H.524, An act relating to health insurance and the individual mandate
Section by section summary of bill as introduced
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Sec. 1. Individual mandate (32 V.S.A. chapter 244)

- ***Penalty.*** Establishes penalty for failure to maintain minimum essential coverage (MEC).
  - Penalty would apply to everyone without coverage who does not qualify for an exemption
  - Penalty would be suspended if the federal government reinstates a federal individual mandate penalty
- ***Amount of penalty.*** Amount of penalty depends on income:
  - > 250% FPL. For people with household income greater than 250% of the federal poverty level (FPL), penalty amount would be the same as it would have been under the federal penalty in 2017
  - 138–250% FPL. For people with household income between 138% and 250% FPL, the annualized penalty for each adult without coverage would be ½ of the federal applicable dollar amount (applicable dollar amount was $695 for 2016-2018), rounded to nearest $5. Using 2018 amount, this would be $347.50 for the year, which would round up to $350.
    - For children under 18, the penalty would be one-half of the adult penalty, or ¼ of the federal applicable dollar amount, rounded to the nearest $5. Using the 2018 amount, this would be $173.75 for the year, which would be rounded up to $175.
    - The maximum for the household would be 1.5 times the federal applicable dollar amount, rounded to the nearest $5. Using the 2018 amount, this would be $1,042.50 for the year, which would be rounded up to $1,045.
    - To determine the monthly penalty amount, divide the annualized amount by 12.
- ***Exemptions.*** The bill creates exemptions from the penalty for failure to maintain MEC:
  - Individuals who cannot afford coverage – an individual is exempt from the penalty if the individual's required monthly contribution for employer-sponsored coverage or an Exchange plan would exceed 8.3% of the individual's monthly household income
  - Taxpayers with lower income – an individual is exempt from the penalty if the individual's income is less than 138% FPL, which is the Medicaid eligibility threshold
  - Members of Indian tribes – an individual is exempt from the penalty if the individual is a member of certain federally recognized Indian tribes
  - Months during short coverage gaps – an individual is exempt from the penalty if the individual was not covered by MEC for a continuous period of three months or less
    - If continuous period is longer than three months, no exemption is provided for any month in the period
    - If an individual has more than one continuous period of three months or less without coverage, the individual can only claim the exemption for the first such period
  - Hardships – an individual is exempt from the penalty if the Commissioner of the Department of Vermont Health Access (DVHA) determines the individual suffered a hardship with respect to the ability to have coverage for that month
  - Nonresidents – an individual is exempt from the penalty if they did not qualify as a Vermont resident for income tax purposes

  - Religious exemptions – an individual is exempt from the penalty if the individual has an exemption from the DVHA Commissioner certifying that the individual is a member of certain federally recognized religious sects, such as the Amish, or of a religious sect that relies solely on a religious method of healing, such as Christian Scientists
- ***Collection of penalty*.** The Department of Taxes would assess and collect the penalty in the same manner as under Vermont income tax law
- ***Reporting by taxpayers*.** Everyone 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
- ***Refunds to be withheld to pay penalties*.** The Department of Taxes would retain a taxpayer's refund if the taxpayer incurred a penalty; if the refund is insufficient to cover the full amount of the penalty, Commissioner would notify individual of the amount due.
- ***Documentation of coverage.***
  - 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.
- ***Outreach to uninsured Vermonters.*** 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 and 3. Conforming changes for individual mandate (32 V.S.A. §§ 3102 and 3112)

- Sec. 2 allows the Department of Taxes to share tax return information with DVHA for outreach
- Sec. 3 allows the Commissioner of Taxes to apply a taxpayer's refund toward the amount of the taxpayer's penalty for failure to maintain MEC

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 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 (AHS), 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
  - Determine the cost and mechanisms necessary to ensure all Vermonters have access to primary care services for $10 or less out-of-pocket
  - 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. Premium assistance expansion; legislative intent

- Expresses legislative intent to use any revenue from the individual mandate to help lower-income Vermonters get affordable health coverage

Sec. 12. Merged insurance markets report

- Requires AHS, 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