H.524, An act relating to health insurance and the individual mandate
Section by section summary of bill *as passed by the House*
Prepared by Jennifer Carbee, Office of Legislative Council
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Sec. 1. Individual mandate (32 V.S.A. chapter 244)

- Exempts from existing requirement to maintain minimum essential coverage (MEC) members of certain religious sects, such as the Amish and Christian Scientists
- Everyone who is required to file a Vermont income tax return would be required to indicate whether they maintained MEC for whole taxable year or claim an exemption
    - Anyone who indicates on their tax return that they had MEC must provide to the Department of Taxes, upon request, a copy of the statement of coverage (Form 1095) provided to them in accordance with federal law
    - If federal government stops requiring statements of coverage, then insurers, employers, and DVHA would provide same coverage information to Department of Taxes
- DVHA would use information from the Department of Taxes about Vermont residents without MEC to provide targeted outreach to help them enroll in appropriate and affordable health coverage

Secs. 2. Conforming change for individual mandate (32 V.S.A. §§ 3102)

- Allows the Department of Taxes to share tax return information with DVHA for purposes of outreach to Vermonters without MEC

Sec. 3. [Deleted]

Sec. 4. Certain consumer protections for group health insurance plans (8 V.S.A. § 4080)

- Prohibits preexisting condition exclusions
- Imposes annual limitations on cost sharing that are the same as those under federal law
- Bans annual and lifetime limits on the dollar amount of essential health benefits
- Prohibits cost sharing for preventive services based on federal recommendations

Sec. 5. Requiring coverage for dependent children up to age 26 (8 V.S.A. § 4089d)

- Requires major medical insurance plans to cover an insured's adult child up to age 26

Sec. 6. Certain consumer protections for individual and small group health insurance plans (33 V.S.A. § 1811)

- Prohibits preexisting condition exclusions
- Imposes annual limitations on cost sharing that are the same as those under federal law
- Bans annual and lifetime limits on the dollar amount of essential health benefits
- Prohibits cost sharing for preventive services based on federal recommendations
- Revises language that currently says Exchange and reflective silver plans provided to an individual or small employer must comply with the laws on Exchange plans and the merged individual and small group market to say that all plans provided to an individual or small employer must comply with those laws. The effect of this change would be to prohibit providing

an association (or other non-QHP/non-reflective silver plan) health plan to an individual or small employer.

Sec. 7. Association health plans; "look-through doctrine" (8 V.S.A. § 4079a)

- Requires Department of Financial Regulation's rules on association health plans to "look through" the association construct to ensure that coverage issued to an association is rated based on size of its underlying member employers. The result would be that individuals would get individual coverage, employers with 100 or fewer employees would get small group coverage, and employers with more than 100 employees would get large group coverage.

Sec. 8. No brokers' fees for non-insurance products (8 V.S.A. § 4796)

- Prohibits insurance brokers from accepting payment for connecting Vermont residents with any arrangement involving the sharing of health-related expenses that does not qualify as insurance.

Sec. 9. Health insurance affordability report

- Requires Agency of Human Services, in consultation with interested stakeholders, to:
    - Develop a strategy for making health insurance more affordable for all Vermonters
    - Explore maximizing co-pays for Medicaid beneficiaries 100-138% FPL and using the State funds saved to help lower-income Vermonters to get affordable health coverage
    - Explore potential for establishing a regional, publicly financed, universal health care program in cooperation with other states
- Report due to committees of jurisdiction by December 1, 2019

Sec. 10. Cost shift information in Green Mountain Care Board annual report (18 V.S.A. § 9375)

- Requires Green Mountain Care Board's annual report to include information about the impact of the Medicaid and Medicare cost shifts and uncompensated care on health insurance premiums

Sec. 11. [Deleted]

Sec. 12. Merged insurance markets report

- Requires Agency of Human Services, in consultation with interested stakeholders, to evaluate Vermont's health insurance markets to determine the pros and cons of:
    - maintaining the existing market structure (merged individual and small group market; separate large group market)
    - moving to a fully merged market structure (individuals, small groups, and large groups all in one market)
    - moving to a fully separated market (individuals, small groups, and large groups each in their own market)
- Report due to committees of jurisdiction by December 1, 2019

Sec. 13. Effective dates