § 4089d is amended to read:

13 § 4089d. COVERAGE; DEPENDENT CHILDREN

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

20 (b) A health insurance plan that provides dependent coverage of children
21 shall continue to make that coverage available for an adult child until the child

1 attains 26 years of age, **provided that this subsection shall not apply to a**
2 **plan providing coverage for a specified disease or other limited benefit**
3 **coverage, and further** provided that nothing in this **sub**section shall require
4 **the a** plan to make coverage available for the child of a child receiving
5 dependent coverage.

6 (c)(1) A health insurance plan that provides for terminating the coverage of
7 a dependent child upon **attainment of the limiting age for dependent children**
8 **specified in the policy** shall not limit or restrict coverage with respect to an
9 unmarried child who:

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

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

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

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

1 (d) A health insurance plan that covers dependent children who are full-
2 time college students beyond ~~the age of 18 years of age~~ shall include coverage
3 for a dependent's medically necessary leave of absence from school for a
4 period not to exceed 24 months or the date on which coverage would otherwise
5 end pursuant to the terms and conditions of the policy or coverage, whichever
6 comes first, except that coverage may continue under subsection (b) of this
7 section as appropriate. To establish entitlement to coverage under this
8 subsection, documentation and certification by the student's treating physician
9 of the medical necessity of a leave of absence shall be submitted to the insurer
10 or, for self-insured plans, the health plan administrator. The health insurance
11 plan may require reasonable periodic proof from the student's treating
12 physician that the leave of absence continues to be medically necessary.

13 Sec. 5. 33 V.S.A. § 1811 is amended to read:

14 § 1811. HEALTH BENEFIT PLANS FOR INDIVIDUALS AND SMALL
15 EMPLOYERS

16 (a) As used in this section:

17 (1) "Health benefit plan" means a ~~health insurance policy, a nonprofit~~
18 ~~hospital or medical service corporation service contract, or a health~~
19 ~~maintenance organization health benefit plan offered through the Vermont~~
20 ~~Health Benefit Exchange or a reflective silver plan offered in accordance with~~
21 ~~section 1813 of this title that is issued to an individual or to an employee of a~~

1 ~~small employer~~ policy, contract, certificate, or agreement offered or issued to
2 an individual or to an employee of a small employer by a registered carrier to
3 provide, deliver, arrange for, pay for, or reimburse any of the costs of health
4 services. The term includes plans offered through the Vermont Health Benefit
5 Exchange and reflective silver plans offered in accordance with section 1813
6 of this title, but it does not include coverage only for accident or disability
7 income insurance, liability insurance, coverage issued as a supplement to
8 liability insurance, workers’ compensation or similar insurance, automobile
9 medical payment insurance, credit-only insurance, coverage for on-site
10 medical clinics, or other similar insurance coverage in which benefits for
11 health services are secondary or incidental to other insurance benefits as
12 provided under the Affordable Care Act. The term also does not include stand-
13 alone dental or vision benefits; long-term care insurance; short-term, limited-
14 duration health insurance; specific disease or other limited benefit coverage;
15 Medicare supplemental health benefits; Medicare Advantage plans; and other
16 similar benefits excluded under the Affordable Care Act.

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

1 ~~(3)(A) Until January 1, 2016, “small employer” means an entity which~~
2 ~~employed an average of not more than 50 employees on working days during~~
3 ~~the preceding calendar year. The term includes self-employed persons to the~~
4 ~~extent permitted under the Affordable Care Act. Calculation of the number of~~
5 ~~employees of a small employer shall not include a part-time employee who~~
6 ~~works fewer than 30 hours per week or a seasonal worker as defined in~~
7 ~~26 U.S.C. § 4980H(c)(2)(B). An employer may continue to participate in the~~
8 ~~Exchange even if the employer’s size grows beyond 50 employees as long as~~
9 ~~the employer continuously makes qualified health benefit plans in the Vermont~~
10 ~~Health Benefit Exchange available to its employees.~~

11 ~~(B) Beginning on January 1, 2016, “small~~
12 ~~“Small employer” means an entity which that employed an average of~~
13 ~~not more than 100 employees on working days during the preceding calendar~~
14 ~~year. The term includes self-employed persons to the extent permitted under~~
15 ~~the Affordable Care Act. The number of employees shall be calculated using~~
16 ~~the method set forth in 26 U.S.C. § 4980H(c)(2). An employer may continue~~
17 ~~to participate in the Exchange even if the employer’s size grows beyond 100~~
18 ~~employees as long as the employer continuously makes qualified health benefit~~
19 ~~plans in the Vermont Health Benefit Exchange available to its employees.~~

20 (b)(1) To the extent permitted by the U.S. Department of Health and
21 Human Services, an individual may purchase a health benefit plan through the

1 Exchange website, through navigators, by telephone, or directly from a
2 registered carrier under contract with the Vermont Health Benefit Exchange, if
3 the carrier elects to make direct enrollment available. A registered carrier
4 enrolling individuals in health benefit plans directly shall comply with all open
5 enrollment and special enrollment periods applicable to the Vermont Health
6 Benefit Exchange.

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

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

14 (c) No person ~~may~~ shall provide a health benefit plan to an individual or
15 small employer unless such person is a registered carrier. The Commissioner
16 of Financial Regulation shall establish, by rule, the minimum financial,
17 marketing, service, and other requirements for registration. Such registration
18 shall be effective upon approval by the Commissioner of Financial Regulation
19 and shall remain in effect until revoked or suspended by the Commissioner of
20 Financial Regulation for cause or until withdrawn by the carrier. A carrier
21 may withdraw its registration upon at least six months' prior written notice to

1 the Commissioner of Financial Regulation. A registration filed with the
2 Commissioner of Financial Regulation shall be deemed to be approved unless
3 it is disapproved by the Commissioner of Financial Regulation within 30 days
4 of filing.

5 (d)(1) A registered carrier shall guarantee acceptance of all individuals,
6 small employers, and employees of small employers, and each dependent of
7 such individuals and employees, for any health benefit plan offered by the
8 carrier, regardless of any outstanding premium amount a subscriber may owe
9 to the carrier for coverage provided during the previous plan year.

10 (2) A registered carrier shall not exclude, restrict, or otherwise limit
11 coverage under a health benefit plan for any preexisting health condition;
12 ~~provided, however, that a group insurance policy may exclude, restrict, or~~
13 ~~otherwise limit coverage for one or more preexisting health conditions for~~
14 ~~any individual insured who failed to maintain minimum essential coverage~~
15 ~~as required by 32 V.S.A. chapter 244 for (the prior calendar year/X or~~
16 ~~more months during the prior calendar year?).~~

17 (3)(A)(i) The annual limitation on cost sharing for self-only coverage
18 for any year shall be the same as the dollar limit established by the federal
19 government for self-only coverage for that year in accordance with 42 C.F.R.
20 § 156.130.

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

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

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

15 (4) Ban on annual and lifetime limits. A health benefit plan shall not
16 establish any annual or lifetime limit on the dollar amount of any covered
17 benefit under the plan for any individual insured under the plan,
18 regardless of whether the services are provided in-network or out-of-
19 network.

1 (5)(A) No cost sharing for preventive services. A **group insurance**
2 **policy health benefit plan** shall not impose any co-payment, coinsurance, or
3 deductible requirements for:

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

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

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

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

19 **(B) Subdivision (A) of this subdivision (5) shall apply to a high-**
20 **deductible health plan only to the extent that it would not disqualify the**

1 **plan from eligibility for a health savings account pursuant to 26 U.S.C. §**
2 **223.**

3 * * *

4 Sec. 6. **8 V.S.A. § 4079a is amended to read:**

5 § 4079a. ASSOCIATION HEALTH PLANS

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

12 (b) The Commissioner **of Financial Regulation** shall adopt rules pursuant
13 to 3 V.S.A. chapter 25 regulating association health plans in order to protect
14 Vermont consumers and promote the stability of Vermont’s health insurance
15 markets, to the extent permitted under federal law, including rules regarding
16 licensure, solvency and reserve requirements, and rating requirements. **The**
17 **Department’s rules shall ensure that coverage issued to an association is**
18 **rated based on the size of its underlying member employers and not on the**
19 **size of the association group, such that individual members are issued**
20 **individual coverage, employers with 100 or fewer employees are issued**

1 **small group coverage, and employers with 100 or more employees are**
2 **issued large group coverage.**

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

5 **Sec. 7.** 8 V.S.A. § 4085b is added to read:

6 § 4085b. REBATES AND COMMISSIONS PROHIBITED **FOR**

7 **NONREGULATED CERTAIN HEALTH EXPENSE-SHARING**
8 **ARRANGEMENTS**

9 No person shall pay any commission, fee, or other compensation, directly or
10 indirectly, to a licensed or unlicensed agent, broker, or other individual in
11 connection with the sale, enrollment, membership, or other connection of a
12 Vermont resident to any arrangement involving the sharing of health-related
13 expenses that **is not an insurance product regulated, in whole or in part, by**
14 **the Department of Financial Regulation does not comply with the covered**
15 **service and consumer protection provisions of this chapter, including the**
16 **provisions requiring community rating, mental health parity, and**
17 **coverage of preventive services without cost sharing and prohibiting**
18 **preexisting condition exclusions and annual and lifetime benefit limits.**

19 * * * Brokers' Fees in the Large Group Market **(DELETED)** * * *

20 * * * Health Insurance Affordability * * *

1 Sec. 8. HEALTH INSURANCE AFFORDABILITY; REPORT **(revised to**
2 **incorporate language from H.114, H.152, H.225, primary care co-pays)**

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

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

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

11 (B) the impact of cost-sharing requirements, including deductibles,
12 co-payments, and coinsurance, on the total cost of care that is borne by
13 individuals with a chronic illness or condition; and

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

17 (2) explore requiring individuals enrolled in the Medicaid program with
18 income between 100 and 138 percent of the federal poverty level to pay the
19 maximum co-payment amounts for their health care services as are allowed
20 under federal law and investing the State funds saved in increasing the amount

1 of financial assistance available to income-eligible individuals enrolled in
2 health insurance plans offered through the Vermont Health Benefit Exchange;

3 (3) determine the estimated cost and appropriate mechanisms that would
4 be needed to ensure that all Vermont residents have access to primary care
5 services with out-of-pocket exposure that does not exceed \$10.00 per visit
6 without requiring prior satisfaction of any applicable deductible; and

7 (4) explore the potential for establishing a regional Medicare for All or
8 similar universal, publicly financed health care program in cooperation with
9 other states in the Northeast, including identifying the opportunities and
10 challenges that would be presented by partnering with other states to create
11 such a program.

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

1 Sec. 9. 18 V.S.A. § 9375(d) is amended to read: **(NEW)**

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

5 (1) The report shall include:

6 * * *

7 (F) **the impact of the Medicaid and Medicare? cost shift(s?) and**
8 **uncompensated care? on health insurance premium rates and** any
9 recommendations on mechanisms to ensure that appropriations intended to
10 address the Medicaid cost shift will have the intended result of reducing the
11 premiums imposed on commercial insurance premium payers below the
12 amount they otherwise would have been charged;

13 * * *

14 Sec. 10. PREMIUM ASSISTANCE EXPANSION; LEGISLATIVE INTENT

15 It is the intent of the General Assembly to use the revenue generated from
16 the penalty for failure to maintain minimum essential coverage, as established
17 in Sec. 1 of this act, to expand the premium assistance available pursuant to
18 33 V.S.A. § 1812 to Vermont residents with income between 400 and
19 500 percent of the federal poverty level.

20 * * * Merged Insurance Markets * * *

21 Sec. 11. MERGED INSURANCE MARKETS; REPORT

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

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

4 (c) Secs. 3 (8 V.S.A. 4080), 4 (8 V.S.A. § 4089d), and 5 (33 V.S.A.
5 § 1811(d)) shall take effect on January 1, 2020 and shall apply to all individual
6 and group insurance policies and health benefit plans issued on and after
7 January 1, 2020 on such date as a health insurer offers, issues, or renews the
8 policy or plan, but in no event later than January 1, 2021.

9 (d) Secs. 5 (33 V.S.A. § 1811(a)–(c) and 6 (8 V.S.A. § 4079a) shall take
10 effect on passage and shall apply to all health benefit plans issued, offered, or
11 renewed for coverage after that date, beginning with plans for the 2020 plan
12 year.

13 (e) Secs. 7 (8 V.S.A. § 4085b), 8 (health insurance affordability; report), 9
14 (18 V.S.A. § 9375(d)), 10 (premium assistance; intent), 11 (merged markets;
15 report), and this section shall take effect on passage.